

HEALTH CARE CRISIS IN AMERICA, 1971

**HEARINGS
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON
LABOR AND PUBLIC WELFARE
UNITED STATES SENATE
NINETY-SECOND CONGRESS
FIRST SESSION
ON
EXAMINATION OF THE HEALTH CARE CRISIS IN AMERICA**

APRIL 7, 1971

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HEALTH CARE CRISIS IN AMERICA, 1971

WEDNESDAY, APRIL 7, 1971

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE COMMITTEE
ON LABOR AND PUBLIC WELFARE,
Washington, D.C.

The subcommittee met at 9:40 a.m., in room 4232, New Senate Office Building, Senator Edward M. Kennedy (chairman of the subcommittee) presiding.

Present: Senators Kennedy, Eagleton, and Javits.

Committee staff members present: LeRoy G. Goldman, professional staff member to the subcommittee; and Jay B. Cutler, minority counsel to the subcommittee.

Senator KENNEDY. The subcommittee will come to order.

Today's hearings bring to a close the Washington phase of our inquiry into the health-care crisis which confronts America.

For the past several weeks the subcommittee has received testimony from a wide variety of health providers and consumers. The more we learn the more we are concerned. With each day's hearing the case against this Nation's health industry has grown stronger. The health industry is America's fastest growing failing business. It is a \$70 billion cottage industry which has grown like Topsy. And the bill is being paid by the American people. These hearings have demonstrated that any reasonable hope for reform requires us to change the rules of the game. A patch-up job won't work. And those who do not have a vested interest in the status quo, know it won't work. The hearing record in that regard is compelling.

What are the major elements of the crisis?

1. *Cost*.—Over the last 20 years health costs have increased by a factor of 6, from \$12 to \$70 billion annually. Much of that increased cost is simply inflation, because of the wasteful and irrational way in which America "does its health thing." The American people pay more and more, yet they receive less.

2. *Manpower*.—The health manpower crisis lies at the heart of our difficulty. We say we are 50,000 doctors short. But that statistic oversimplifies the problem. While it is true we don't have enough of some kinds of physicians, we have too many of other kinds. We desperately need more primary care physicians. But we have too many surgeons. And we do too much surgery, some of which is unnecessary. The physician manpower we do have is maldistributed. If you live in the inner city or in a rural area, your chances of having easy access to a doctor are poor. Finally, we need to break open the rigid caste system which entraps all health professionals.

3. Financing mechanisms.—One of the seeming sacred cows of the present system is the fiscal intermediary—the health insurance industry. For more than 30 years we have relied upon them to adequately insure the American people against the economic consequences of illness. By and large they have failed. With high administrative overhead, the need to make a profit, regressive experience rating, bias in favor of hospital care rather than ambulatory care, and little or no effort to reform the health care system, the health insurance industry has become part of the problem.

4. Quality.—Incredibly, we have learned that the quality of care which is rendered is uneven at best. By and large the consumer has no way to know whether he has been properly treated. And this fact affects every segment of our society. A nonsystem which permits, even encourages, the absence of quality control needs to be changed.

Next week the Senate Health Subcommittee begins extensive field hearings on the health crisis. The subcommittee will visit New York, West Virginia, Tennessee, Ohio, Illinois, Iowa, Colorado, and California. Our basic objective will be to permit the consumers of health care to have an opportunity to tell us what they think about health care in America. It's time to open the industry up and let the people in. For too long their voice has not been heard.

Today we have some of their most distinguished public servants here with us. The Legislative Action Committee of the U.S. Conference of Mayors consists of 17 mayors. Mayor John Lindsay of New York is chairman of that committee, and he is here with several of his colleagues to present testimony on the health care crisis from their perspective as elected city officials.

Senator Javits.

Senator JAVITS. I thank the Chair and I will be very brief.

Mr. Chairman, we take great pride in presenting the testimony of Mayor Lindsay to the committee and to the Congress and the country.

New York City shows a unique anomaly. We have, according to Dr. English's testimony before the subcommittee, 278 physicians per hundred thousand people in New York, more than double the national average of 131, and we have 632 hospital beds per 100,000 people, more than one-third above the national average, and yet from my personal experience—I am sure the mayor confirms this—New York's inner city ghettos, slums, and barrios suffer more from deprivation of medical care than perhaps any place in the country. Certainly they are no better—they are among the worst in the United States. It is a similar anomaly in all the other States. It is the health crisis into which, under the fine direction of Senator Kennedy, this committee is looking.

For example, I am sure that the mayor is very well acquainted with this, but the director of the New York Health and Hospitals Corporation testifies that the 346-bed Lincoln Hospital in the South Bronx, originally built as an old age home for runaway slaves, is the principal health facility for 350,000 of the city's neediest citizens, and its tiny emergency room is, and I quote, "the busiest in the entire Nation, a single X-ray machine is held together with adhe-

sive tape." And this in New York with, as I say, a wealth of medical resources and talent.

Is it the sense of outrage that the poor feel over this situation, any wonder?

Now, Mr. Chairman, as I shall be unable to remain throughout the entire hearing I would like to submit a list of questions to the Chair to be put to Mayor Lindsay when the mayors' testimony is over.

I thank the Chair, and I would like to join the Chair in assuring all the mayors that we mean business this time, and that if human power, influence, and persuasion triumph, with your help we will achieve a national health scheme for this country and resolve these tremendous injustices which almost cause the society by its operation to exercise the right of life and death over human beings. Who shall live and who shall die is determined not by nature or Providence, but by the medical system of the country.

Thank you, Mr. Chairman.

Senator KENNEDY. Thank you very much.

We are glad to welcome the distinguished mayors here. Mayor Lindsay of New York comes to testify before the subcommittee with a most impressive record of public service. He began his career by joining the staff of the U.S. Department of Justice as an executive assistant to Attorney General Brownell. In 1958, he was elected to the U.S. Congress and served four terms. In 1965 he was first elected mayor of New York. He is a member of the Citizens Committee for Children for New York City; member of the Council of Foreign Relations; member of the Board of Directors of New York Mission Society.

Mayor Thomas D'Alesandro, in addition to serving the people of Baltimore since January 1967 as mayor, has been President of the City Council of Baltimore during the years 1962-67, and was a member and President of the Board of Supervisors during the years 1958-62. At the age of 37 he also has the distinction of being the youngest mayor in Baltimore's history.

Mayor Tate of Philadelphia served in the Pennsylvania State Legislature from 1940-46; was President of the National League of Cities in 1967, and President of the U.S. Conference of Mayors in 1970. Mayor Tate began serving the city of Philadelphia in 1951 when he became a member of the city council. He became the mayor in 1962, and was reelected in 1963 and 1967.

We have three mayors whose service to their cities and to their community has been well recognized by the people they have represented and whose understanding of the problems of their communities is well indicated from their records. And we express the great appreciation of the members of the subcommittee for their appearance here before us to talk about the health crisis in the cities and the country.

Mayor Lindsay.

Mayor LINDSAY. Thank you very much, Mr. Chairman, Senator Javits.

Let me first invite the president of the United States Conference of Mayors, Mayor Tate, to make a comment.

Mayor TATE. Mr. Chairman, Senator Kennedy, and Senator Javits, we have a routine that we would like to follow, with your permission. It is not a voidable act, it is a serious act.

But I do want to say that following a meeting of much concern in the city of Atlanta at the time we had a conference in December of last year some of the mayors got together and suggested to me, as the presiding officer of the United States Conference of Mayors, that we begin to take action to implement some of the very fine policies that have been enunciated down through the years by both the National League of Cities and the United States Conference of Mayors. At that time we selected a group of 16 mayors stretching from the west coast to the east and from the north to the south, mayors who have been very active in the national scene as well as in their own communities, and mayors who mean business with respect to getting legislation not only in the Congress, but in their respective State legislatures.

We were pleased to have twisted John Lindsay's arm to ask him to act as chairman of this legislative committee, especially in view of his former association with the Federal Congress.

We have on this committee, as I say, 16 members, and three of us are here today—I in my position as the president of the United States Conference of Mayors and past president of the National League of Cities—and we appointed John as the chairman. And we have been moving around the country for the last couple of months visiting various cities to concern ourselves with these respective problems. Joining us on this committee is the very active young mayor of Baltimore, Tom D'Alesandro. In fact, we visited his city only 3 weeks ago.

And so today with Mayor Lindsay leading off, we would like to present our testimony in this very important legislation. And I would like to recognize Mayor Lindsay at this time.

**STATEMENT OF HON. JOHN V. LINDSAY,
MAYOR OF NEW YORK CITY, N.Y.**

Mayor LINDSAY. Thank you very much, Mayor Tate. Mr. Chairman, Senator Javits, we of the legislative action committee would like to express our thanks to you, Mr. Chairman, for your leadership and initiative in bringing about these hearings here in Washington and in the country. We regard it as significantly important to all of our communities, to our cities, and the legislative action committee on behalf of the U.S. Conference of Mayors and all of the mayors of the country speak as one voice in expressing thanks and also the hope that the hearings will be productive and will result in a national program.

My thanks to my own Senator, the senior Senator from New York, Senator Javits, for his constant concern, his constant leadership, and his never-failing presence at all important occasions.

We are in Washington to report on the state of medical services in the cities. And our report is not particularly encouraging. As mayors, all of us live constantly with the very simple but very tragic reality that the wealthiest Nation in the world is not the

healthiest Nation in the world. We see millions of our citizens going without medical care under a medical care system that is neither fair nor adequate. In our cities we struggle to do more at a time when national inflation and national recession are eroding our local fiscal ability to do even as much as we have in the past.

Today, every mayor here will tell you about a health crisis in his own city. I can tell you that in New York, the human price of a failing health system is far too high.

The reported cases of gonorrhea in our city have increased 100 percent in the last 10 years.

Virtually no treatment is received by 300,000 alcoholics.

Infant mortality, though it has been reduced, is still almost 22 per 100,000.

In that figure, as in some of the other figures I have given you, New York City, according to statistics, may have been in better shape than a great many other parts of the country.

And incredibly, last year, there were 2,600 new cases of tuberculosis in our city and 1,400 prior cases were still alive.

Failure on this scale is intolerable—and New York City has refused to accept it. Last year our budget allocated over a billion dollars for health. We set up a new, independent Health and Hospitals Corp. to improve efficiency in the expenditure of over \$600 million in our 18 municipal hospitals—18 municipal hospitals which last year served New Yorkers to the extent of 4.6 million in patient days and 4.75 million ambulatory visits.

Incidentally, one of the municipal hospitals out of the 18 is the Lincoln Hospital that Senator Javits referred to. All is not in despair because the city is in the process of constructing at this moment a brand new very large, we hope very intensive, and new Lincoln Hospital.

We funded a tenfold increase in the number of children tested for lead poisoning just this past year. This is not only the largest lead poisoning program in the country—it is the only one that has managed to reach three-quarters of the children living in dilapidated housing in any city. We are now asking for State aid in mounting a comprehensive attack on alcoholism.

Another statistic that may be of interest to you is, in our municipal city hospitals alone we are now performing abortions at the rate of 35,000 a year.

But the effective resolution of the medical care crisis is impossible at the local level. Even what New York City is able to do now depends heavily on help from other levels of government which have too often let the people of my city down.

The Federal decision to slash the regional medical programs grant is a case in point. Most of the Nation has suffered a 10-percent reduction. The New York metropolitan area was cut back twice as sharply. The damage can be counted in dollars—but it must also be measured in less attention to vital health problems like heart disease, cancer, and stroke. And the city has borne the brunt of other, equally insensitive economies.

The control of syphilis in New York was finally becoming effective when support for federally financed casefinders was cut off.

This was a major reason for the loss in the first 6 months of 1970 of all the gains against syphilis during the previous 3 years. That is our own city budget money. The city has refinanced the case-finders with local tax levy funds. But as our fiscal crisis deepens, our ability to sustain such critical health care programs is increasingly threatened.

Parenthetically, I should note few things are more damaging to morale and to citizen well-being than the cut-off of Federal programs of this nature once established.

The threat looms larger after the meatax cuts made by our State legislature in State aid to the cities last week. Unless it reverses itself, there will have to be stunning, across-the-board reductions in essential city services and city employment. No area, including health, will escape the devastation. In fact, health services have already been hit hard.

By lowering the medicaid eligibility ceiling from a \$5,000 family income to a \$4,500 family income, the State legislature saved the State \$75 million. The price of that "saving" to the city is almost incredible. We will lose, not only \$75 million in State money, but \$150 million in Federal funds that would have been allocated to match the State grant. To maintain the level of medicaid service previously available in New York City would now cost us an additional \$225 million in city resources—out of our city budget, which we don't have.

With a deficit of \$300 million in the current fiscal year, with a \$1 billion deficit projected for the next fiscal year, and with a legal obligation to balance the budget, the city's only present alternative is to not make up the State medicaid cutbacks. It is very difficult to be in that position, almost impossible not to absorb those cuts because what are 18 municipal hospitals and another network of voluntary hospitals that are supported by the city out of its budget, and all of the ambulatory family clinics located in the neighborhood as satellites to those hospitals—what are they to do with families of incomes under \$5,000 when they come in for medical treatment? Are they going to throw them back out on the street? Are they going to demand cash as a prepayment? Hardly possible.

Therefore, what the State has done in this particular case here—perhaps reflecting national indifference in the process—what the state has done is just increase the burdens on city people, taking care of their own situation on the backs of the cities.

Medicaid was a response to a crying need for medical care. Now we are told that we must get along without it. But what are the mayors of New York State to tell the sick who come to the steps of city hall with their problems?

Far too frequently, the real cost of saving money is wasting lives. But the real solution is not simply to restore the cuts. Much more far-reaching reform is essential. Even if we fully fund the present medical care system—even if the system functions at its best potential—millions of Americans would never receive adequate health care. We must redesign and reshape the system itself, if we are ever to reach the goal of a healthy Nation.

Only the Federal Government can financially guarantee access to decent medical care for all citizens. The time is past for prolonged

debate about Federal responsibilities and States' rights and local control. In my city—and in every other city—catastrophic illness is daily destroying the savings and hopes of countless families. In my city—and in every other city—the quality of medical care for the poor is uneven, uncertain, and frequently inhuman. In my city—and in every other city—hard-working middle-income Americans are reluctant to seek care because they worry about the costs their private or group insurance will not cover.

Senator JAVITS. Mr. Mayor, would you mind if I asked, with the Chairman's permission, a question at that point?

Senator KENNEDY. Yes.

Senator JAVITS. I notice you said something about the Federal Government having to take this up. But isn't it a fact, Mr. Mayor, that the plan which we are hearing is a mutual plan for all the people of the United States which will, because it covers all the people actuarially, enable us to do more, to contribute effectively even financially, for those who can't pay their way rather than the present system when it is all in relatively smaller units disbursed in the way of private insurance, Blue Cross, Blue Shield, State, cities, et cetera, and we don't have the weight of the total actuarial experience of the United States and therefore the benefit for those who need it most?

Mayor LINDSAY. True. What you are saying, Senator Javits, is that any comprehensive health care program that underwrites the health of the Nation, the burden has to fall on the private sector as well as the public sector. We agree with that. The public sector cannot escape the portion of underwriting that it must contribute in order to make it possible, because the fact of the matter is that a comprehensive program must be universal. It cannot have such kinds of income cutoffs that you block out a whole section of the economy, which in effect some of the proposals would do with their \$5,000 or \$6,000 cutoffs; and at the same time it has got to set up standards and controls that will federalize the program to get rid of the local inequities that you speak of, and at the same time has got to make sure that there is some control over the skyrocketing costs of health care when it is handled by the private sector.

Right now it is scandalous, with a cost-plus formula built in throughout the whole thing. No wonder the costs are galloping in this area way ahead of just common garden variety inflationary costs which are bad enough.

Senator JAVITS. Mr. Mayor, if the Chair will allow me—it is critical to him and critical to me. The chairman and I each have bills in, and I am also a cosponsor of Senator Kennedy's bill. The point I was trying to make is that the astronomical estimates with which people seek to damn these bills, like Senator Kennedy's and my own, are based upon the theory that this is all money just going out without any consciousness of where it comes from or the economy of scale which you have just described, and all I was trying to emphasize is the mayors are not asking the United States to shoulder a 30 billion dollar burden or something like that, which people say we just can't do it, but we are trying to mutualize and rationalize a system which is today spending 70 billions, except as you

have just said, and as the evidence here has shown, that that money is going out in many cases very wastefully, very inequitably, and at very, very high costs.

Mayor LINDSAY. I would agree with that completely.

Well, just a word about the consequences of the present irrational system under which we are required to perform. The consequences are not good and they don't speak well of what we are doing in this Nation in this area. In 10 other countries, women have a higher life expectancy at birth than in the United States; in 17 other countries men do, too. The death rate among our middle-aged men is higher than anywhere in Western Europe. And we lag behind in other measures of health as well.

So I think that our position, in short, would be that the time is now, and overdue, to take action to insure the health needs of all of our people. The insurance must be national in financing as well as national in scope. No city can afford it. The States are progressively less able to act. The Federal Government, which has the strongest tax base, must guarantee adequate access to medical care in a system based on sound, efficient financing.

But guaranteeing the availability of medical care for every American will not solve the whole problem. We must also reform the structures for delivery and the cost control of health services. Just as structural reform would be meaningless without a Federal decision to finance universal health insurance, so universal health insurance would accomplish very little without structural reform. We must work for both—in the context of a total overhaul of the medical care system.

Reform is essential in the delivery of health services. Across the country, there are not enough doctors. In New York and virtually everywhere else, the doctors we do have are seriously maldistributed.

As Senator Javits pointed out, in my city of New York we perhaps have the highest ratio per thousand of any other city in the country of doctors, and yet we are still in short supply and this maldistribution is very real.

As a result, Americans who live in the inner city have no family physician to call when illness strikes. And the effect of the shortage and maldistribution of doctors is further compounded by our failure to take full advantage of the potential for the employment of paramedical personnel. New York City has introduced a bill in the State legislature that would provide for an expansion in paramedical employment. Its fate, at this time, can best be described as uncertain.

What we need is a system of national incentives to open more medical schools and train more doctors, incentives for doctors to locate in areas of the greatest need, and financial incentives and changes in practice that will permit the maximum use of paramedical workers.

All of this will obviously cost money—but what we are doing today costs human lives and human health. And even the dollar cost of a rational health system can be partially offset by effective price controls on medical services. Such controls are almost nonexistent today.

For example, the rate of inflation in New York City for hospital care is twice as high as the rate of the general price rise in the city. The reimbursement mechanisms for private health insurance have been a major contributor to this problem. They do not—and perhaps realistically cannot—include cost controls that would hold down hospital bills.

The tendency of both private and public programs to pay for hospital care rather than ambulatory or long-term services has also inflated costs. While this does not push the unit price of medical treatment up, it raises the total health bill enormously. Many patients are cared for in the expensive setting of a hospital, when they could be effectively treated in a more economical context—outpatient clinics, ambulatory care centers, and even at home. Other patients often remain in the hospital even after hospitalization is no longer necessary. In New York City, for example, one study indicates that 15 percent of the patients in our short-term hospitals do not belong there. Another study reports that 40 percent of the patients staying more than 21 days in municipal hospitals do not require acute hospital care.

We are moving on a broad scale in New York to attempt to counter cost inflation in New York City's hospitals. Specific measures range from the construction of neighborhood family care centers, which we are doing, to establishing prepaid group practice operating in conjunction with several of our public hospitals, which we are also doing. But once again, the only real remedy is a Federal system that includes nationwide, across the board cost controls. The cities are already close to being priced out of health services. The Federal Government must respond.

In the testimony of my colleagues this morning you will hear stories of a health crisis similar to New York's. The places are different, but the problems are the same. Though we may disagree on specific solutions, I think we can all agree on the basic fact that the medical care system in our cities is in deep trouble. We need help, not just for the sake of our budgets, but for the sake of our people. For America's cities and America's citizens the Federal Government must take the disabling dollar sign out of medical care.

Thank you, Mr. Chairman.

Senator KENNEDY. Thank you very much.

STATEMENT OF HON. THOMAS D'ALE SANDRO, MAYOR OF BALTIMORE, MD.

Mayor D'ALE SANDRO. Senator Kennedy, Senator Javits, Senator Eagleton. The problems that face the cities are the same in the area of providing proper health services, but I would like to draw a comparison between New York and Baltimore.

I listened very attentively as Mayor Lindsay drew reference to the many municipal hospitals that service your people. Well, the exact opposite is true in Baltimore, because with the exception of one municipal hospital all of the medical institutions in Baltimore are privately endowed, privately financed, privately controlled, and privately operated. What is happening in our city is that the gen-

eral practitioners leave the inner city and leave the ghetto areas of our community, and then the people that remain, in order to seek medical help, have to go to the various private hospitals.

Now this is working a tremendous financial hardship on these private hospitals, so much so that three of our biggest hospitals have left the city.

Senator KENNEDY. What do you mean left the city?

Mayor D'ALE SANDRO. They have gone into the county, have actually packed up and gone into suburbia.

Senator JAVITS. Mr. Mayor, would you add, though, that—it is pertinent, if the Chair will allow me—why can't a ghetto resident take a bus or a taxi or get in his car and go to the county or to, let's say, the medical center, wherever he could get care? I know it is so, but tell us why.

Mayor D'ALE SANDRO. Well, you know, Senator Javits, that a tremendous number of ghetto residents—I am talking now of people 40 and over—statistics and studies will show this—don't travel beyond eight blocks of their immediate vicinity. We don't have an adequate transportation system in the big cities to get people to and from hospitals, to and from work, to and from job opportunity. And all that has a pancake effect to the problems that affect people needing health care in the inner city.

Senator JAVITS. And if they did go wouldn't they inundate the existing facilities and they would become slum facilities, too?

Mayor D'ALE SANDRO. That is exactly what is happening. When I drew reference to the fact that three hospitals have left, let me add that two hospitals that have remained are in very serious financial trouble and face bankruptcy, and this is beginning to spread to some of our more wordly reknown medical institutions that are housed in Baltimore.

Mr. Chairman, I am very pleased to have the opportunity to appear before you to testify on the health care crisis of Baltimore City.

Much of what I will have to say will be in terms of statistics. But we must not overlook the fact that health has a deep impact on the lives of every person living in the city. It affects their ability to work. It affects their ability to learn, and play. And most of all, it affects their ability to raise a family.

There is probably no more destructive force in our cities than poor health. In Baltimore we are seriously afflicted by poor health. Our infant mortality in Baltimore City is 25 percent higher than the national average. Twenty percent of the newborn babies under medicaid in Baltimore City require special care because they are either premature or have congenital defects. This is about four times the national average. And these children are often chronically ill the rest of their lives. Although Baltimore City has less than a quarter of the population of the State of Maryland, we have well over 50 percent of the number of people in the State who are eligible for medicaid. One out of every four or five persons in the city of Baltimore is eligible for medicaid and probably one out of every three people in our city should be considered medically indigent. They simply can't afford adequate medical care for themselves and for their families.

I would like to review briefly some of the major problems our city experiences with the delivery of health care services, particularly in the areas of distribution of physicians, the role of teaching hospitals, and the skyrocketing costs of health care. Then I would like to recommend to your committee some measures that might be taken to meet some of our immediate needs.

First let me discuss the distribution, or maldistribution, of physicians in Baltimore City. Although Maryland, and the Baltimore area, has a very high number of active physicians per hundred thousand people compared with most other areas in the country, we have in our city serious shortages of primary care physicians. Fifteen census tracts in the inner city of Baltimore have absolutely no neighborhood primary care physicians and one-half of the people in our city live in areas where there is a serious deficiency in neighborhood physicians.

The geographic maldistribution of physicians is largely accounted for by the dominant role that the large teaching hospitals play in the health care system of our city. Forty percent of all patient care visits in Baltimore occur in four hospitals. Fifty percent or more of the active physicians in our area are in training or teaching. So it is clear that medical care in Baltimore City is closely related to the large medical institutions at the University of Maryland and Johns Hopkins University and the teaching hospitals connected with our medical schools. As you could expect, less than 10 percent of our physicians in Baltimore City are in general practice compared with a national average of about 20 percent. So that when we speak of the medical care of the medically indigent and the health needs of Baltimore City we must deal primarily with the major teaching hospitals in the inner city.

I have with me an article from Public Health Reports written by members of the Baltimore City Health Department about physicians manpower in the Baltimore area which is a much more detailed breakdown of our situation. Senator Kennedy, if the committee would like this article for the record I would be very happy to make it available to you.

Senator KENNEDY. It will be printed at the conclusion of your remarks.

Mayor D'ALE SANDRO. The next major problem which we share with every other city in the country is that of rising costs. Just in the last year alone hospital in-patients costs in Baltimore City have risen 30 percent. The available figures for fiscal year 1971 suggest that these costs are presently rising at an even greater rate than 30 percent yearly. Our own city health expenditures based on our 1972 budget will be up 26.7 percent between 1970 and 1972, whereas we experienced less than a 20-percent rise in costs in the 5-year period 1965-70. The city of Baltimore makes up a \$7 million annual deficit at Baltimore City hospitals. We must also provide 20 percent of the cost of hospital care for medicaid patients as well as clinical services throughout the city which cost over \$8 million yearly.

Let me make some suggestions to you, based on my Baltimore experience, of measures you might take to improve the critical

health situation in our inner cities. I believe, and I fervently hope, that Congress will enact this year major reforms in health care financing and health care delivery. But let me suggest that it will take several years before these reforms bring significant aid to inner city health institutions. We need help now if our city health systems are to survive the next 12 to 24 months.

First, we need immediate fiscal relief for the hospitals which are now serving inner city health needs. Our hospitals in Baltimore City are slowly consuming their capital assets to cover their operating expenses. I am not crying wolf when I tell you in all seriousness that many of our hospitals are going bankrupt. Two of our hospitals will be bankrupt within 24 months unless some unforeseen rescue operation occurs. These hospitals are caught between the rising costs of labor and house staff and changing populations that bring a higher bad debt experience. Johns Hopkins Hospital, for example, provides each year over \$1.5 million worth of free medical care to inner city residents who do not qualify under the medicare or medicaid programs.

Our Baltimore City hospitals are not suffering as severe financial problems as many other large public charity hospitals around the country. One reason for this is that Baltimore City Hospital is not located in the inner city.

Our Baltimore experience indicates that the need for Federal emergency aid for primary health care services in our cities should not be confined to city hospitals, but should be available to the city for distribution to private hospitals or health maintenance organizations that are clearly serving inner city health needs.

A second recommendation I would make to the committee stems from the heavy reliance we have in Baltimore on health services provided by teaching hospitals. Present trends in medicaid cost control, and the issues that the insurance commissioner of Pennsylvania is raising regarding regulation of Blue Cross-Blue Shield and other health insurers, are leading to a much harder look at the way we are subsidizing medical research and medical teaching through hospital fees. This is a healthy trend that I expect will be reinforced in new legislation.

But we must be careful not to destroy the economic foundation of our teaching hospitals. In a city such as Baltimore where one half of the active physicians are full time in our teaching hospitals, a weakening of the hospitals could have disastrous effects on inner city health services. I would urge you to consider providing special subsidies to those teaching hospitals that are actually serving inner city health needs.

I cannot overemphasize the urgency and the immediacy of our health service problems in the city. The cities can no longer afford to redistribute its scarce resources to the medically indigent, or to bear the brunt of the gap between what the medicaid program defines as medical indigency and the reality of medical indigency. We need your help.

Thank you, Mr. Chairman.

(The article referred to from the Public Health Reports follows:)

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Assessing the Balance of Physician Manpower in a Metropolitan Area

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and MARTIN K. GORTEN, M.D.

THE PATTERNS established by persons seeking medical care are determined largely by their socioeconomic level, whether they have private health insurance, are eligible for Medicare or Medicaid, and the availability of medical services. Andersen and Anderson (1) correlate the socioeconomic status of persons with the type of physicians' care purchased, that is, whether that of a specialist, general practitioner, or clinic. Among income groups, the lowest makes the greatest use of clinics and the upper, the greatest use of specialists. Moreover, families in the upper income group report more recent physician examinations and respond more actively to symptoms of illness by seeking a physician's care.

The authors are with the medical care services section, Baltimore (Md.) City Health Department. Mrs. McMillan is a statistician, Mrs. Gornick a public health analyst, and Mr. Rogers a systems analyst; Dr. Gorten is director of the section.

Other members of the Baltimore City Health Department who contributed to the study were Dr. John B. DeHoff, Dr. Henry W. D. Holljes, and Dr. Matthew Tayback (who is now with Maryland State Department of Health), who helped plan and design the study; John B. Russell, who helped design and execute a system for processing the data; Mrs. Edith O. Mullahey, who edited the incoming questionnaires and set up procedures for maintaining the files; and Mrs. Agnes Mitchell, who coded the questionnaires.

In the decade 1960-70, changing economic factors have emerged to increase the demand for medical care services—greater national prosperity, broader participation in private health insurance plans, and inception of the Medicare-Medicaid programs. Data from the National Health Survey (2) illustrate some of the effects of programs for the aged and needy. For the period July 1966-June 1967, persons with family incomes under \$3,000 per year averaged more physician visits than persons with annual incomes in the range \$3,000-\$10,000. The high rate of physician visits among persons with family incomes of less than \$3,000 reflects both the need for medical care among the elderly, who comprise a high proportion of this income group, and the availability of publicly funded care for the needy, care which is not available to persons with incomes above the poverty level.

These factors, combined with an expanding population, have placed considerable strain upon medical care resources, especially manpower. Current experience has shown that funding does not necessarily make services available. What it has demonstrated recently is that organizing and delivering health care services may be more difficult than financing the cost of such services.

An important aspect of the delivery of health services is the manner in which medical care facilities are spatially distributed vis-a-vis the distribution of the population. Hence, much of

planning consists of attempts to optimize these relations (3).

Our study presents an analysis, at the census tract level, of physician manpower in relation to the population, with special emphasis on the analysis of sources of primary care services. We hope that the methods used in our study and its results will be of interest to community-oriented health professionals and planners in metropolitan areas across the nation.

In the summer of 1967, the Baltimore City Health Department initiated a study of physician manpower. Data were needed from physicians in order to determine (*a*) whether the physician was in training or beyond the training stage, (*b*) his type of practice (general or specialty) and—for the physician beyond training—whether he was eligible for an American specialty board or certified by one, (*c*) whether the physician was engaged in caring for patients or in teaching, research, administration, public health, and other professional activities, and (*d*) whether, if he was engaged in caring for patients, he had a private or hospital-based office.

Our objectives included plans for keeping the results current.

Study Area and Population Characteristics

The geographic boundaries set for the study area included Baltimore City and the five adjacent counties of Baltimore, Anne Arundel, Harford, Howard, and Carroll. These subdivisions form the Baltimore Standard Metropolitan Statistical Area (SMSA). Baltimore County nearly surrounds the city, except in the southern area, where Anne Arundel County is adjacent to the city. Harford, Howard, and Carroll Counties are contiguous to Baltimore County.

In preparation for our analysis of physician manpower, we divided the Baltimore SMSA into 24 study districts, using census tract boundaries. The residents of each area had similar demographic characteristics. Baltimore City was apportioned into 15 districts, with an average of 11 census tracts per district: Baltimore County, into four districts; and Anne Arundel, into two districts, Harford, Howard, and Carroll Counties, with relatively small populations, were each considered as a district.

In 1966, the total population of the SMSA was estimated at 1,961,960 persons (4). This figure reflected approximately an 8 percent growth over the 1960 census counts. The 1966 SMSA population was distributed as follows: Baltimore City—46 percent, Baltimore County—29 percent, Anne Arundel County—14 percent, Harford County—5 percent, Carroll County—3 percent, and Howard County—3 percent.

Although the Baltimore SMSA experienced an 8 percent increase in population during the period 1960-66, Baltimore City had a 3 percent decrease. Much of the decrease was due to an exodus of white middle-income families to the nearby suburbs. During the 6 years, there was also a general shift of persons within the city from the inner areas to the outer boundaries. The northeastern area of the city experienced the greatest increase in population while the south-central area showed the largest decrease. During the same period all counties in the SMSA had a large growth in population. The age composition of the Baltimore SMSA in 1966 was similar to that of the nation: about 8 percent (156,000) of the population was 65 years and over and 37 percent (722,000) was 17 years or under. The ratio of whites to nonwhites in the SMSA was 78 to 22, compared with 88 to 12 for the nation. In Baltimore City, the ratio was 59 whites to 41 nonwhites.

Methods of Study

To compile a complete list of licensed medical doctors in the area (doctors of osteopathy were not included in our study), we researched and cross-referenced every known directory containing information on physicians of the Baltimore metropolitan area. Each physician whose name appeared on the list was initially included in the study. The directories included the licensure book of the Maryland State Board of Medical Examiners (triennial), the membership book and monthly reports of the Maryland State Medical and Chirurgical Faculty, monthly reports from the circuit court of Baltimore City, the directories of faculty, medical staff, and administrative personnel of Johns Hopkins Hospital and University Hospital, the student-faculty centrex telephone directory of the University of Maryland in Baltimore, the

State's list of vendors for the Medical Assistance Program (Medicaid), and telephone directories.

Physicians and others knowledgeable in survey techniques prepared a questionnaire designed to gather information to fulfill the objectives of the study. It was to be self-administered and the questions were arranged so that they could be answered with minimal effort and time by the respondent physician. To facilitate coding and tabulating, data processing personnel were consulted in the design of the form (samples of which are available upon request to the senior author). Information about physicians who were beyond training was to be processed in detail. Coding sheets were designed for storing the data from the questionnaire; three Hollerith cards were allotted for each physician.

In September 1967, questionnaires were mailed to approximately 3,400 physicians. A checklist was kept on those that were returned and, in December 1967, followup was begun with telephone calls to the physicians who had not yet responded. A new form was sent if the original questionnaire had been lost or misplaced. Additional followup telephone calls were also made, although a precise record of the number was not kept.

To obtain complete counts of interns, residents, and fellows, we made direct inquiries to all hospitals in the Baltimore SMSA.

Each physician responding to the questionnaire was "mapped" into the appropriate census tract and district according to his professional address. His responses were edited, coded, and keypunched. Stored data included name, year of birth, year physician received his M.D. degree, year of licensure, years in practice, field of practice (generalist or kind of specialty), his eligibility for—or certification by—an American specialty board, the percentage of his effort expended in patient care, research, teaching, administration, and so forth, professional address or addresses, hospital affiliations and privileges, and membership in national professional organizations. In addition, and of particular value to the medical care services section, the physician's vendor number was included if he participated in Medicaid.

Procedures were instituted to keep the files

current. Changes in professional address, as well as additions and deletions to the files, are made by checking new telephone directories and scanning reports of the medical societies, the Maryland Board of Examiners, the Circuit Court of Baltimore City, and the bureau of biostatistics of the Baltimore City Health Department, and obituaries in newspapers.

For our study, an active physician was defined as a physician in training or beyond the training stage who was practicing—that is, engaged in patient care—or who was nonpracticing—that is, engaged in administration, public health, research, teaching, and so forth. The first tabulations for the Baltimore SMSA were made in May 1968. Of the physicians originally surveyed who were in training and beyond the training stage, the number lost to survey and the number remaining were as follows:

<i>Physicians originally surveyed</i>	<i>Number</i>
Lost to survey.....	659
No response to questionnaire.....	175
Moved, retired, deceased, or former house of officers who left area.....	425
In Armed Forces.....	59
Remaining in survey.....	4,297

Results

Of the 4,297 known active physicians in the Baltimore SMSA in May 1968, a total of 2,571 were beyond the training stage and 1,726 were in hospital training. Physicians in training comprised 40 percent of all the active physicians in the Baltimore SMSA. Physicians beyond the training stage comprised 60 percent. The ratio of practicing physicians to nonpracticing physicians and physicians in government service was more than 4 to 1. A practicing physician was defined as one beyond the training stage who was expending some or all of his efforts in caring for patients. Table 1 shows the distribution of physicians in the SMSA according to whether they were in training or beyond. Nine of 10 who were in training and seven of 10 who were practicing had offices in Baltimore City.

Physicians giving primary care. Almost two-thirds (62 percent) of the practicing physicians in the SMSA were primary care physicians. This group includes general practitioners, general surgeons, specialists in internal medicine, pediatricians, and obstetrician-

gynecologists. Specialists in internal medicine comprised the largest proportion of the group, accounting for 18 percent of all practicing physicians in the SMSA. General practitioners and general surgeons each comprised 13 percent of the practicing physicians, obstetrician-gynecologists 11 percent, and pediatricians 7 percent (table 2). Baltimore City had 46 percent of the SMSA population and 67 percent of the primary care physicians.

Physicians in other specialties. The remaining 38 percent of practicing physicians reported 27 other specialties, distributed over 11 broad categories. Among these 11 categories, psychiatry (including child psychiatry) accounted for the greatest proportion of practicing physicians—10 percent (table 2). Baltimore City and Baltimore County combined had 92 percent of the specialists not in the primary care category.

Location of physicians' offices. Eighty-eight

Table 1. Distribution of active physicians, in training and beyond, Baltimore SMSA, May 1968

Area	Active physicians (100 percent)	In training (40 percent)			Beyond training (60 percent)		
		Interns, residents (31 percent)	Fellows (9 percent)	Total	Practicing (49 percent)	Nonpracticing (11 percent)	Total
Baltimore SMSA-----	4,207	1,320	406	1,726	2,085	1,486	2,571
Baltimore City-----	3,450	1,178	381	1,559	1,457	1,434	1,891
Baltimore County-----	584	135	25	160	390	34	424
Anne Arundel County-----	132	4	0	4	120	8	128
Harford County-----	57	3	0	3	53	1	54
Carroll County-----	55	0	0	0	49	6	55
Howard County-----	19	0	0	0	16	3	19

¹ Includes 50 physicians in government installations.

Table 2. Distribution of practicing physicians, by type of practice, Baltimore SMSA, May 1968

Type of practice	Baltimore SMSA		Number in Baltimore City	Number in counties				
	Percent	Number		Baltimore	Anne Arundel	Harford	Carroll	Howard
Total-----	100	2,085	1,457	300	120	53	49	16
Primary care-----	62	1,320	880	267	81	14	35	13
General practice-----	13	281	143	74	21	18	18	7
General surgery-----	13	278	218	32	15	7	6	0
Internal medicine-----	18	380	275	66	19	10	6	4
Pediatrics-----	7	148	74	59	11	2	2	0
Obstetrics-gynecology-----	11	233	170	36	15	7	3	2
Other specialties ¹ -----	38	765	577	123	39	9	14	3
Psychiatry-----	10	198	134	41	11	2	8	2
Internal medicine subspecialties-----	4	81	68	7	3	1	2	0
Radiology-----	3	68	59	3	4	2	0	0
Anesthesiology-----	4	82	38	36	4	2	2	0
Pathology-----	2	42	30	7	3	1	1	0
Ophthalmology-----	3	65	52	11	2	0	0	0
Otolaryngology-----	3	53	42	8	3	0	0	0
Orthopedic surgery-----	3	53	47	2	4	0	0	0
Neurosurgery-----	1	22	21	0	1	0	0	0
Urology-----	2	33	30	1	2	0	0	0
Other-----	3	68	56	7	2	1	1	1

¹ Psychiatry includes child psychiatry; the subspecialties of internal medicine are dermatology, allergy, cardiovascular disease, gastroenterology, neurology, and pulmonary diseases; radiology includes diagnostic and therapeutic; pathology includes forensic; "other"

includes colon and rectal surgery, plastic surgery, thoracic surgery, administrative medicine, aviation medicine, occupational medicine, general preventive medicine, physical medicine and rehabilitation, public health, and other nonrecognized specialties.

Table 3. Distribution of physicians, by type of practice, with percentage having private offices, Baltimore SMSA, May 1968

Type of practice	Number	Percentage with private offices
Total number	2,085	88
Primary care	1,320	93
General practice	281	98
General surgery	278	93
Internal medicine	380	88
Pediatrics	148	95
Obstetrics-gynecology	233	95
Other specialties ¹	765	80
Psychiatry	198	76
Internal medicine subspecialties	81	80
Radiology	68	54
Anesthesiology	83	84
Pathology	42	36
Ophthalmology	65	91
Otolaryngology	53	94
Orthopedic surgery	53	94
Neurosurgery	22	82
Urology	33	94
Other	67	84

¹ See footnote, table 2.

percent of the 2,085 practicing physicians in the Baltimore SMSA had private offices. In the primary care group, 98 percent of the general practitioners had private offices. Among the other specialty groups, the range was from 94 percent of the otolaryngologists, orthopedic surgeons, and urologists to 36 percent of the pathologists (table 3). Other specialty groups had high proportions of physicians with hospital-based offices; aside from the pathologists, 46 percent of the radiologists and 24 percent of the psychiatrists had hospital-based offices.

The distribution of physicians in Baltimore City by kind of office site was similar to that for the SMSA.

Physician's age and type of practice. The 2,085 practicing physicians in the SMSA were distributed by age and type of practice to three major categories—(a) general practice, (b) specialties in internal medicine, general surgery, pediatrics, and obstetrics-gynecology, and (c) all other specialties (table 4). Two hundred eighty-one (13 percent) of the 2,085 practicing physicians were general practitioners; the remaining 87 percent had a specialty prac-

tice. Six hundred eighty-nine (33 percent) of the 2,085 practicing physicians were in the age group 36–45 years; only 164 (8 percent) were 35 years or younger, and 238 (11 percent) were over 65.

Figure 1 illustrates how small the proportion of general practitioners is among the younger age groups. In the age group 25–35 years, only 9 percent of the physicians are general practitioners whereas, in the age group over 65 years, 25 percent are general practitioners. The other primary care physicians account for nearly the same proportion (50–52 percent) in all age groups except the one over 65 years, in which 42 percent are primary care specialists.

Table 4 also shows the proportions of physicians who were certified by an American specialty board or eligible for such certification. Of those in a specialty type practice, 42 percent were certified and 39 percent were either board eligible or had memberships in recognized national specialty organizations. Figure 2 il-

Figure 1. Percentage distribution of practicing physicians, by type of practice, Baltimore SMSA, May 1968

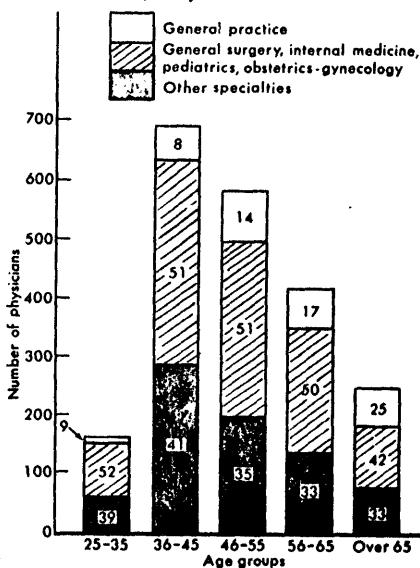


Table 4. Distribution of practicing physicians, by age group, with and board certified, Baltimore

Type of practice	All ages			25-35 years			36-45 years			46-55 years		
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
	C	E	C	E	C	E	C	E	C	E	C	E
Total.....	2,085	39	34	164	16	46	689	44	35	582	35	31
General.....	281	21	4	15	20	0	53	34	2	85	23	2
All other types.....	1,804	42	39	149	15	51	636	45	38	497	49	36
Primary care specialties.....	1,039	37	43	85	18	47	350	41	43	207	40	42
General surgery.....	278	36	47	15	27	13	87	33	40	90	42	49
Internal medicine.....	380	29	48	33	9	61	128	29	51	102	33	46
Pediatrics.....	148	49	28	21	29	48	50	76	12	39	51	29
Obstetrics-gynecology.....	233	42	40	16	13	50	85	45	41	66	45	36
Other specialties ¹	765	49	33	64	13	56	286	50	32	200	64	26
Psychiatry.....	198	40	44	18	0	67	77	34	46	57	60	30
Internal medicine subspecialties.....	81	36	43	3	0	100	25	44	36	19	58	26
Radiology.....	68	60	16	8	38	25	27	67	7	18	61	22
Anesthesiology.....	83	43	46	4	25	50	46	44	46	25	52	40
Pathology.....	42	69	12	6	0	50	20	70	5	9	89	11
Ophthalmology.....	65	57	28	12	25	42	15	73	27	14	79	14
Otolaryngology.....	53	62	23	2	50	50	12	67	25	15	80	13
Orthopedic surgery.....	53	76	19	2	0	50	24	67	25	14	92	7
Neurosurgery.....	22	73	14	3	0	67	11	73	9	6	100	0
Urology.....	33	42	33	4	0	75	14	50	21	7	43	29
Other.....	67	28	35	2	0	100	15	33	40	16	31	50

C—Percentage of physicians in a specialty who were certified by an American specialty board or general practitioners with membership in American Academy of General Practice.

E—Percentage of physicians eligible for board certification or with membership in a recognized national specialty organization.

Illustrates what percentage of physicians were eligible or certified, by age group. The proportion that was board certified was highest among physicians in the age group 46-55 years (49 percent), and the proportion that was eligible was highest in the age group 25-35 years (51 percent).

Specialty practices with high proportions of diplomates (more than 40 percent) included: orthopedic surgery—76 percent, neurosurgery—73 percent, pathology—69 percent, otolaryngology—62 percent, radiology—60 percent, ophthalmology—57 percent, pediatrics—49 percent, anesthesiology—43 percent, obstetrics-gynecology—42 percent, and urology—42 percent (table 4).

Physician-population ratios. To gain insight into the availability of physicians' services, the practicing physicians were distributed by census tracts and study districts. Rates for the number of practicing physicians per 100,000 population were computed by districts and by whether the physician had a private or a hospital office.

Table 5 shows that the number of practicing

physicians in the Baltimore SMSA was 2,085 and that the calculated rate per 100,000 population was 106.3. The rate for physicians in the primary care group was 67.3, of whom pediatricians had the lowest rate—7.5—and specialists in internal medicine, the highest—19.4. All other specialists as a group had a rate of 39.0, neurosurgeons having the lowest rate—1.1—and psychiatrists, the highest—10.1.

There were 2,212 other active physicians in the Baltimore SMSA. The number of interns and residents was 1,320, or 67.3 per 100,000. There were also 406 physicians in the SMSA with fellowships, a rate of 20.7. Fifty additional practicing physicians served in government installations not separately identified and in other facilities, giving a rate of 2.5. Nonpracticing licensed physicians numbered 436, or a rate of 22.2.

There were 93.8 practicing physicians with private offices per 100,000 SMSA population and 12.4 with offices in hospitals.

As expected, Baltimore City had the most favorable rates of practicing physicians in the

**percentages board eligible
SMSA, May 1968**

Number	50-65 years		Over 65 years		
	Percent		Number	Percent	
	C	E		C	E
412	34	36	238	34	27
68	16	7	60	12	3
344	38	42	178	41	31
200	33	48	101	38	33
58	31	57	28	43	29
74	32	49	43	33	33
24	22	48	14	36	21
50	41	35	16	44	50
138	44	33	77	45	36
34	44	56	12	43	33
24	22	52	10	20	50
13	54	23	2	100	0
5	40	40	3	0	100
5	100	0	2	100	0
11	64	9	13	39	46
14	42	38	10	60	10
4	50	50	9	100	0
2	100	0	0	0	0
4	100	0	4	25	75
22	26	9	12	25	50

¹ See footnote, table 2.

NOTE: The percentages are based on number of physicians in the age group.

Baltimore SMSA. The number of practicing physicians of all kinds per 100,000 population was 160.0 (table 6). The primary care group had a rate of 96.7. The rates for pediatrics (8.1) and for internal medicine (30.2) were more favorable in the city than for the SMSA as a whole, but these specialties held the same rank position in both, that is, the rate for pediatrics was the lowest and the rate for internal medicine, the highest. The rate in Baltimore City for all other specialties as a group was 63.4, the lowest rate being for neurosurgery (2.3) and the highest for psychiatry (14.7).

There were 1,993 other active physicians in Baltimore City, or 219.1 per 100,000. The number of interns and residents was 1,178. There were 381 physicians in the city with fellowships. Fifty additional practicing physicians served in government installations. Nonpracticing physicians numbered 384.

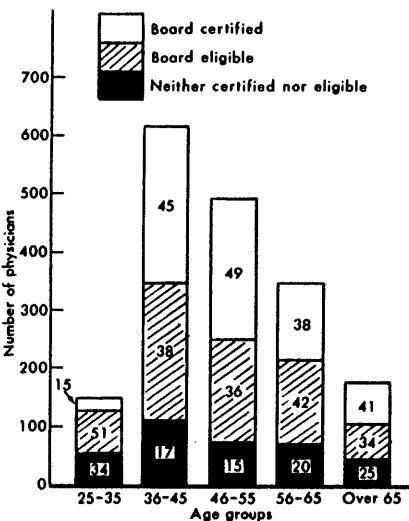
Among the 15 study districts within Baltimore City, the rates of practicing physicians ranged from 25.8 in district 6 to 504.1 in district 9. The rates for primary care physicians

ranged from 25.8 in district 6—all of the practicing physicians were in primary care—to 265.0 in district 9. The practicing physicians in district 9 were nearly evenly distributed between primary care (296) and other specialties (267). There were also 92 other active physicians in district 9—65 interns and residents and 27 non-practicing physicians (table 6).

Fifteen census tracts, distributed over six districts, each had a population of 5,000 or more and no primary care physician (table 7). Eleven of these 15 census tracts were in four districts—3, 8, 10, and 13—in which the rates for primary care physicians fell below the mean rate of 96.7 for Baltimore City.

Baltimore County had a rate of practicing physicians of only 68.1, although two of its districts had relatively high rates; the western district had a rate of 101.6 and the central, a rate of 102.2. The county's eastern district had a low rate of 30.9; the northern district, a rate of 53.4. Of all county districts, the north-

Figure 2. Distribution of practicing physicians, except general practitioners, by age group, with percentage board eligible and board certified, Baltimore SMSA, May 1968



ern district of Anne Arundel County had the lowest rate—27.2.

Physicians rendering patient care. Because interns and residents, as well as physicians in primary care practice, render a substantial amount of care to patients, physician-to-population ratios were computed for the combined group. There were 1,320 interns and residents and 1,320 primary care physicians in the SMSA in May 1968, giving a total of 2,640 persons rendering care and a rate of 134.6 for the combined group. The rate for the combined group in Baltimore City was 226.2, or 133 percent greater than the rate for primary care physicians alone. In the city, however, four of the 15 study districts had no interns and residents to supplement the primary care physicians. Conversely, two census tracts in district 9 had a high concentration of "in town" specialists who served the entire metropolitan population. Therefore, in calculating the rate for the combined group in district 9, the physicians and populations in these two census tracts were excluded so that the ratio between (a) the physicians rendering care to patients and (b) the population of the district would be more realistic. Table 8 shows the number and rate

per 100,000 population for the combined group of primary care physicians and residents and interns in the Baltimore SMSA, in Baltimore City, in the study districts in the city with the highest and lowest rates, and in district 9.

Discussion

Statistics for 1966 show that Maryland had a generous share of the nation's physicians based on its share of the nation's population. The rate of active physicians in Maryland in that year was 167 per 100,000, compared with 138 per 100,000 for the nation. Maryland's rate exceeded the nation's by 21 percent, and only five other States had higher rates—California, Vermont, Connecticut, Massachusetts, and New York. The rate in 1966 for the Baltimore SMSA—219—compared favorably with the average rate for all SMSA's in the nation—166 (5). These are impressive statistics for Maryland and the Baltimore area and could conceivably suggest that, although the nation is experiencing a severe shortage of physician manpower, Maryland is comparatively exempt from the intricate difficulties of providing its population with adequate medical care.

Table 5. Distribution of physicians and rates per 100,000 population, by type of practice and site of office, Baltimore SMSA, May 1968

Type of practice	Total		Private office		Hospital office	
	Number	Rate	Number	Rate	Number	Rate
Total.....	2,085	106.3	1,841	93.8	244	12.4
Primary care.....	1,320	67.3	1,232	62.8	88	4.5
General practice.....	281	14.3	276	14.0	5	.3
General surgery.....	278	14.2	258	13.2	20	1.0
Internal medicine.....	380	19.4	336	17.2	44	2.2
Pediatrics.....	148	7.5	141	7.1	7	.4
Obstetrics-gynecology.....	233	11.9	221	11.3	12	.6
Other specialties ¹	765	39.0	600	31.1	156	7.9
Psychiatry.....	198	10.1	151	7.7	47	2.4
Internal medicine subspecialties.....	81	4.1	72	3.7	9	.4
Radiology.....	69	3.5	37	1.9	31	1.6
Anesthesiology.....	83	4.2	70	3.6	13	.6
Pathology.....	42	2.2	15	.8	27	1.4
Ophthalmology.....	65	3.3	59	3.0	6	.3
Otolaryngology.....	53	2.7	50	2.5	3	.2
Orthopedic surgery.....	53	2.7	50	2.5	3	.2
Neurosurgery.....	22	1.1	18	.9	4	.2
Urology.....	33	1.7	31	1.6	2	.1
Other.....	67	3.4	58	2.9	11	.5

¹ See footnote, table 2.

NOTE: The estimated population of the Baltimore SMSA in 1965 was 1,961,960.

Table 6. Distribution of physicians and rates per 100,000 population, by type of practice, in Baltimore City and the 2 study districts of the city with the lowest and highest rates for practicing physicians, May 1968

Type of practice	Baltimore City		District 6		District 9	
	Number	Rate	Number	Rate	Number	Rate
Primary care and other specialties.....	1,457	160.0	0	25.8	563	504.1
Primary care.....	880	96.7	6	25.8	296	265.0
General practice.....	147	15.7	3	12.9	23	20.6
General surgery.....	218	24.0	0	0	102	91.3
Internal medicine.....	277	30.2	1	4.3	96	86.0
Pediatrics.....	74	8.1	1	4.3	5	4.5
Obstetrics-gynecology.....	170	18.7	1	4.3	70	62.7
Other specialties ¹	577	63.4	0	0	267	239.1
Psychiatry.....	134	14.7	0	0	73	65.4
Internal medicine subspecialties.....	68	7.5	0	0	35	31.3
Radiology.....	59	6.5	0	0	20	17.9
Anesthesiology.....	38	4.2	0	0	5	4.5
Pathology.....	30	3.3	0	0	9	8.1
Ophthalmology.....	52	5.7	0	0	33	29.5
Otolaryngology.....	42	4.6	0	0	22	19.7
Orthopedic surgery.....	47	5.2	0	0	22	19.7
Neurosurgery.....	21	2.3	0	0	17	15.2
Urology.....	30	3.3	0	0	16	14.3
Other.....	56	6.2	0	0	15	13.4
Other active physicians ¹	1,993	210.1	0	0	92	82.4
Additional practicing physicians ²	50	5.5	0	0	0	0
Nonpracticing physicians.....	384	42.2	0	0	27	24.2
Interns and residents.....	1,178	129.5	0	0	65	58.2
Fellows.....	381	41.9	0	0	0	0

¹ See footnote, table 2.

² Not included in total.

³ In government installations not separately identified, and so forth.

The rates cited are crude measures of physician manpower and are greatly influenced by the proportion of physicians in the count who are in training. In the nation, 18 percent (5) of the active physicians were in training, whereas in the Baltimore SMSA the proportion was 40 percent. A sensitive index for measuring the availability of private care is the rate of privately practicing physicians per 100,000 population. The overall rate in 1966 of privately practicing physicians beyond training in the Baltimore SMSA—97—compared unfavorably with the rate for all SMSA's—107 (5). Although the Baltimore SMSA rate was just 9 percent below the mean SMSA rate, the imbalanced distribution of physicians in the Baltimore City area resulted in grossly deficient physician manpower in some neighborhoods.

For many persons, the availability of physicians' services depends upon the accessibility of the sites that deliver medical care. Our major concern was physician manpower in Baltimore

NOTE: Estimated 1966 population: Baltimore City—910,000, district 6—23,293, district 9—111,685.

City. In our study, we pinpointed several areas, in some outlying neighborhoods as well as in the inner city, which were totally lacking in physicians' services for many of their citizens. One study district included five census tracts, each with a population of 5,000 or more, in which there were no primary care physicians; another district included two such census tracts. These two districts were socially and economically disadvantaged inner city areas having a combined population of approximately 174,000 and with rates for primary care physicians well below the overall rate for the city. The plight of many residents in these areas is not one of shortage, but of a total absence of a personal physician's care. Might these residents receive adequate primary care from some of the hospital outpatient clinics that are not too distant? Two other districts, both outlying and growing, which are relatively affluent, each included two census tracts with 5,000 or more persons and no primary care physicians. Al-

though physicians tend to set up practices in more affluent areas, evidently there is a time lag.

The present national ratio of practitioners in specialties to those in general practice is 80 to 20 (6); in the Baltimore SMSA, it is 87 to 13. This trend must be reversed if we are to provide a system of total health care. It is hoped that the newly approved Board of Family Practice will serve to bring a better distribution of the physicians seeking specialty training and those concentrating on general practice. Baltimore City has only 143 generalists (9 percent of the practicing physicians in the city), but the reports on physician utilization issued by the Medical Assistance Program (title XIX of the 1965 Social Security amendments) show that at least 300 physicians in the city have a practice similar to that of a general practitioner.

The results of the Baltimore SMSA manpower survey demonstrate how unplanned the distribution of physicians is by location and specialty. We hope that the results from studies such as ours can be a guide in influencing the number and the distribution of physicians as well as their type of practice. But coordinated planning by medical organizations, public health officials, and governmental authorities will be required.

Immediate and Prospective Uses of Study

The data collected for our study were used to produce a list of physicians by census tract which has proved to be a valuable reference source. Prepared by computer printout, the list contains a 1-line entry for all practicing physicians in the Baltimore SMSA, showing each physician's name, primary professional address, whether the physician has a second address, his specialty, whether he is a Medical Assistance Program participant (a later printout gave the Medicaid vendor number), and his hospital affiliations. Biographical data included are the birth year, the year licensed, years in practice, whether he is certified by an American specialty board, and his professional organizations. The list is ordered by specialty within the census tract and within the district. Thus, the printout for any one census tract gives all the general practitioners (in alphabetical order), followed by all the general surgeons, the specialists in internal medicine, the obstetrician-

Table 7. Study districts in Baltimore City with census tracts having 5,000 or more population and no primary care physicians, May 1968

District No.	Primary care physicians per 100,000	Practicing physicians per 100,000	Number of census tracts with no primary care physicians
3.....	79.1	128.4	5
8.....	79.5	160.3	2
9.....	265.0	504.1	2
10.....	67.4	102.2	2
13.....	38.3	60.9	2
14.....	163.1	261.3	2
Baltimore City.....	98.7	160.0	15

Table 8. Number of physicians rendering substantial care to patients and rates per 100,000 population in the Baltimore SMSA, Baltimore City, the 2 study districts of the city with the highest and lowest rates, and district 9, May 1968

Area	Number in group			Rate
	Interns and residents	Primary care physicians	Both groups	
SMSA.....	1,320	1,320	2,640	134.6
Baltimore City.....	1,178	880	2,048	226.2
District 8.....	306	61	369	478.4
District 6.....	0	6	6	25.8
District 9.....	65	68	133	128.6

gynecologists, pediatricians, allergists, and so on.

To our knowledge, this resource is the only listing of physicians in a greater metropolitan area arranged by census tract. These data have been of great value to the medical care services section of the Baltimore City Health Department in its efforts to assist needy citizens in obtaining available medical care. The list of physicians and the Medical Assistance Program reports on physician utilization formed the basis for a system of referring patients to physicians. Primary care physicians and physicians combining a general practice with a specialty were selected for the referral panel from the

physician utilization reports. Since the list of physicians was arranged by census tract, physicians on the panel could be arranged in the same way; those physicians with several office locations were listed in all the appropriate census tracts. Information about a physician on the panel included his name, address, and kind of practice. If a patient eligible for medical assistance calls for the name of a physician participating in the Medical Assistance Program, the census tract of the patient's address is quickly located. By using a city map showing census tracts and consulting the referral panel, the staff of the medical care services section can offer the patient the names and addresses of the three nearest physicians.

The list of physicians by census tract has served also as a referral source for other persons and agencies requiring data on small areas. Several community agencies have used it in planning improved medical services for residents of the metropolitan area.

Summary

A study, begun in 1967 in the Baltimore Standard Metropolitan Statistical Area (SMSA) to assess physician manpower at the census tract level, sought to identify each physician in the area and then to determine whether he was in training or beyond the training stage. Physicians beyond the training stage were sent a self-administered questionnaire. For counts of interns, residents, and fellows, inquiries were made to all hospitals in the SMSA. Each physician was subsequently mapped into his census tract and into a study district according to his professional address.

There were 4,207 active physicians in the SMSA, 40 percent of whom were in hospital training. Of the 60 percent beyond the training stage, the ratio of practicing to nonpracticing physicians was about 4 to 1. Of the practicing physicians in the SMSA, 13 percent were general practitioners and 87 percent were specialists. Almost two-thirds of the physicians were engaged in primary care—general practice, general surgery, internal medicine, pediatrics, or obstetrics-gynecology. Of those in a specialty-type practice, 42 percent were certified by an American board. Eighty-eight percent had private office locations.

The ratio of physicians in specialty practice to those in general practice was 87 to 13 in the SMSA, compared with 80 to 20 for the nation. In Baltimore City, only 9 percent of the practicing physicians were in general practice. Moreover, the proportion of physicians in general practice was smaller in the younger age groups than in the older.

The rate of practicing physicians in the SMSA per 100,000 was 106.3; in Baltimore City, 160.0. The rate of primary care physicians in the SMSA was 67.3; in Baltimore City, 96.7. The rate for the combined group of interns, residents, and primary care physicians in the SMSA was 134.6; in Baltimore City, 226.2.

Among the 15 study districts within Baltimore City, the rates of practicing physicians ranged from 25.8 to 504.1; the rates of primary care physicians, from 25.8 to 265.0. Fifteen census tracts in the inner city as well as in some outlying areas totally lacked primary care physicians. The results of the survey demonstrate how unplanned the distribution of physicians was by specialty and location.

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Tearsheet Requests

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Senator KENNEDY. Mayor Tate, please proceed.

**STATEMENT OF HON. JAMES H. J. TATE, MAYOR OF
PHILADELPHIA, PA.**

Mayor TATE. Mr. Chairman, with the permission of the Chair and Senator Javits, and now Senator Eagleton—I am delighted that Senator Eagleton is able to join with the committee to hear our testimony—I would like to join with my fellow mayors in relating some of the experiences that we have in Philadelphia, but at the same time address myself to the overall problem as we see it throughout the country. And I am hopeful that my testimony will shed some light on several needs which might be considered in your review of this very important program.

I am sure you are aware of the fact, or you wouldn't be here, you would not have proposed this, Mr. Chairman, that this particular proposal is of vital concern to all citizens and to public officials who labor now to insure that good health care is available for all.

For a number of years Congress has moved toward a universal system of health security. There are many landmarks—such as title 18 and title 19—the medicare and medicaid amendments to the Social Security Act. However, Congress has not acted on such sweeping legislation encompassing the entire population, which I do believe is the purpose of your bill. Rather, remedial efforts have been applied to some portion thereof, such as the aged, the poor, or infants. Never before has the Congress addressed itself to legislation that not only would underwrite the right of all to good health care, but which would also seek to correct the failings of our health care system.

The National League of Cities, of which I am past president, has adopted a position statement on national health protection which I would like to submit for the record in the interest of time and have it printed.

(The position statement follows:)

Measures to alleviate the critical health care situation today should include the establishment of a program of comprehensive, national health protection superceding all existing health programs to provide better health care for all people by emphasizing the maintenance of health as well as the treatment of illness. The goals of such a program should be to insure that all persons residing in the nation have the opportunity to receive good health care without barriers to the care they need, and without the crushing financial burdens that too often accompany the delivery of health services today.

To meet the health needs of the nation, we must do the following—

1. Insure that we have the needed health manpower and institutions;
2. Keep the cost of health care within reasonable bounds;
3. Develop a system which provides more efficient use of our existing health resources and encourages the availability of increased resources for the future.

To succeed in alleviating the health crisis, each of these problems must be attacked simultaneously. Divided and categorical approaches have been attempted in the past under governmental and private sponsorship, and have often met with frustration and defeat. Such mistakes should not be repeated.

Actually I do want to say that we have been moving in the direction of our national mayors policy in the city of Philadelphia,

where our innovative Department of Public Health has been seeking to mesh the public and private health enterprises into an effective health care system equally available to all.

On the local level cities such as Philadelphia and New York, and now Baltimore, as Mayor D'Alesandro has related, are spending millions of dollars a year to reimburse voluntary hospitals for emergency and outpatient care provided for indigent citizens who have no other place to go because of the failure of the doctors to provide this kind of service at the local neighborhood level. Thus the mayors, I do believe, know at first hand the problems of patients, of providers, and of a system that is so disjointed as to constantly cost more and more while giving less and less.

In Philadelphia we have enough doctors, but really they are in the wrong places, and I think this is demonstrated in many other sections of the country. They are often occupied, frankly, with the less important activities in health care. The city of Philadelphia, like so many other cities, contributes millions of dollars a year of its own funds to educate doctors in our Philadelphia General Hospital, as well as nurses and other health workers. We have too many hospital beds, however, because many institutions, such as our voluntary hospitals, cling to the need to "go it alone" whether their beds are fully utilized or not.

This year our city budget calls for an increase of \$18 million in public health expenditures to a total of \$39 million for the Public Health Department. In addition the operation of Philadelphia General Hospital will cost \$38 million, an increase of \$6.4 million over the previous level. Much of this is to implement the recommendations of a committee appointed by me to study the entire future of local investment in personal health care, and which committee itself endorsed the entire proposal of national health insurance.

This group, known as the Mayor's Committee on Municipal Hospital Services, recommended that we invest heavily in family-style ambulatory care programs, stressing the prevention of poor health and the maintenance of good health. It also recommended that we build a completely new public hospital to back up the neighborhood care programs, and this has just been included in our capital program. This facility will cost more than \$105 million, depending on the cost factors in future years.

I cite these figures to demonstrate that on the local level you simply cannot cut back on public health costs. Some years ago we conducted a management survey which recommended substantial reductions in the level of services at Philadelphia General Hospital, but when we tried to implement this the public outcry was so great that all the cutbacks had to be restored.

Thus, we in Philadelphia are moving in the direction the whole Nation must move. That is—assured health care for all with cost and quality controls. But no city can do it alone, because all are caught in the stranglehold of an inadequate health care system.

Recognizing this, Philadelphia in its 1971 proposals to the Pennsylvania General Assembly called upon the legislature to support a national health insurance plan which—

1. Provides for universal coverage;
2. Provides for financing like the social security system;
3. Should be subject to a public review process; and
4. Should provide incentives for the improvement of the delivery of medical care.

We do believe that some sort of health insurance bill is certain to be enacted in the near future, and I am heartened by what Senator Javits has said about "we do mean business." But the form of that bill is vitally important, too. Your committee has the grave responsibility for considering all aspects of this overall problem and arriving at a final recommendation.

From this background I believe that Senate bill 3, introduced by you, Senator Kennedy, and others, and its twin bill H.R. 22 submitted by Representative Martha Griffiths, for the establishment of a national system of health security, most nearly meet the urgent needs of the Nation today.

It provides universal coverage of all persons on American soil and of our own citizens abroad through reciprocal arrangements. The health benefits to be provided are comprehensive and avoid the complications of involved formulae for calculating deductibles which show up in insurance policies.

On the other hand, thought has been given to economies and controls by avoiding coverage of the exotic or unnecessary. The establishment of cutoff points for the care of certain special and long term problems is reasonable and proper in order to assure the wise expenditure of our dollars. At the same time, due provision is made for local health care planning efforts.

The method of financing by social security type payments and general revenues to spread the costs of covering persons who are not gainfully employed seems the best and fairest mechanism.

There are striking efforts in this legislation to reform the health care delivery system. This is the goal toward which we have been working in Philadelphia, and it is comforting to note the intent of Congress to make incentives for reform a part of our national policy.

I am pleased with the inclusion of careful definitions of new systems for delivering health services. I refer both to the concept of the Comprehensive Health Service Organization, and the inclusion of public health services organized in an equally comprehensive way.

In Philadelphia our 10 conveniently located district health centers are being converted to comprehensive family care centers for all residents of the surrounding neighborhoods. These services are often more complete, convenient and accessible than those of fragmented and overspecialized outpatient departments in private hospitals, which seem to be troubling the hospitals in the cities of America, as indicated by Mayor D'Alesandro. Yet we have encountered difficulty, under the present system of federally assisted third party payments, in obtaining reimbursement.

In this legislation there also appear for the first time incentives in the form of favorable payment formulae to providers of care who keep people well and productive. I refer to the section on payment to comprehensive health service organizations and professional foundations under this proposal.

The creative uses of money can be a massive lever to improve a system. You, Mr. Chairman, expressed this when you introduced a similar measure in a previous Congress. At that time I believe you quoted from a Philadelphian, an early American patriot, Thomas Paine, when he said "Give us a lever, and we shall move the world."

Since our local government in Philadelphia invests in the purchase of care from the nonpublic sector, we have had to examine even more closely the ways in which we determine the choice of providers. We believe that our citizens benefit the most if we use local tax resources to help reward the efficient, high quality and humane providers. But the leverage of our local dollars is minor compared to that of the combined resources of all parts of the Nation. Only a federally guided insurance and incentive system can achieve the necessary uniformity, objectivity and leverage.

Finally, there is a certain courage displayed in this legislation in providing that State laws which deny receivers of health care a voice in the management of their health insurance systems, or which restrict the mobility of health manpower or the use of well-trained new professions, be overridden.

State representatives in Pennsylvania, led by members of the Philadelphia delegation, have already introduced our own House bill 60. This would do away with the previous requirement that nonprofit health service plan corporations must have physicians as the majority of the board. My city administration strongly backs this legislation, as well as the concurrent thrust of the Pennsylvania State Insurance Commissioner to see that the people who pay for health insurance have a greater voice in the management of their money.

All of these concepts which I have mentioned are essential elements of any fair and productive national health insurance system. Whatever form the final legislation may take, these concepts seem the most essential, lest we are to be left once again with an inequitable, restrictive, or too expensive system.

There is only one improvement I would like to suggest which I believe will give added dimension to the legislation before you. This would provide public accountability for disbursement into the health care system of the dollars from all of us through a Federal and regional system. It does not, however, fully consider the role of State and local government in health care delivery. Local government involvement would bring health care closer to the people.

We all know that expenditures on short-term voluntary hospital care have risen sharply in one decade, from \$5 billion to over \$12 billion. In Philadelphia Blue Cross requested a 20-percent emergency rate increase after one of 29 percent granted just last summer, causing the State Insurance Commissioner to focus intensive public hearings on this problem.

Each year the city of Philadelphia is confronted with requests for more and more funds to support deficits covering emergency and outpatient care services provided by voluntary hospitals under contract with the city. Yet we cannot check the relation of these stated deficits to the total financial picture of each hospital because the Social Security Administration will not share the uniform fiscal

reports of the hospitals with our own cost people. Furthermore, contracts between the individual hospitals and the local fiscal intermediaries such as Blue Cross expressly forbid such sharing. Thus, necessary data is hidden from the public.

It seems to me that in the interests of both public accountability and cost control, some responsibilities should be delegated to local governments with proven capabilities. It is important for some authority to be delegated to local administrators who know local needs and local problems. A portion of the National Health Security Trust Fund should be set aside to raise the capabilities of State and local health departments for these tasks where the technical competence does not now exist, as I think it does in our city of Philadelphia, and I am sure in New York and Baltimore as well.

I think it is equally important that we continue to support regional comprehensive health planning with strong input from local governments and their public health agencies. We recognize that neither public nor private expenditures for services or facilities should proceed without a clear and well-researched knowledge of needs, costs, and the comparative benefits of different approaches. The Nation's health needs are too diverse for the Federal Government to make one universal plan that will be appropriate to all.

On the other hand, the public has every right to expect a clear enunciation of national health policy from the Government that represents us all. In seriously considering Senate bill 3 with the suggested additions, the Congress would take the clearest step in our history toward meeting this responsibility.

Mr. Chairman and members of the committee, I do want to say that we deeply appreciate and are most grateful for your thoughtfulness in giving us this time to get our stories on the record. We could probably bring in 50 more mayors who could tell a similar story, but we do believe what you are doing is a significant step in the right direction, and we hope it will pass, and if there is anything we can do to talk to other Members of the Senate and the House to support this legislation we would be very glad to do so.

Senator KENNEDY. Well, thank you very much. I think you have all outlined very graphically the real health crisis that exists in your respective cities.

I gather from what Mayors Lindsay, Tate, and D'Alesandro have stated that you favor some legislation that incorporates a national health insurance policy. Do I understand correctly?

Mayor TATE. I do, and we do.

Senator KENNEDY. I know you speak as individual mayors now, but also because of your particular responsibilities and association with the Conference of Mayors, this carries great weight. If you, who are involved most critically with the problems of urban health, take the strong position that you have this morning that, a national health insurance program is best equipped to meet problems of quality, cost, manpower, and innovation in the health care delivery system, many people must listen.

Mayor LINDSAY. Correct; we agree with that.

Senator KENNEDY. You gentlemen speak for urban health. It is probably unfortunate we didn't have a mayor from a small rural

town as well because so many of the problems we face in urban areas apply just as readily to rural life in this country. We are hopeful in our travels around the country to be able to demonstrate this as well.

I am wondering if you gentlemen could just describe the conditions which exist in emergency rooms in your hospitals. Can you give us some kind of graphic description of the situation that exists within these urban hospitals; has it improved in all frankness, over the time that you gentlemen have been in office? And can you explore with the members of the committee how your hands are tied in trying to alleviate the enormous pain, suffering, anguish, humiliation, and indignity which people who visit these emergency rooms in these hospitals in your cities experience?

Mayor D'ALE SANDRO. As I tried to explain in my prepared remarks, as the general practitioners vacated the ghetto areas an avalanche has fallen on the emergency rooms of the hospitals, and these are primarily, if not in the main, all poor people who need medical attention, and the hospitals are giving that attention. But as a critique their funding, financing—they realize that to continue this type of service they are faced with bankruptcy. And as I quoted to you, Senator, three of the major hospitals in Baltimore City have left the inner city, right from the inner city, and have moved to suburbia.

We are in the process of critiquing the type of emergency service that is being provided by those hospitals that have remained, because there is some question if they are following through with full faith and credit to the 24 hour a day service because of the funding problem.

And I will be perfectly frank in stating that, in my opinion, the numbers have increased to an avalanche form, the hospitals are properly motivated, but because of the numbers they can't get to the people. And a tremendous amount of people that are going there are really the type that should not be seeking that type of medical attention in the hospitals—a cough, some other type of illness that could very easily be dispensed, say, in the clinic if a clinic were available. But by process of elimination they have no other place to turn but to the hospitals.

Another ingredient in describing the health crisis, while it doesn't answer your question directly, and I don't have the correct percentage, but it is a high percentage—youngsters in Baltimore City under the age of 16 that have never had a physical examination in any sense of the word, absolutely no physical examination.

So here you have people receiving no medical attention by way of a physical examination per se on the one hand, and those that need it by process of elimination having all of the weight shouldered by hospitals which in Baltimore are privately endowed, not under the control of the municipal or State governments, and can leave at the whim of the majority of the members of the board of directors.

Mayor LINDSAY. Well, Senator, and members of the committee, I would invite you most cordially to come to New York at any time and take a tour, whatever time you might have available, particularly at night, and visit the outpatient clinics, emergency rooms

of the 18 municipal hospitals that we operate, or in fact take a look at some of the 30 to 40 voluntary hospitals in our city that we partially fund.

The ones that everyone hears about, of course, would be Bellevue, for example. We are building a new Bellevue, it is nearing completion. And we have just completed a new Harlem hospital which is a fine institution, and gotten rid of the old one except portions of it. Take a look, however, at the one that Dr. English, the head of our new hospital corporation, described, which is Lincoln Hospital, which is now being replaced, too; or take a look perhaps at Kings County Hospital in Brooklyn which is undergoing massive renovation, but it is still one of the older institutions we have. And visit those emergency clinics particularly at night. What you see are hallways and corridors filled with poor people who are awaiting emergency care. You go there at 3 o'clock in the morning and you will see maybe two or three dozen mothers with little children, you will see elderly persons hardly able to walk. Then you will see the night's work of narcotics and heroin addicts, knife wounds, and all of the other trauma of American urban life today.

Then you will see dedicated interns and doctors and nurses up all night long in a vicinity like Lincoln Hospital, or to some extent even Kings County in Brooklyn. These are persons who have their own problems, these nurses and doctors and interns, particularly housing.

I think my thinking is right that our city at the moment and our hospital corporation now is employing about 4,500 nurses, and we need another 2,000 to be nearly in shape. And the critical problem, of course, is housing more than anything else, particularly in a ghetto area.

The work that is done—I don't think I am saying this just because I like to boast about my own city—is very high quality medical work nonetheless. We pride ourselves, and despite all of the pressures and all of the problems, in being able to deliver high-quality medical services. So that the poor person who comes for emergency treatment at 2 o'clock in the morning, whatever the problem is, gets a high-quality medical care. A lot of those people we get no reimbursement from, and we will get less after the State of New York took the drastic action in the legislature last week. And we have to treat them.

We are in the process of building, according to strategy that we laid out a few years ago, a series of ambulatory family care units around these massive hospital complexes, to use the hospital as a backup, in order to keep people out of these emergency clinics, particularly during the nighttime hours. And that promises to take some pressure off.

But the point is that the health needs of urban people, particularly poor people, are so massive that even the introduction of another few billion dollars in capital construction to build clinics of this kind is not going to really ease the pressures that much in the outpatient emergency portions of these massive hospital complexes.

I really think that the only way that you can assess it is to see it. The only way you can feel it is see it and watch it, particularly

those aspects of hospital work today that have to concern itself with drug addiction.

Senator KENNEDY. How would you describe it—as crisis ridden?

Mayor LINDSAY. Yes, but we have lived with it so long it is hard to call it any more of a crisis now than it was. The fact of the matter is that medicaid was a tremendous advance even with all of its problems and all of the headaches connected with it and the massive difficulty in mounting systems of collection, third party collection that goes with that. We in fact in each of these hospitals have to have a whole system of managers, comptrollers, budget people, examiners, and all kinds of things. It will still be a while before the whole business is computerized in our hospital corporation.

But I would say that it is critical, I think it is in crisis proportions, but probably better than it was before medicaid came along.

Senator KENNEDY. What about middle-income people or even upper-income people? Do they feel the pinch in the availability of doctors or in their assurance of getting quality health care?

Mayor TATE. Mr. Chairman, I really think so. Listening to both Mayor D'Alesandro and Mayor Lindsay, of course they related the problems with respect to their own—Tom calls his municipal hospital—we used to call ours municipal hospital, we call it the Philadelphia General now. And John has other names for his hospitals since he has had this matter placed at the corporation level in order to relieve some of his problems. But we find that the hospitals have not really expanded as well as they should in the suburban area. As a result we get a large influx of people in from the suburban areas who come to our general hospital, because first they don't have enough money and in many cases they go to one of the 25 voluntary hospitals in our own Philadelphia area. So that gives us another factor which we can't very well cope with.

It does become a problem for middle-income patients because they have to go into these voluntary hospitals which are getting some help from the city or State government, and stand in line with the people who are in the crowded corridors waiting for outpatient or clinical attention. Many times they have to wait weeks and sometimes months for a bed, in order to have a necessary operation performed.

So that the problem for those who reside in the suburban areas, is just as critical as it is in the cities themselves.

I like your reference to the fact you would like to hear from some of the smaller cities, too, because I could take the entire metropolitan area—there is one particular State which joins us, and I am not going to mention it because I don't want to refer to it disrespectfully—they have three hospitals in the entire State, so they go to New York or they go to Pennsylvania for their hospital attention. And this is a situation that, of course, has existed for many years, with some efforts made to correct it. But they go to New York—you know that, John—and they come to Philadelphia because they have no other place to go. And I think the idea of the universal health insurance plan should be very helpful because it will help them to beef up their own services, and that is why I think it is a problem of the middle class.

Mayor D'ALE SANDRO. Senator Kennedy, if I can respond to that question, the poor have their problems, but they have medicaid as somewhat of a cushion to cover and seek medical attention, and the senior citizen has medicare. But it is getting so that now the people of middle income and above that fall in that category can ill afford to get sick because they have to pay the freight in many instances themselves with their own insurance protection, and in the absence of insurance protection on their own resources, especially those that fall into, say, catastrophic type of injury, and can really break a family.

When you start looking at the day-by-day cost for hospital care the middle-income people in particular can ill afford to be sick.

Senator KENNEDY. Well, two-thirds of the American people are within the \$5,000 to \$15,000 range. Do you hear these people saying that the reason they are in the hospital is that their insurance doesn't cover a particular problem; therefore, because their insurance does cover hospitalization, it is cheaper for them to go into a hospital, take up a bed, and burden the city with staying a few days in order to get treatment which might be handled in an outpatient clinic.

Mayor LINDSAY. Sure. That happens. We know that happens because for the most part people don't have nonhospital related insurance.

The national figures that I have would dovetail with yours, Mr. Chairman. Two-thirds of the country falls within that bracket. Why, then a big percentage of that middle group is affected also by the following statistics. And that is that 13 million Americans have no form of private or public health insurance at all, and almost half of the population in the United States lacks health insurance for outside of hospital services. That would follow, of course, that the only way a person can afford to get sick would be hospital related, which is going to drive population in the hospitals where they shouldn't be.

And then when you match that statistic, which is a third of the country's population has no major form of medical insurance at all, that probably falls within, for the most part, the middle-income group not covered by medicaid. And I would guess, without knowing, that—here I am departing from my data that I have in front of me—but I would guess that that may be growing because of the terrible cost of private insurance. We all know what has happened in Blue Cross and Blue Shield. The escalating costs on that are staggering to the average family. And the result of this is that you do have a growing crisis in respect to these groups that are between medicaid and medicare that may be of greater significance to the well-being of the country than these other areas.

And then on top of that when any level of government makes a move that drives down the eligibility levels on medicaid it just compounds that problem all the more.

Senator KENNEDY. Well, why do they drive it down?

Mayor LINDSAY. Because of cost factors. The State legislatures have done this. As I testified in the main testimony, New York State Legislature just got through doing it just to get rid of cost

burdens. But what that does in human terms is indescribable, and what it does to a local government like New York City is beyond measure in the damage that it does. The motivation was primarily cost.

Senator KENNEDY. Then you would agree with me that the insurance companies who have been in this business for some 30 to 35 years only cover one-third of the total health cost of people in this country at this time, only one-third of the cost; and most of the other costs for people who live in the cities today have to be paid by the taxes that you gentlemen are required to raise from the people who live in the cities.

Mayor LINDSAY. Correct.

Senator KENNEDY. And that the insurance company as an institution in terms of really meeting the health crisis, in holding down costs, in providing quality as well as availability, is completely inadequate.

Mayor LINDSAY. Something is wrong with what the private sector has been doing in respect of controls, and this figure really ought to be part of the record because it speaks for itself. In the last 5 years health care prices have risen by 34 percent and hospital prices have risen by 89 percent.

Senator KENNEDY. Now that is more than the construction industry. I have a lot of people up in my State who say "Well, we have a policy in the construction industry to hold down costs; why don't we have it in health?" Next year health expenditures will exceed the sum this country spends on defense; and if you really want to meet the problem of inflation in this country, we ought to be moving into the health area as well.

Mayor TATE, you have had an extraordinary experience in your city in the rise in Blue Cross rates.

Mayor TATE. That is correct.

Senator KENNEDY. And you refer to it at the top of page 6 in your testimony. The increases in Blue Cross, of course, have been extraordinary in all parts of the country. We had it recently up in our neighborhood; in Providence, their plan 65A increased costs during the last 6 months of close to 70 percent, which has disadvantaged thousands of senior citizens.

Could you tell us a little bit about the increases that have affected the people in Philadelphia, going back to last year where you had an increase of about 20 percent, this past fall an increase of 29 percent, and I think you anticipate another increase?

Mayor TATE. Thank you, Mr. Chairman. That is correct. I am pleased that you note your conditions in New England. I have a daughter that teaches in your public school system and she can't afford the Blue Cross and Blue Shield in Massachusetts. She has to come back to Philadelphia if she needs any attention. And I am aware of it. But I do want to point out that in my testimony the Blue Cross has requested an additional increase after receiving one of 29 percent last summer.

They have had hearings before the Insurance Commissioner of Pennsylvania, and more recently in Philadelphia, where they expect to have an increase of from 20 to 25 percent, and they allege

that the reason for this is the unusually high hospital costs, which I think they have helped to create themselves.

Actually the Blue Cross and Blue Shield organizations are overpopulated by way of their management with physicians, and we are now undertaking legislation in Pennsylvania to require them to have more citizens, just patients of the hospitals, on their boards in order to make it more acceptable to the community. I think the physicians in many cases control these programs, and this is not good. And even though we do have Blue Cross and Blue Shield the average cost for the middle-age person who can afford Blue Cross and Blue Shield is sometimes \$100 a day for a private room in the hospital.

I think that we all experience that when we have illness in our own family, if it is the catastrophic or long-term illness problem; why, it is pretty expensive even with the help of Blue Cross and Blue Shield.

So I don't think that they are actually solving the problem, they are just adding to the dimensions of the cost. And as has been indicated, by increasing the cost of Blue Shield and Blue Cross they drive the poor people or those who can't afford it into the voluntary hospitals, which in turn get appropriations from the city government, and into our general hospitals as well.

Now I want to indicate a very significant point. We have a city employees union made up of the blue-collar workers, the fellows who collect the trash and remove the garbage—something similar to yours, John, only I have better luck than you do. But we have about 14,000 employees in the city government who belong to this union. They have their own hospital. It is the John F. Kennedy Hospital, if you please. And the reason they have that hospital is because our own employees cannot afford the difference in the Blue Cross payment. We have an allowance for fringe benefits for hospital and clinical services in our union contract. This is not sufficient to support the allowances which are given by Blue Cross and Blue Shield, and therefore the employees either have to pay the difference to Blue Cross and Blue Shield or conduct, as they have, their own hospital.

They established their own hospital and they handle most of their employees through their clinical work and their actual clinical cases at this hospital.

This is a very significant situation because they, too, cannot get into the voluntary hospitals because of these overcrowded situations. So that even where the city government in its union contracts pays as high as \$5 million and \$6 million to Blue Cross and Blue Shield the union itself has to provide some hospital.

And the same thing applies to the police and firemen who have to conduct their own medical facilities and work out arrangements on a contract basis with other hospitals.

So I think what the Insurance Commissioner is doing in Pennsylvania with respect to Blue Cross and Blue Shield, where he is now reviewing all of the contracts between the hospitals of Blue Cross and Blue Shield, will be very helpful because in many cases these hospitals do not actually meet the problem either costwise or

from the standpoint of the need of the patients. And this has been demonstrated by days and days of testimony before the Insurance Commissioner, and I look forward to some change in the delivery of this kind of service. Whether this can be done throughout the entire country I don't know.

Senator KENNEDY. Well, would you not agree with me that a strong case could be made that we shouldn't increase the rates; that the Insurance Commissioner shouldn't permit rate increases by the Blues unless they are going to do something about cost control?

Mayor TATE. I agree.

Senator KENNEDY. There has been very little indication that the Blues have done anything about cost control, and I think the Blues have really written what hospital administrators have desired in terms of increased rates in hospitals and in terms of the medical societies. The people who have been left out have been the people who live in your cities.

Mayor TATE. That is correct.

Senator KENNEDY. And they are having to pay the increased rates; at the same time, no pressure is being brought to bear on the Blues to control costs.

Mayor TATE. I think you have put your finger exactly on the problem. The Blue Cross and Blue Shield organizations say that they negotiate these contracts with respect to the costs and the payments they make to the hospitals, but in many cases, in my opinion, they represent what the labor organization calls sweetheart contracts, so that there is no real control. And this is where I think Government has to step in—after all, hospitals and delivery of health care are affected with the public interest like public utilities. So that there should be some form of board which could control this cost, and I think that is exactly what you are proposing.

Senator KENNEDY. I would be interested in any observation that you might make on the fact that many hospitals want the most sophisticated type of equipment; cobalt machines, open heart surgery units; who foots the bill, but Blue Cross? Then, when they expand these extraordinary resources and very sophisticated equipment that obviously increases the rates, you find under-utilization of this equipment in these hospitals, along with a very natural deterioration of quality. Blue Cross does not provide cost control; it does not say "Well, how many open heart surgery units do you need in New York City or in Philadelphia?"

Nearly every hospital wants the latest kind of gadgetry; it is a matter of prestige to have sophisticated equipment. But the consumers are paying for it. Do you feel that this is a situation which has occurred in your cities very often? You need not point the finger at any particular situations unless you would like to.

Mayor LINDSAY. Your point is well taken. It is a very solid point. Of course, it goes right to the heart of this debate that is raging in the health community, in the medical world at the present time, as to what are the priorities and where do you cut off.

First of all, your central point is absolutely correct, that the Blue Cross, Blue Shield, and other insurance carriers have not controlled the costs and taken no tough steps to do that. They have simply

passed it along on a cost-plus basis so that it lands right on the backs of everybody else, which is no way to do business. In those circumstances you have no choice but to allocate resources among first priorities. And so there is a very real question as to whether or not you should continue this system as a means of financing open heart surgery or blood renewal program, kidney renewals, for example.

On the other hand, not doing those things in either the public or the private sector is very difficult.

Not too long ago I witnessed in one of our municipal hospitals the massive kidney machine program they have to keep alive some of our people. And there was a policeman there, and there was another municipal employee, and they were middle-class people, and there was a husband and wife being kept alive by this vastly expensive, enormously complex medical machinery. And right there you had the argument—it was being argued that we should not be doing this, the city ought to get out of this business. The fact is if our city got out of that business it wouldn't be done, because the voluntary hospital down the street which has come to us begging for support because of their cost problems is probably not going to do that.

And it is a difficult thing to say well, because the cost of this is weakening our ability to serve all the people that come in at night with their problems we shouldn't be in this area. It is okay to argue that as a priority, but you try to close down that kidney clinic and see what you are doing. You are in effect letting some people die who would otherwise live.

Senator KENNEDY. Would you agree with me that the question of the payment of that extraordinary kind of treatment ought to be borne by healthy people as well as the sick?

Mayor LINDSAY. Sure.

Senator KENNEDY. If you are really going to have a health insurance system, it ought to be spread in a progressive way across the length and breadth of our society, rather than just focus on the person who happens to be sick. That is the thrust and the basis of my health security legislation. If someone is sick and needs extraordinary treatment, the cost ought to be borne generally, in as progressive a way as we can possibly devise, rather than putting all the burden either on the sick person alone and wiping him out with catastrophic illness or putting all the burden on a particular community or city.

Unfortunately, this is the basis of a great debate that will continue, and I think you have expressed yourself on that question.

Secretary Richardson has testified before the subcommittee as well as representatives of the American Medical Association and representatives of the insurance companies. Even though they all have different approaches or pieces of legislation to meet the health crisis, they have all endorsed the concept of deductibles and coinsurance; they have stated that this provides cost consciousness for people who are going to use the system. In other words, deductibles and coinsurance are going to keep people from using facili-

ties, whether it is a neighborhood health center, hospital or doctor's office, because they know they are going to have to pay so much.

First of all, I think that this concept is quite contrary to the general and accepted concept of medicine, and that is that preventive medicine is extremely important as an ideal that we ought to be seeking: it has its pay-offs in health and in fiscal terms.

Secondly, it has been my experience that there is an underutilization of these facilities by disadvantaged people and even middle-income people. People don't like to go to the doctor. They don't like to go to the dentist. And there isn't this great overutilization.

There certainly isn't overutilization in the Army of the United States which provides what you might consider comprehensive services. Do you find that people abuse health resources, such as neighborhood health centers, clinics, various group practices, or even hospitals?

Mayor LINDSAY. No. Definitely not. We know what happened in medicaid when we reached out in the area of dental care, for example. We found that for the most part of the population hadn't been touched with proper dental care.

We found in our lead poisoning program in New York, which, as I testified earlier, we mounted to such degree that it was probably hitting 85 percent of the lead poison or threatened lead poison population in our city, a massive program—but what we found in the lead poisoning program was just what you might expect, which was that most of the children and their families that we are treating and testing in this program were in massive need of general medical care. And if all of those persons had come flooding into our municipal hospital system it would have compounded an already pressurized problem.

People do not come to hospital or outpatient clinics unless they are in trouble. And if all people came who needed medical attention and weren't getting it we would be overwhelmed. That is true of middle-income, middle-class groups as well as poor.

Mayor TATE. Senator, Mr. Chairman, you addressed yourself I think to the problem of the deductibles which are usually manifested in the typical insurance policy, whether it be for health care or for automobile insurance or just owner's liability for your household. And this I think if reflected in a national health insurance program would certainly exclude the class which should have the prime consideration with respect to our problem.

In other words, if you put that old \$100 deductible which prevents the person from going to a doctor because it would cost them for that first visit or for the first \$100, whatever figure is developed, you exclude a class which would have to go some other place. So they go to that voluntary hospital which is getting aid from the city government or from the State government, or they go to—in some cases they call them charity hospitals, to the general hospital, municipal hospital, because they have no other place to go.

Senator KENNEDY. Or they don't go at all.

Mayor TATE. And in a great percentage of cases, as indicated by Mayor Lindsay when he referred to the dental care program—we found that to be the case in our program which we started some 15

years ago, where the kids never got to the dentist because mother and father didn't take them or they weren't motivated in the area with respect to the neighbors or they really didn't care, and the only time that they went was when they went to school in the first grade and the doctor at the school said you have to go to the dentist, and this, of course, began the problem of dental care.

Now I am against the idea of a deductible with respect to health care. There may be a reason for automobile insurance or perhaps household insurance, but from the standpoint of health care I don't think you can exclude anybody because sickness itself moves on everybody regardless of their station in life.

Senator KENNEDY. I agree.

Mayor LINDSAY. I think it can be fairly said in these cities like the average city of the United States now, any size at all, middle size city, big cities, and now the smaller cities—you are talking about 30 percent of their populations that are poor people, they are nontaxpayers for the most part. They are too poor, they are below the poverty line. And you have other groups where they are known as the working poor, and then you have a large blue collar group that increasingly feel squeezed to death in every direction, particularly cost and inflation and the pressure of living and getting along. Any time you mount national programs that have cutoff levels, income cuts, deductibles, what you are doing is you are taking care of once again for the most part to some degree that vast population outside of these inner cities. But in the inner cities you are just loading more pressure and more trouble on the backs of those areas. And if we continue to do that you are going to see the collapse of the inner cities, then your suburbs will go next. That is the only domino theory that I know that works.

Senator KENNEDY. I don't think the consumers need any more cost consciousness. They are footing the bill. No one knows what the cost is better than they do. And they have been the ones who have really been discriminated against by the system.

Senator Eagleton.

Senator EAGLETON. Thank you, Mr. Chairman. I would like to address two questions, the same two questions, to both Mayor Lindsay and Mayor Tate.

Mayor Lindsay, in your prepared statement you referred to the medical manpower problem and to its maldistribution. Later in answer to a question posed by Senator Kennedy you gave this very interesting statistic—that New York City has on its governmental payroll, in terms of its municipal hospitals, some 4,500 nurses and that you need 2,000 additional nurses to fill the requisite spots that your system would require.

Based on that let me ask you this question. Assume that you had an adequate budget in New York City to cover the whole multitude of municipal endeavors with which your city is faced—so assume for the moment the unrealistic—that your budget was sufficient. Even if you had money in the kitty could you find and hire 2,000 additional nurses to staff your system?

Mayor LINDSAY. Yes, that is a very complicated question, Senator Eagleton. There are several parts to it.

The big, expensive system we run, our Hospital Corporation, is budgeted at \$600 million, just for those 18 municipal hospitals and some funding to the voluntaries is included in there.

I think the key problem on registered nurses is housing. I mark that down as the No. 1 problem which you have in my city, and I would guess it is true of most cities. If you can lick that problem then you have made a giant step forward in the business of recruiting nurses.

Second, we train a lot of nurses in our municipal system. We have our own nursing schools in the city that we operate and run, and we train a lot of nurses through our own system and elsewhere we recruit them that then are spun off to the private sector. We lose a lot after we have trained them for a number of years and they go out. And I think our new Hospital Corporation because of the vast difference that has made in the management of these vast hospitals has improved our ability to attract interns, registered nurses, and paraprofessionals at every level.

Our hospitals couldn't exist just with the 4,500 registered nurses. We have vast numbers of technical aides and assistants and paraprofessionals and others who help the registered nurses.

The Hospital Corporation has been an exciting adventure for a lot of medical people, including the professionals, which includes the nurses. And my own guess is that if we had sufficient funds, which we don't, that if we could make additional strides toward improving housing and other benefits for the nursing profession that we would attract more nurses than we can attract now.

Senator EAGLETON. The testimony that we have had before this committee this year and also during the 2 days of hearings that I held last year on medical manpower problems revealed that on a nationwide basis we are short some 50,000 doctors, 150,000 nurses and 20,000 dentists. And I have been laboring under the assumption, and I still think I am reasonably correct, that even if we had all the money in the world to pay salaries, and if you had it in New York and we had it in my home city of St. Louis, that after all the jockeying around trying to attract competent medical manpower, there would still be these shortages unless we substantially and quickly beef up the medical manpower system. And you are absolutely correct, it is not only these professionals heretofore mentioned, but the whole gamut of medical personnel, including the paramedic, dental assistants, nurses' aides, and the like, of which there is a desperate shortage.

Mayor Tate, what is your problem in Philadelphia insofar as staffing your municipal hospitals is concerned with a whole range of medical manpower?

And I will cite one example from my municipal hospital in St. Louis. We do not have an anesthesiologist on the payroll of the St. Louis city hospital, either No. 1 or No. 2—we don't give them fancy names, we just give them numbers—and haven't had for 4 years. Thus, on any operation in those city hospitals where the presence of a board certified anesthesiologist is required, one is imported on an ad hoc basis or the patient is shipped out to a charitable or private hospital on a contract basis because we just

can't find one who will work for a salary at the St. Louis city hospitals.

So do you have problems manpowerwise?

Mayor TATE. I agree, sir. I am sorry that you do have that experience in St. Louis because anesthesiologists are perhaps the highest paid medical officer in any hospital. I know I had the shocking experience when I was a member of the city council of finding in checking the budget one day that back 15 years ago anesthesiologists were getting \$20,000 at that time. I think they are close to \$30,000 now, and we have four or five of them. But they are difficult to recruit.

Senator EAGLETON. If you give me the name of one of those I will buy him away from you.

Mayor TATE. Well, what do you pay? That is what they will say. I think they are attracted by what is the better price as they go from place to place.

On the question of doctors we have five medical schools in the city of Philadelphia. And you probably would get the impression that we were just overcrowded with doctors. We probably are overcrowded with doctors who are students and they become interns. But I think that one of the difficulties is at the time that they go to medical school they should sign a contract to the effect that they would serve some time in a ghetto hospital or in a related voluntary hospital.

We have an old age home for senior citizens at Riverview, which is a very fine place. Someone got the idea about 5 years ago that we ought to beef up our infirmary. You know, we can't get doctors who will go far enough to that home for the aged because it is too far to take care of those older people. Certainly they have all sorts of problems. First of all, they say we can't afford the money, it doesn't pay as much as it does some place else; and second, it is too far to go, or we have to go all hours, day and night.

And I think unfortunately—and I say this respectfully—that some members of the medical profession lack the commitment they should have for the ghetto. Many of them don't want to go into the old-fashioned practice on a neighborhood basis, and this is why this tremendous change has happened in the delivery of medical care. Where the family doctor had his office in a neighborhood, received everybody regardless of what price they paid, whether it be 50 cents or \$3 or \$5, they no longer exist, because as so many people know—and I am sure your testimony has borne this out—they are now specialists and they have medical clinics. So they have a cluster of doctors' offices in a very fine shopping center or an area which is similar to a shopping center where you can go from one specialist to another depending on what you have. This may be all right so far as their own profession is concerned, but it doesn't help the people back in that little old neighborhood which makes up the city.

In my testimony I said we have doctors but they are in the wrong places, and I think that happens.

Our doctors leave our five medical schools and they just fly over this home for the aged and say "isn't it too bad, so many old people

here," but yet they don't understand there are so many old people in that home for the aged that need their medical attention, going off to someplace where they get an attractive salary.

So as far as nurses are concerned I agree with Mayor Lindsay that it is a question of whether or not you provide appropriate facilities for them, because in recruiting nurses you have got to say that we have good facilities. We have a good training program. We do conduct our own nurses training program at the Philadelphia General Hospital, and as a result, we don't have as much difficulty with the recruitment of nurses for that Philadelphia General Hospital as some other places do. But when you have to take them in from other places you have a real problem.

Mayor LINDSAY. Some more data for you, Senator, in New York on nurses our exact figure is 4,400 at the moment. We are up 10 percent from last year, which I again attribute to the new Hospital Corporation. We should be around 6,500. We have between 20,000 and 21,000 licensed physicians in New York City.

Senator EAGLETON. What was that figure?

Mayor LINDSAY. Somewhere between 20,000 and 21,000 licensed physicians—18,000 of those physicians are involved in patient care. The ratio is 1 to each 444 persons.

On nursing an interesting Federal statistic is that of all Federal programs directly related to nurse training in the country you have had an increase of only \$3 million in the last 4 years, from 1966 to 1970—\$3 million, from \$53 to \$56 million.

Senator EAGLETON. That is, your figures show that the Federal Government's investment in terms of training programs, grants, and the like relating to nurses training, despite the figures that a quarter of a million additional nurses are needed in this country, has increased only from \$53 million nationwide to what?

Mayor LINDSAY. \$56 million.

Senator EAGLETON. In 4 years.

Mayor LINDSAY. Yes. One other point that is worth noting because it does relate to the question of nursing care, that is that the Congress has enacted legislation for alcoholism and lead poisoning and appropriated money in those areas, but none has been released or spent by the executive branch under the existing authorization.

Senator EAGLETON. That is part of the 11 billion dollar freeze that Senator Ervin and others have mentioned.

Mayor LINDSAY. Yes. Now that hurts us, particularly in view of the fact that our studies indicate that the concentration of attention in the area of narcotics and drug abuse, and to some extent on lead poisoning, has tended to lead people to lose sight of the problem of alcoholism, which is a very real problem and may be growing in the country.

Senator KENNEDY. Not only hasn't there been any money made available, there was nothing in the administration's budget for lead poisoning for 1972 in spite of the fact that legislation passed overwhelmingly in both the House and the Senate; and there is not a cent in the request for Senator Hughes' alcoholism legislation, in spite of the fact, as Mayor Lindsay suggested in his opening testimony, it is one of the principal problems.

Mayor LINDSAY. I won't go into the details of some of the programs and lengthy efforts that we have suggested in the area of alcoholism, but you may be interested in these statistics in New York. We estimate that public and private agencies probably reach less than 5 percent of the alcoholic population in the city. We estimate that number at about 300,000 persons who are in need.

Senator EAGLETON. The total estimate of the alcoholics which you and private organizations reach is 5 percent of 300,000?

Mayor LINDSAY. Correct; we figure that there is an annual bill approximately of \$150 million for the 15 percent of our welfare population who are alcoholics. Our data shows that an average of one-third of our adult psychiatric patients in New York City are alcoholics, and close to 40 percent of our emergency clinic outpatients have an alcoholic problem. Fifty percent of our tuberculosis patients have an alcoholic problem.

We have submitted a series of measures to New York State and the legislature, a series of bills to provide for State financing for treatment and various other measures having to do with alcoholism.

We have also experimented in our so-called Bowery program in New York, which is an experiment street level oriented to end the cycle of Bowery derelicts, very successfully. It has worked with foundation money, with city money, and a mixture of modalities, as they call it.

The Hughes bill was enacted last year which authorized grants to provide for alcoholism treatment and rehabilitation services, and there is no appropriation on that bill as yet, as you know.

Senator EAGLETON. One final question to either or both of you. You mentioned the five medical schools affiliated with a hospital. What is the interrelationship between those medical schools and their related teaching hospitals and your municipal hospital system insofar as the utilization of your municipal system in the training process? Are they getting the benefit of using your facilities for training purposes and are you also getting the benefit of having manpower supplied to you? Is there an ongoing relationship?

Mayor TATE. We advocated this some 10 years ago, Senator, when I was a member of the city council, and the program commenced rather well, and each of the five teaching institutions cooperated and we did pay them a fee for their services as required. Each of them had a contract. They operated for about 5 years, and two of the training institutions withdrew because they said it was too costly for them even though they had the advantage of the patient service and they had the advantage of having interchange with their interns and residents and students.

It is now down to three of the five, and I predict that within the next couple of years it will be down to just one of them because they are not satisfied with the amount of money they get for their interns and residents and student salaries.

There was a time—I don't know whether you remember it or not, but there was a time when an intern got nothing except his bed and board. Now they want a salary. A resident wants a salary which is better than an intern. And a student didn't get anything at all, just the privilege of going to the hospital with a group,

things like that. And the teaching institution now says that they must have this money or they cannot provide the service to our general hospital.

Now this is more than just ridiculous. It is prohibitive for us; if we had to go out and hire all of these people this would be a very difficult situation costwise. At the same time the teaching institution is getting a direct advantage of those patients whom they study and whom they treat with respect to their particular training program. I could name the institution, but it would serve no purpose because we have five fine medical schools in Philadelphia, and we are very proud of them, but they do say that this is a big cost. We feel the crunch, too, because the cost is getting prohibitive. I am sure that you probably have the same trouble out in St. Louis.

Mayor LINDSAY. In New York City we have nine teaching hospitals, approximately a dozen medical schools. All of our 18 municipal hospitals, with one exception, has an affiliation with a teaching hospital and/or medical school combined.

Senator EAGLETON. Would you describe those affiliations to be generally satisfactory?

Mayor LINDSAY. Satisfactory, yes; we have found that we couldn't function without them, and we would not be able to attract particularly the doctors and high-quality people, and in some cases nurses, in the absence of those affiliation arrangements. We know, and I guess everybody has found this out to be true in most cases, that you cannot run and operate a successful high-quality public public hospital without a medical school teaching hospital backup arrangement. The two must go together.

Now the affiliation arrangement to bring that about is very complicated and it has a lot of problems in connection with it. One of those problems again is cost control, and it is the same problem that the chairman was talking about a moment ago with respect to Blue Cross. When you are talking about medical schools, which are private for the most part, and teaching hospitals which may be private, again you are talking about areas where the pass-along becomes very easy. And the chief problem we have had on this is procedures and control systems that will correct imperfections.

Our Hospital Corporation under the leadership of Dr. English and Gordon Chase, the chairman of the board of the Hospital Corporation, and their able staffs, are in the process now of taking additional steps to bring this under tighter control in New York.

But the main point is that in the absence of this kind of a direct connection between the doctors, the professionals, the medical schools, the teaching hospitals, our municipal system could not exist and deliver high-quality medical care.

Senator EAGLETON. Thank you, Mr. Chairman.

Senator KENNEDY. Thank you very much, Mr. Mayors.

Senator Javits had some questions he would like you to respond to, and you could later file a written response.

Mayor LINDSAY. Yes, of course.

(The response to questions submitted by Senator Javits follows:)

The City of New York - Health Services Administration • 125 Worth Street, New York, New York 10013

Gordon Chase, Health Services Administrator

July 20, 1971

M E M O R A N D U M

TO : HONORABLE JOHN V. LINDSAY
FROM : GORDON CHASE CC.

The five questions asked at the Senate hearings on "Health Care Crisis" are:

- 1) What are our priorities for health care in New York City?
- 2) What is the estimated shortage of physicians needed to provide medical care to the City's "inner city residents"?
- 3) Would we support the concept of a term of public service in urban health care shortage areas by graduates of medical schools, as consideration for credits toward the repayment of student loans?
- 4) What would we recommend at the Federal level to assure greater recruitment and training of minority groups in our medical schools?
- 5) What is the estimated cost of modernizing health care facilities in the City to provide quality health care to all our children?

Priorities for Health Services

There are three basic dimensions to our priorities for health services in New York City.

The first relates to improving ambulatory health care, and we are acting on this in a number of ways. In order to increase volume and more evenly distribute these services, we are initiating programs that include construction of Neighborhood Family Care Centers, expansion of services in

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existing Health Department clinics and the establishment of Health Maintenance Organizations at some of our municipal hospitals. We plan to explore and implement innovative approaches to ambulatory care, such as the use of physician assistants and nurse practitioners to extend the scope of a physician's care, and we intend to refine procedures for monitoring ambulatory care in such areas as the "Ghetto Medicine" program (by which outpatient departments at voluntary hospitals are publicly funded) and the Health Department's audit of care given to Medicaid enrollees by private physicians, dentists and others. Importantly, we also initiated a State legislative proposal (the Ambulatory Care Bill, a copy of which is enclosed) that would provide adequate funding to hospitals and clinics that are willing to reform their method of delivering ambulatory care to provide comprehensive quality medical care efficiently, economically and with dignity. This proposal, however, failed in the most recent session of the legislature.

The second dimension focuses upon several kinds of health problems that are special afflictions of major urban areas. These include drug addiction, alcoholism, lead poisoning and rat infestation in deteriorated housing. These health problems affect large numbers of people. For example, in New York City there are over 100,000 heroin addicts and roughly 300,000 alcoholics. Further, these problems, particularly addictive diseases, reach far beyond patients to victimize many who do not suffer from the disease itself. The City's efforts in this area include our rapidly expanding methadone maintenance treatment program, an expanded VD control program, continued expansion of the lead poisoning and rat-control programs and increased treatment facilities for alcoholics.

The third basic dimension relates to broad health care issues such as scarce and maldistributed manpower, cost inflation and the inadequate catastrophic health insurance for most New Yorkers and non-existent coverage for others. These are of course national problems as well. Space does not permit recounting all our efforts, but I am enclosing copies of four State legislative proposals we recently initiated to help solve some of these problems. (These proposals are a Medical Scholarships Bill; a Physician Assistants Bill that is not dissimilar to Governor Rockefeller's subsequent Physician Associates Bill which was passed by both houses; a Unified Mental Health Services Bill and the above-mentioned Ambulatory Care Bill.) In addition I am enclosing a copy of my statement on hospital cost controls that was delivered to Senator Hart's Sub-committee on Anti-trust and Monopoly on January 28, 1971.

Estimated Shortage of Physicians in "Inner City Areas"

As you know, in the aggregate New York City is fortunate to have a relatively large number of doctors serving its population, even though the City, as a national medical center, provides medical services for many non-residents and though many of our doctors participate in research and teaching. Thus the physician to population ratio for New York City far exceeds the national average.

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Despite these facts, the distribution of physicians providing direct care to City residents is quite uneven. For example, in 1966 the national ratio of physicians in private practice to population was about 92 physicians for each 100,000 persons. Figures for 1967 indicate that in 12 of the City's 30 Health Districts the ratio of physicians in private practice to 100,000 persons was less than 92, and that in seven of these districts the ratios were from less than one-half (37) to about two-thirds (64) of the national average. To provide these 12 Health Districts merely with the national average of physicians in private practice to population would have required roughly 800 additional physicians practicing in these areas. This is by no means an insubstantial number, for in 1967 it represented about 6% of all physicians in private practice in the City.

The foregoing example may overstate my case a bit, to the extent that any shortage of physicians in private practice is compensated for by an adequate supply of salaried physicians working in health care institutions that serve the community. Unfortunately, however, the Health Districts in question are generally the areas of the City in which there is also insufficient hospital and clinic care.

Public Service in Health Care Shortage Areas

I definitely support the concept of giving credits on the repayment of loans to medical students who serve a term in an urban (or rural) health care shortage area. One could expect at least an incremental improvement in health care in these areas. Further, the exposure of involvement of numbers of young physicians to health problems in such areas could lead participants to develop career goals for the amelioration of health care conditions in "physician-poor" areas. Our Medical Scholarships Bill mentioned above was designed to initiate just such a program in New York State.

Possible Federal Action to Increase the Recruitment and Training of Minority Groups in Medical Schools

The most important thing that can be done on the Federal level to increase the percentage of minority group physicians would be to make it financially possible for any student, who is interested and capable, to pursue a medical career. The pressure on students from low income backgrounds -- in which category fall the bulk of minority group students -- to pursue a vocation that will improve their economic condition more rapidly than allowed by a career in medicine is almost overwhelming, especially when many of these students cannot see any way of financing the lengthy course of medical study.

The Federal Government can assist further by helping the nation's medical schools to expand their enrollments, to allow them to accept increased numbers of minority group applicants.

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Grants based on expanded entering classes and on greater numbers of graduates would inevitably change the makeup of the doctor population.

Finally, all Federal action, whether financial or programmatic, that demonstrates the Government's commitment to improving the health care of all will necessarily help enlist members of minority groups in the medical profession.

The Estimated Cost of Modernizing the City's Health Care Facilities in 5 to 10 Years

Current projections of the planning staff indicate that over the next five to 10 years the City will require roughly \$2.5 billion for capital expenditures in municipal and private non-profit agencies, in order to provide quality medical care to the City's population. This total represents estimated expenditures required for (i) hospital construction, replacement and renovation, (ii) neighborhood family care center construction and (iii) research and supportive facility construction, including staff housing and parking.

Of the \$2.5 billion, projects representing about \$547 million in replacement and new construction are in the City's capital budget and have been started. The remaining \$2.0 billion is distributed as follows:

<u>Voluntary Sector</u>	
Replacement and New Construction	\$ 500 million(1)
<u>Municipal Sector</u>	
Replacement	\$ 523 million
Renovation	332
New Construction	684
Subtotal	\$1,539 billion(2)
Total	\$2,039

(1) According to an estimate of immediate need made by the Health Services Administration.

(2) Of this total, \$300 million is currently in the City's capital budget. The resulting gap of \$1.2 million must be met by funds from additional sources.

Senator KENNEDY. I want to thank both of you gentlemen very much for your appearance. It has been enormously valuable and helpful.

Mayor TATE. Mr. Chairman, if you will permit me, I would like to send to you as the Chairman of this committee a very fine report we have with respect to delivery of medical care which was just published in Philadelphia just last year.

Senator KENNEDY. We would like to have it and include it as part of the record. And we want to thank you very much.

Mayor TATE. We appreciate your receiving us.
(The information referred to follows:)

**REPORT
OF THE
MAYOR'S COMMITTEE
ON
MUNICIPAL HOSPITAL
SERVICES**

THE CITY
OF
PHILADELPHIA



James H. J. Tate, Mayor

MAYOR'S COMMITTEE ON MUNICIPAL HOSPITAL SERVICES

Room 523, City Hall Annex
Philadelphia, Pennsylvania 19107

Earl Perloff
Chairman

James P. Dixon, M.D., M.P.H.
Principal Consultant

Joanne E. Finley, M.D., M.P.H.
Staff Director

February 16, 1970

Dear Mayor Tate:

I have the honor of transmitting to you the report of the Mayor's Committee on Municipal Hospital Services which was charged by you with determining the City's future role in the delivery of personal health care to the citizens of Philadelphia.

The main thrust of our report is a recommendation that the City place its primary emphasis on ambulatory care as opposed to inpatient hospital care. Such a change will result in an improvement in health maintenance through prevention, early detection and health education which will be accomplished by a program of comprehensive health care, in contradistinction to one of "crisis" medicine.

Furthermore, we recommend that the City's Health Department be assigned the responsibility of planning, evaluating and coordinating the personal health services for all Philadelphians. This necessarily includes supervision of administration of the Philadelphia General Hospital.

We furthermore recommend that the City increase its organizational and financial support of education and training of health manpower.

And finally we suggest that both at the planning and at the operational level there be important participation by the community.

The Committee is deeply grateful to its principal consultant, James P. Dixon, M.D., and his staff for their very important contribution to our deliberations.

Respectfully submitted,


Earl Perloff
Chairman

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- Walter J. Lear, M.D., Deputy Commissioner; Lewis D. Polk, M.D., Deputy Commissioner for Community Health Services; Dr. John L. Clay, Director, District Health Operations; Elton W. Barclay, Executive Director, Philadelphia General Hospital;-- all of the Department of Public Health; Norman R. Ingraham, M.D., Commissioner.
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Clarence Farmer, Chairman.

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PART I - INTRODUCTION AND FINDINGS

INTRODUCTION

The Mayor's Charge

In the Spring of 1968, Mayor James H. J. Tate asked a number of representative citizens of Philadelphia to form a Mayor's Committee on Municipal Hospital Services. In his invitation to participate in this important task, he made the following charge:

"... There has been much discussion concerning the Philadelphia General Hospital and what its role as a municipal medical institution should be in a modern urban society.

"These metropolitan problems demand thoughtful planning to determine both immediate and long-range objectives and goals so that the medical mission is always current with the times. This of course involves an analysis of the stated program of the Philadelphia General Hospital and determination

of its relationship with other facilities of City government delivering personal health services to its citizens. It also involves the immediate relationships with the private voluntary facilities and the changing patterns of social legislation affecting such services at the local, state and federal levels."

This report attempts to provide the answers to the charge made to the committee by the Mayor.

Study Design

In 1969 the committee named Dr. James P. Dixon as its principal consultant.

Dr. Dixon had been the Commissioner of the Philadelphia Department of Public Health in its first years under the new governmental structure defined by the Reform Charter of 1951. He had been most active in helping organize and implement the role of a modern urban Health Department, and of public hospital services within it. Although he had left Philadelphia to become the president of Antioch College, his reputation in public health and medical care is still well known.

Dr. James Dixon and his staff director, Dr. Joanne E. Finley, also director of health planning in the Philadelphia Department of Public Health began the preparation of a study containing:

Historical review of the development in Philadelphia of public participation in the provision of personal health care services.

Review of all physical facilities in which the city houses programs of personal health services. Therefore not only PGH, but Riverview Home for the Aged, and all the District Health Centers were carefully assessed by architectural consultants versed in health care facilities and their functions.

Statistical analysis of patients' characteristics -

The committee needed to know as much as possible about the use of health care resources by Philadelphia's citizens, and particularly the use of services supported by the local tax dollar. The characteristics of users of PGH, the District Health Centers, and hospitals from which the city purchases ambulatory care were studied.

The objective was to understand the impact local input might have on improving the whole health care system.

While statistics are revealing, they do not search into the attitudes and feelings of health facility users. Therefore, several hundred personal interviews of patients using PGH were conducted.

The goal was to determine why patients came to PGH; their subjective feelings about the hospital, its services and personnel; and their knowledge of and feelings about other sources of care.

The financial patterns related to the provision or purchase of medical care in Philadelphia were studied carefully.

The major question to be answered was what is being done with the City's own budget to provide personal health services and what leverage does this afford to change the system for the better?

Education for the health professions--The Philadelphia Department of Public Health, and Philadelphia General Hospital, train people for the health professions, either by direct conduct of training programs, or by the subsidization of training.

The committee examined these health education programs in terms of the need to use public dollars more effectively in meeting community requirements to expand the supply of manpower necessary to provide health care merited by all citizens of Philadelphia. The increased productivity of Philadelphia's own citizens was also at issue.

Management - Public hospitals and other publicly sponsored or administered health care programs are exercises in public responsibility for the health of citizens, under particular sets of administrative and management practices. In Philadelphia the policy for these practices is embodied in the Charter.

The goal of this important portion of the study was

- . to examine the efficiency of the current management system, and particularly of the hospital as it relates to other publicly supported health care services;

to examine strategies, within the limits of public law, for alternative systems for the production of good medical care at public expense.

The key issue at all times, was to design feasible administrative policy that kept accountability to the citizens of Philadelphia as the primary focus.

FINDINGS

Introduction to the Findings

Philadelphia has many assets that should produce a rational, effective health care system for all its citizens. Among these are a history of commitment to the well-being of its members, a modern and effective structure for the public administration of human services produced by the Reform Charter of 1951, and a tradition of productive public-private planning. This climate has also resulted in a commitment of local revenues to the production of personal health care services that is greater than the resources allocated to this worthy cost in many American urban centers.

Philadelphia City-County (they are synonymous) is the fourth largest city in the nation. It now has more than 2,000,000 citizens. It will probably hold its rank among cities in the next decade.

Two demographic projections stand out:

- The number of older persons over 65 in Philadelphia will substantially increase in the next decade--by as much as 40,000 more elderly persons.

The black population will continue to increase somewhat. These residents will be predominantly children and young adults.

The Charter charges the Philadelphia Department of Public Health with a responsibility to ensure the good health of all citizens. More and more government money has been poured into the existing health care system of Philadelphia in an attempt to produce good levels of health for all. In fact, of the approximate \$487 million spent on personal health care in Philadelphia in 1968, government at all levels bore 35.1% of the bill. But 63% of these public funds went to hospitals in the city, and the greatest portion of these large sums of money were used to cover the costs of hospital bed care.

The city's own general funds contributed \$26 million to personal health services, and 60%, or \$17.6 million of this went to the Philadelphia General Hospital where inpatient care again consumed the greatest portion of these dollars. Only a small portion of this sum purchased outpatient and emergency care in other hospitals. Shortcomings in the system have generally been attributed to a serious lack of funds, and in these times of reported financial strain, some hospitals have even suggested the need to close their emergency rooms.

The committee feels, in view of its findings, that in the past there has been no real examination of the relationship between expenditures of funds and the operation of the whole health care system. Past movement has been only toward increasing public funds--federal, state and

local to shore up the existing system, with few guarantees exacted that facilities and programs would be used effectively, or that incentive would be supplied to the parts of the system best organized to prevent costly illness, or to maintain health and productivity.

While costs have gone up, and public contributions to these costs have risen, there is no evidence that the health status of Philadelphians has improved.

Relative to many big cities with less in the way of good prenatal and obstetrical care, Philadelphia's overall infant death rate of 28.3 per 1000 live births, fortunately hovers close to the national average. But the U. S. infant death rate is far worse than that of at least 15 other countries. Still there is a health district in which the infant death rate is 47.4, and three other health districts in which it tops 30. There are three health districts in which diseases of early infancy are the fourth leading cause of death. This is out of keeping with national ranks. In another health district, accidents--many of them occurring to children at home--vied with pneumonia and influenza as a third leading cause of death. Again this is far ahead of national ranks.

In contrast to the national picture, in several health districts, debilitating emphysema has become the tenth leading cause of death.

Accidental deaths are preventable often by massive health education or better housing code enforcement. Most pneumonia and influenza deaths are preventable by good and regular medical care, not by last minute recourse to an emergency room, or no recourse at all. The rapid increase in emphysema in urban centers is felt by many to be related to an increasingly hazardous and polluted environment. The most massive prevention programs of the 1970's must be in restoring man's liveable environment. It is a mark of civilization to plan and spend to provide personal health care of high quality for all, but if the conditions which bring chronic disease and disability are permitted to increase, all of us will be disabled patients rather than contributing citizens and the cost of care will be beyond the means of any government.

Finding One

Of the nearly \$500 million spent in Philadelphia in 1968 for personal health services, the city contributed only 5-6% or \$26 million. This was divided between direct operation of services, especially PGH, and some purchase of care. In distributing some local funds for health care, the city has neither made this a major priority, nor has it slighted health altogether. In 1960 personal health functions received 10.7% of the total operating resources of the city; in 1968 9.2%

was allocated to health. Federal contributions rose during that period, however.

The amount of local budget given to health care does not provide sufficient leverage to give the City an effective economic voice in changing the system. Marginal leverage is present. Because the City has much greater flexibility in its decisions of how to allocate its funds than does the federal government, it could push the system in other directions.

This does not mean that Philadelphia can alter its own unwieldy health care system alone. But in terms of money, talent, and administrative organization the City can organize itself and its allocations of resources for the proper delivery of health service, with the proper input of resources.

Certain programs will only work to ensure the health of Philadelphians if they are regionally-based. This is especially true of the prevention and control of ill-health related to our noxious environment.

Personal health services will only become relevant when they are organized comprehensively and supported by national policy that provides purchasing power. This implies a social health insurance system that covers all. It predicts that the federal government has learned the same economic lessons as has Philadelphia from the mistakes of Medicare and Medicaid which have covered mainly the costliest hospital-based

care for the citizens with the costliest health needs.

The City of Philadelphia is in a position of early advantage with regard to federal and regional arrangements that are bound to come.

Finding Two

What is this system that needs to be changed? It includes 44 private hospitals, one large public hospital--all told about 13,000 beds; 7900 of these beds are for short-term acute inpatient use; 4500 more beds are associated with medical schools or the College of Osteopathic Medicine. There are nine public health centers and a tenth to come, three comprehensive neighborhood health centers funded by OEO, at least four more self-help neighborhood health centers and four union-funded comprehensive programs--one includes a hospital. The city purchases ambulatory clinic care from 34 hospitals and emergency room care from 30 hospitals.

Nine of twelve catchment areas in the city are developing the spectrum of mental health care required by Community Mental Health Centers legislation; there are also at least 7500 psychiatric beds in the city, most in state institutions.

There are over 600 rehabilitation beds in a variety of institutions, including PGH and specialized rehabilitation hospitals. There are 109 facilities, including the city's own River-view Home for the Aged, providing 9,357 beds

for the long-term care of the aged and handicapped. About 65 of these institutions are classified as nursing homes, and only 12 are in conformance with state standards.

There are about 5500 physicians in Philadelphia of whom approximately 3500 are involved in direct patient care activities.

As to Hospitals -

There are 6.5 beds per 1000 persons in Philadelphia. Comprehensive health care plans (such as Kaiser-Permanente) estimate and use only 2 beds per 1000 enrollees. These beds are kept more than 90% occupied. In Philadelphia the average occupancy rate is 78.5%. However, where there are beds, uses are found. These may not be the appropriate uses of costly acute care beds. In Philadelphia, the average length of stay in these beds is 11.4 days compared with a national average of 8.4 days.

An over-abundance of beds does not mean suitably organized facilities. Hospitals are mainly centered, sometimes in sizeable clusters in center city and fringe areas of dense population. This is serviceable for today but will not be responsive to known population migration patterns within the city of tomorrow. In addition 14 of the City's 44 hospitals have less than 150 beds, another 16 hospitals have less than 300 beds.

Yet most hospitals are still fighting for their own existence--whether serviceable to the city's needs or not.

As to Physicians -

There is also an overabundance of physicians. In Philadelphia there are 2.32 medically trained physicians to 1000 persons. The national average, regarded as adequate, is 1.25. (The figures do not include osteopathic physicians. In Philadelphia these comprise 11% of the doctors in practice. Thus the ratio of doctors in practice to population base is even greater.)

Again, overabundance does not spell adequacy of service or suitable organizational patterns. In Philadelphia, because of the number of medical schools, there is a high degree of teaching hospital based practice. There are also an above average number of physicians in specialties. Office locations concentrate in the center city commercial area; therefore, physicians are maldistributed throughout the city. One health district with 9% of the city's population has only 4% of the physicians and a surprising proportion of these--29%----have no hospital affiliation.

As to Ambulatory Care -

There are virtually no group practices nor any Kaiser-type plans. The comprehensive ambulatory programs which have been in-

spired with federal assistance and do have back-up hospital arrangements, are already showing a lesser need to hospitalize their patients, even though they are low income people with poor health histories from previous lack of coordinated care.

Three-quarters of the hospitals do have some form of organized outpatient department. These are the only other ambulatory facilities that show some consistent pattern of neighborhood use. The city's funds to purchase care, used in greatest proportion to meet some of the deficits of outpatient departments, may have assisted this process, and have certainly decreased the geographically illogical use of the clinics of PGH.

The city's district health centers could not, heretofore, be considered part of an ambulatory care system because their programs were largely limited to the categorical care and prevention of certain diseases.

Because there are so few comprehensive, well-arranged ambulatory care programs, use of hospital emergency rooms in lieu of family physicians continues to increase in Philadelphia. Over the whole city, an average of only 38% or less of the cases treated in emergency rooms appear to be of a true emergency nature.

Most of this walk in care in emergency rooms is now rendered for the common

illness such as upper respiratory infections, gastro-intestinal disturbances and the like.

As to Long-Term Care -

When a community has no central focus for total health planning there will be a mal-distribution of services and a lack of relevance of existing services to actual requirements. Philadelphia's most marked example of this truism is in its critical lack of facilities and programs for the medical and social problems of older persons.

There is an absolute shortage of long-term care facilities in the city, and many of the existing institutions are of substandard quality. Most of these institutions--good or poor--find it impossible to provide services to public assistance clients at the present state rates. This has resulted in the over use of acute care hospital beds to provide extended care for large numbers of individuals unable to find help in less costly facilities. This is especially true at PGH. The waiting lists at Riverview also increase each year.

With the great likelihood of a substantial increase in the older population of Philadelphia in the next decade, it is projected that about 1500 to 3500 new nursing home beds will be needed by 1980. In addition, 3000 existing non-conforming beds must be replaced. But the incentive is not now

available to the private sector either in capital costs assistance, or in allocations for the purchase of care, to create the very necessary solution to this important problem.

As to Education for the Health Professions -

There is an abundance of training for the health professions taking place in Philadelphia. This is occurring in a multitude of duplicated programs, without any central knowledge of projected manpower needs, or plans for meeting defined need.

Future emphasis of local effort and subsidy need not be on training physicians and dentists. There is clearly a sufficient supply in terms of numbers, though there are the problems of maldistribution and over specialization already mentioned.

However, the number of practicing registered nurses per population is critically under the national average. Local nursing school enrollment continues to decrease.

One important fact is that black and other minority citizens of Philadelphia are presently acutely under-represented both in training programs, and in the higher echelons of professional health practice.

Black physicians make up only 3% of the practicing doctors in Philadelphia. Black dentists make up 7% of dental manpower. Black RN's employed

in local hospitals make up 6% of the nurses employed by these same hospitals. In 1969, medical interns and residents in training at PGH were respectively 2% and 1% black. Candidates for these positions are wholly under the control of the affiliated medical schools, though the city subsidizes this post-graduate education in return for receiving these physician's services.

However, only the medical lab technician training and the licensed practical nurse programs at PGH, more directly under the Hospital's control, had substantial numbers of nonwhite enrollees in 1969.

Finding Three

This health system is supposed to provide excellent personal health care for all Philadelphians. Within the system the city operates the largest hospital, Philadelphia General, Riverview Home for the Aged, and nine district health centers plus their satellite programs. It also purchases outpatient and emergency care from over 30 voluntary hospitals. In actual fact, much of the patient care offered at PGH is purchased via the affiliation contracts with three medical schools.

The Department of Health administers and distributes city-federal funds to the Maternity and Infant Care Projects. A component of the Department of Health holds the role of county administrator and fiscal agent for the community mental health and mental retardation programs.

The Board of Health, presided over by the Commissioner of Public Health, has the clear authority to regulate in behalf of the public's health, and its regulations are ordinarily enacted by the City Council to give them the force of law. In relation to the Philadelphia General Hospital, the Board of Health does create general policy, but is only given the clear specific of setting the admissions policy of PGH. A separate Hospital Board of Trustees is given a cloudy mandate to be responsible for daily operation, not a function characteristic of the board of trustees of voluntary hospitals.

These mechanisms of public management--often unwieldy and insensitive--have produced both progress and obstacles.

In accepting a progressive role of purchaser of care (and therefore subsidizer of the private system) the City has not, until recently, concerned itself sufficiently with the quality or effectiveness of the services for which it pays. This is implied in the lack of conditions in most of its contracts, and the lack of funds and personnel to evaluate contract performance against public policy and good health care standards.

Until recently the Department of Health, though it has the clear authority to plan, and to set standards, has not had the funds or personnel to do the necessary planning its authorities imply. Health planning, initially conceived as required for the internal perfection of the public health role.

is evolving into a planning relationship with the entire community system.

Because of these gaps in the definitions inherent in the Charter, the public hospital has been one of the most difficult operating programs to bring within the context of public policy. The committee therefore, has emphasized the whole system at all times and the importance of viewing PGH within this system, not unilaterally beside it.

As to the Public Hospital

Administration

The physician manpower shortages during World War II dictated the necessity for public hospitals, including Philadelphia's, to enter into agreements with medical schools to preserve high quality medical staff to care for patients who were then quite clearly public responsibilities. But, today new evaluation is required to ascertain how the substantial differences in mission between medical schools and public hospitals can be resolved.

At PGH, disjointed administrative relationships to the rest of the Health Department, and the presence of three medical schools, all with differing interests, have created an unmanageable institution deprived of the means of fulfilling its mission of good patient care within a total delivery system.

Buildings

Care is being conducted at PGH in buildings that were obsolete when planned and are therefore extremely inefficient and expensive to operate. The city could build a new hospital to back the imperative ambulatory care programs that, by its design, size, type of beds and programs, would be considerably less expensive to operate than the present PGH.

Patients

PGH itself has become a major illustration of the adage that where there are hospital beds, they will be used and mis-used and their use may complicate and impede the best solutions to certain health problems.

As some freedom of choice has become available to previously indigent or elderly patients through federally assisted payments, the number of beds at PGH, and their rate of occupancy, has been declining. PGH reported 1858 beds in 1960, and 1577 beds in 1969.

- Today, though it is still classified as an acute care hospital, perhaps half of the patients occupying beds at PGH are
- patients chronically ill from addictive diseases;

- long-term care patients for whom other facilities do not exist or are not within their means;
- psychiatric cases;
- and other special problem patients for whom the city assumes responsibility.

There are only two health districts from which patients who become users of hospital beds are found in PGH in greater proportions than they are found in other hospitals. One is Health District 5, far to the east across the Schuylkill River. Here a high percentage of the city's poor and black citizens reside. In the same health district vocal citizens have firmly requested a different allocation of public resources--more to ambulatory and preventive neighborhood care than to beds. In Health District 4, patients are already using the beds of three other hospitals almost as much as they use PGH.

Other statistics taken from a 1969 census conducted by committee staff, confirm that PGH's inpatients differ in that 73% were black, while all other hospitals together averaged about 1/3 nonwhite inpatients. In total numbers, however, more black patients from all areas of the city were in other hospitals than at PGH on census day. Significantly more of the PGH inpatients were also over 50. In other hospitals 68% of patients at the time of the census had been there less than two weeks;

at PGH 55% had been there longer, many much longer.

The most significant finding to explain PGH inpatients may be that other hospitals reported no source of payment for the in-patient care of only 2% of all those in the hospital. Blue Cross paid for most, Medicare and Pennycare for many others. PGH is increasingly a last resort for patients who have no means to pay, or who have disorders with which others will not cope.

The emergency room users of PGH are even more characteristic of the deficiencies of the whole system. Patients do come from every health district, and are over 80% black. But there are indications that they have either been refused by other hospitals, or brought sometimes great distances by the police, or they simply have no other recourse. They come out of habit rooted in the lack of ability to purchase health service. They know they will not be turned away at PGH.

And yet, only 10% of the users of the emergency unit at PGH had any form of traumatic injury by its broadest definitions.

There is also a pattern discovered of use of multiple sources of care by all these patients in any one year. Still, residents of Health District 1, 2, 3, 4 and 5 used the

PGH emergency unit more than those of any other hospital.

- In stark contrast, from other hospitals, 65% of all inpatients at PGH came originally from the emergency unit--not from their own physicians, or regular care clinics, or by plan. In other hospitals, the average number of total admissions emanating from emergency units between 20 and 30%.
- An analysis of the use of outpatient clinics at PGH shows that these are in no way the primary source of ambulatory care for residents of any health district. The clinics most often used by residents of each health district are those most conveniently located.
- 176,944 visits occurred in the outpatient clinics of PGH in 1968, not including required use by city employees of the compensation clinic. Since the average number of visits per patient was high--8.5 visits per year--this represents about 20,800 actual patients. At least one other large teaching hospital, not in affiliation with PGH, recorded more clinic users.
- 90% of the clinic patients at PGH were black, and 2/3rds were female; 56% were over 50.
- The trust in the ambulatory resources of PGH is great among users. Only 31% of a large number of patients interviewed

felt care was better at PGH, but most felt it was the same as that in any other hospital. In the end, 65% said they would still prefer to choose PGH for their care, inpatient or ambulatory, even if all avenues of choice were open to them.

As to the Public Health Centers

Seven of the city's nine operating district health centers are excellent buildings that lend themselves, with very little alteration, to much more comprehensive programs for ambulatory care and screening and referral of patients into the most useful parts of the health care system.

For many years, study commissions and City Council, have recommended this more comprehensive and relevant utilization of the centers. They are now grossly underutilized by the citizens of Philadelphia, perhaps because their categorical and fragmented services are not relevant to the individual's total health requirements.

Funds were not provided, however, to support this important transition of the health center programs, until 1970. Even now, there is virtually no linkage between the health centers and PGH, or for that matter, any other hospitals. Nor can the medical director of Riverview achieve a staff appointment at PGH.

As to Public Provision for Long-Term Care -

Riverview affords the largest single component in the city for the care of the aged and chronically ill. Dedicated effort is producing a more modern program for good medical care and rehabilitation services to its residents.

Riverview's older group of buildings are totally obsolete. A second group of buildings, erected after 1955 are generally well conceived, but will require renovation. New facilities under a Riverview Master Plan are well programmed, but not provided for in current city capital plans until 1973. However, serious consideration must be given in the city's extended care facilities planning, to the fact that Riverview is geographically isolated and difficult for workers and visitors to reach.

In the meantime, the city has no system for evaluation and referral to appropriate levels of care for chronically ill, aged and disabled patients.

As to Public Support of Manpower Training

The cost of health professions education at PGH was \$4,550,301 in 1968. Some indirect revenue returns were received by the city so that its actual input into train-

ing was probably about \$2.5 million.

The budget of the Board of Education contributed to fine programs for motivation and preparing young people for certain health careers. The City also contributes to the operating costs of the Community College.

At PGH, \$3,231,097 of the \$4.5 million went to underwrite post-graduate training of physicians and dentists, as interns and residents.

The City's contribution to nursing education was its most significant in terms of manpower needs. Of 53 1969 graduates of the PGH School of Nursing, 43 stayed with the hospital to work, 8 more stayed to work in the hospitals of Philadelphia.

The lack of need for greater numbers of doctors to be trained has been previously documented. Equally, the need to train and retain more black physicians for Philadelphia has been underscored. The city's substantial subsidization of doctor training has not, to date, brought this result. Nor has it been managed in such a way, as is the case with public health residents in post-graduate preparation in the rest of the Health Department, so as to insure that the doctors remain to serve the citizens of Philadelphia.

The city's direct subsidy of training primarily through PGH has not contributed substantially to the preparation of allied health manpower for which there is a great need. The Community College and its students are bearing much of the cost unassisted, and training the greatest proportion of black citizens for useful and dignified health occupations.

There was no city expenditure for health manpower planning.

These are the major findings of the Mayor's Committee on Municipal Hospital Services.
These are the facts which, on most careful deliberation, have led to our recommendations.

PART II - RECOMMENDATIONS

RECOMMENDATION #1

That the City participate actively in shaping national and state policies affecting the provision and delivery of personal health services.

The City has a major stake in these policies. These policies are the major constraints upon the City's own decisions. Gradually, national policy is coming into accord with Philadelphia's historical position. It is now held that access to personal health services is a right of citizenship, not a privilege of social class, economic group or accident of birth. This change in national policy is being implemented by economic means. Both the Federal and State Governments have instituted systematic payments of public funds to provide health services to persons. Such funding has made substantial impact upon the revenues produced by Philadelphia General Hospital and, to a lesser extent on the income of the Community Health Services.

To date, the principal local emphasis of this policy has been on the provision of institutional services. This is a natural first step in accord

both with the urgent priorities of people and the acute financial need of hospitals. But this first step calls promptly for some subsequent steps. In a very short time it has become clear that the support of institutional care without a concurrent vigorous support of ambulatory care, and attention also to the education and training of health personnel, is counter-productive. Institutional services are productive, only when correctly used. If they are the only services available, they will be over used at great economic, social and psychological expense, or misused to the detriment of the patient and the reputation of the institution.

As access to health services becomes a right, then decisions as to what health services are appropriate and how they will be organized, financed and staffed, increases in importance. Philadelphia is in the process of working now on these decisions. The City has both a stake in national and state policies and a contribution to make to their formulation.

RECOMMENDATION #2

That the City accept as a public responsibility the planning, evaluation, coordination and facilitation of personal health services for all Philadelphians and that it assign the conduct of this responsibility to the Department of Public Health.

It is in the genius of American politics to act to assume public responsibility when failure to do so would result in destructive conflict between chaotic free enterprise and repressive authoritarianism. Such conflict usually arises when change goes unrecognized and people see the present as if it were no different from the past.

The pattern of the provision of personal health services in Philadelphia is changing. What exists now is not free enterprise, but a system of highly interdependent activities. Activities generated by several thousand physicians, nurses, and other health workers, two or three score hospitals, more than a dozen health centers, a half-dozen medical schools, a Department of Public Health and 2,000,000 people. In the past, by defining its obligations in terms of indigency and special services, the City could deal expeditely with the other elements in the system, because it could meet its objectives as a member of the system by the direct provision of services by its own agency. Traditional public health services could be provided by public health

centers; medical care could be provided by Philadelphia General Hospital.

With the removal of indigency as a criterion for public responsibility at the local level, and with huge new expenditures of public funds for the purchase of personal health services, the City's role has shifted from one of accountability to the needy and those needing special health services, to accountability to all Philadelphians for access to adequate personal health services.

In order to carry out this new responsibility, the City will need to establish and maintain an activity for health care planning, equivalent in its sophistication to city planning as a whole. Such an activity would apply economic, social, and professional analysis to the community to define where beds should be, where health centers should be located, how health services should be financed. It would develop minimum standards for health care. It would deline the strategy for the City's own operations.

The City's intent shall be to work cooperatively with, and assist the existing regional planning agencies, rather than to operate in conflict with them.

The Philadelphia Department of Public Health is widely acknowledged as one of the best in the nation. Historically, the Department has had an interest in the community system for personal health

services, but does lack a clear public mandate to oversee this system. With such a mandate it could move with competence and dispatch into the coordination of personal health services for all Philadelphians.

RECOMMENDATION #3

That the City now place its primary emphasis on the provision of ambulatory health services, changing the role of health centers and the Philadelphia General Hospital accordingly.

Our study shows that the provision of ambulatory care services is the most pressing need to Philadelphians.

This is so for humane reasons. Many Philadelphians do not have family physicians. This is most strikingly true but is not limited to those who live in inner city areas. This also happens because of the increasing specialization of medical practice, the uneven provision for reimbursements for ambulatory care and most importantly the absence of any social institution other than the hospital which can provide appropriate services.

This is so for economic reasons. A visit at a comprehensive primary care clinic costs about \$15.00; a hospital day about \$75.00. Well-managed ambulatory care extending into evening and weekend hours is less disruptive of family and employment patterns than when similar services are provided by the hospital.

This is so for professional reasons. One of the most useful recent inventions in the provision of health services is group practice. Its combination of accessibility to services with availability of specialists' services results in better health and in a markedly lower use of hospital beds. Group practice can operate only if it can concentrate on ambulatory care.

Further, our economic studies support that there is a clear possibility that the City can gradually switch the emphasis in its own health care expenditures to ambulatory care and away from hospital care. By providing good ambulatory care, the City can reduce the need for and the cost of hospital care. The cost of managing an illness on an ambulatory basis is substantially less than on an inpatient basis. This has been demonstrated for closed systems such as Kaiser-Permanente, where the highest degree of efficiency can be expected when such management is applied.

The main outlines of such a change over strategy are as follows:

The City would begin now to extend the services of the District Health Centers to furnish primary health care at hours most convenient to the clients. The conversion of all existing and new health centers to this new service should be undertaken over a three-year period. These services would be an addition to hospital outpatient clinics and existing neighborhood health centers.

Any person in the community might go to a health center. If he could pay for it the city could be reimbursed for the services, payments would be expected. Access to this method of care would be denied to no one.

The Centers would be staffed on the group practice principle. They would include the widest possible range of services including, even those for addictive diseases. Each center would have back-up hospital services. As the centers become activated, much of the outpatient demand and part of the in-patient demand on Philadelphia General Hospital would be reduced.

Since the present Philadelphia General Hospital is obsolete and beyond economic renovation, the City could decide not to build new hospital beds, merely to phase out the present beds. This is a

theoretically possible solution, but we think it is not practical. It is possible because Philadelphia as a whole has more hospital beds per person than said to be needed for an efficient system. But close analysis suggests that the excess beds are not equally available, or more particularly beds are not now provided in proper relationship to the proposed methods for delivering a total spectrum of health care.

We believe that there are three reasons why the city needs to construct a new hospital. First of all, it needs to offer some back up for its new ambulatory system with some beds that it controls in order to avoid being completely at the behest of contract arrangements. Second, it needs to provide services which cannot or will not be provided elsewhere and to provide them in the most progressive and efficient way. Third, it needs a model of excellence to demonstrate the role of a hospital in a progressive delivery system. Caution is needed, however, not to overemphasize the number of necessary beds.

It seems clear, for instance, that alternative satisfactory arrangements can be made for the Police and Firemen's Ward and Compensation Clinic. New strategies in psychiatric care might reduce the need for city beds. If the city had available more extended care facilities, a variety of patients with special problems of chronic illness would be cared for elsewhere and in different and more appropriate ways.

We recommend then that concurrent with the development of ambulatory services, the City should plan and construct as soon as possible a hospital of an appropriate number of beds to be determined by detailed master planning. We suggest that the construction be prompt because of the vast diseconomy of conducting medical care in the present Philadelphia General Hospital facility, and that there be adequate support for services at the present Hospital in the interim period.

A new hospital could be, but need not be, built on the present site of Philadelphia General Hospital. Building on another site would simplify the construction, free the Philadelphia General Hospital space and land for other purposes and correct some maldistribution of beds in the community. Nor would such a hospital necessarily be staffed by contract with medical schools, but might be staffed by agreements with medical group practices. Such a hospital should be part of a teaching program and this program does require a medical school affiliation on a mutually agreeable basis.

RECOMMENDATION #4

That the City of Philadelphia adopt the major recommendations of the Pennsylvania Economy League report - "Caring for Philadelphia's Needy Aged", as a basis for its own action program in meeting the growing crisis in the provision of facilities and services for the chronically ill, and infirm needy.

Our findings substantiate the fact that in the midst of an otherwise sophisticated and relatively well conceived system, there is a dearth in Philadelphia of both planning and facilities and services for the chronically ill, and for infirm older persons. This is particularly true if the needs of these citizens include some aspects of medical care, as will most often be true in parts and periods of their life span.

Therefore, the City should join with others in

- . Encouraging the Commonwealth of Pennsylvania to assume the complete responsibility for the governmental financing of needy Pennsylvanians who are chronically ill or impaired.

In the meantime, the City should not withdraw its interest in the care of the aged and chronically ill. It should

- . Include in its plans the facilities and services required
- . Stimulate and persuade private organizations to furnish essential services as needed.
- . Provide "seed money" by contracting with private agencies for innovative and experimental programs.

In the event that the Commonwealth, assisted by redirected national policy, does not assume the responsibility for the financing of care for the needy aged and/or chronically ill in the very near future, the City will have to meet the responsibility to its citizens through construction and operation of facilities and programs. This should be done within a most flexible posture so that these programs can be turned over to private operation, but under public surveillance, when the financing system permits.

Therefore, we recommend

- . That the master planning process for the new Philadelphia General Hospital take appropriate recognition of the need for convalescent care arrangements after acute illness episodes.
- . That an extended and chronic care facility of at least 200 beds be constructed as a part of the new public hospital complex, and in a location more accessible to the friends and families of the patients than is the site of Riverview.
- . That public capital budgets for health care, or redevelopment and other funds over which the City has planning and disbursement control, be studied for their application to assisting the construction of extended care and/or skilled nursing home facilities related to
 - . housing resources for the aged;
 - . the ambulatory care centers;
 - . the back-up hospitals for the ambulatory care centers.

RECOMMENDATION #5

That the City take certain steps to bring the administration of the Philadelphia General Hospital under the supervision and control of the Department of Public Health.

As long as the City was meeting its health services obligations by the direct provision of services alone, there was some justification to maintain the distinction between the administration of public health services and the Hospital's patient care services. It seems to us that this effort to maintain a distinction is now counter-productive. Far from bringing clarity to public accountability, it seems to produce ambiguity and confusion, and this, despite a high level of competency and commitment of the individuals serving on the Departmental Boards.

As things presently stand, responsibility and accountability is divided between the Board of Health, the Hospital Board of Trustees, the Health Commissioner, and the Executive Director of the Hospital. On some matters, the hospital works with central city agencies as an autonomous unit. In other instances, the Department of Public Health is responsible for elements of the administration of the Philadelphia General Hospital. In still other instances, the Board of Health and the Board of Trustees act jointly. It would be nearly impossible to implement the central recommendations of this report

which direct the Health Department to provide health systems coordination for the entire community if the City itself was unable to clarify, in a corresponding fashion, its own internal arrangements.

We have considered the possibility that the creation of a health care authority might serve as a means of establishing new cooperative relationships. We reject this solution because there is not evidence of the possibility of merging into it other non-public community agencies, nor is the access of an authority to public funds direct or clear. Under this circumstance, the creation of an authority would mask rather than solve the present administrative problems. We propose, instead, that the City take the following course:

- Since the mission of the Department of Public Health, according to the Charter, is to set policy for all aspects of the public health system, mechanisms must be found whereby the actions and functions of the Board of Trustees of the Philadelphia General Hospital are brought into conformity with the policies of the Board of Health and of the Department of Public Health concerning all elements of personal health services and patient care.
- It is essential that the direction of the Hospital shall be by a person who in all ways is a ranking member of the senior

executive staff of the Department of Public Health with the same relationship to the Health Commissioner as the heads of the other operating units of the Department. With such a relationship established, it will be possible for the Health Commissioner, for the first time to truly make the Executive Director of the Hospital and his staff responsible for all elements of the administration of the institution.

- The City should merge its two budget accounts (the Health Department's and the Hospital's), into a single account to be administered by the Department of Health.

The power of the Board of Trustees of the Philadelphia General Hospital should be strengthened by the addition to it of citizens most involved in the hospital, and by a clarification of its responsibilities.

- In addition, the responsibility for the medical care aspects of the extended care functions of the Department of Public Welfare should be transferred to the Health Department.

We believe that unless these changes are accomplished there is little chance for needed improvement in the affairs of every day management of the Hospital and little chance that the strategy of interrelationships here proposed between health centers and hospitals could be made to work.

RECOMMENDATION #6

That the City, for the years immediately ahead, increase its organizational and financial support of education and training of health manpower.
That it do this in accordance with the plan to be prepared by the Department of Public Health in collaboration with all appropriate community agencies and interests.

In our study of the condition of health manpower in Philadelphia, we discovered a disappointing fragmentation of available information, and unfortunate gaps in relevant data pertaining to employment, vacancies and projected needs. We were dismayed by the extraordinary division, discontinuity and duplication of training programs. We were struck by a lack of coordination and an absence of planning for a rational health manpower system.

Following are some of the conflicting forces of change and reaction mainly responsible for the chaotic state of health manpower in this period of transition: a rapid growth in need and demand for health services as a concomitant of rising incomes; the development of technological tools which continues to create new health care specialities; continued general acceptance of the fee-for-service, solo-practitioner model that no longer reflects the complex reality of modern health care; the influence of federal funding that is rooted in a philosophy which defines health care as a right rather than a privilege.

There exists in Philadelphia a great potential for creating a rational manpower model that could significantly influence the health manpower structure throughout the nation. It must be understood, however, that the development of a viable local model will necessitate changes in attitude and policy on the part of professional associations and schools, health care institutions, licensing and accrediting bodies, public and private funding agencies and certain sectors of public opinion.

Unfortunately, there also exists in Philadelphia a condition that could permanently inhibit the growth of a rational manpower system within the health care field. An important sector of the population is virtually disbarred from participation in the upper echelon of the manpower hierarchy and, therefore, from the opportunity to influence policy. A health model must make provision for the utilization of the talents and capabilities of blacks and others in dispossessed groups in significant numbers at all levels within the manpower system.

Furthermore, health care consumers, especially blacks, have little opportunity to affect the manpower complex. No manpower system can be rational or acceptable which does not incorporate expressions of consumers' needs within its policy and decision-making apparatus. A health manpower model, therefore, must make provisions for obtaining and utilizing appropriate consumer feedback.

The data in subsequent sections of this report contain the outline of a necessary health manpower planning process, and the building of training programs upon this. We recognize that the counsel of certain components of the minority community was not included in the formulation of these recommendations in the same way as it was for the details of health services delivery. Professionals involved in minority group education, and equal opportunity, were consulted, but those to whom the educational programs might apply were not specifically involved. As already suggested, this will be an imperative part of the planning process.

RECOMMENDATION #7

That the City create in the Department of Public Health a Health Services Council representing the widest possible range of community interest and that the Commissioner of Public Health be required to seek the advice of this body on major policy matters.

Everything that has happened in the course of this study has confirmed the opinion that not only is the system for provision and delivery of health services complex, but so also are the related community interest. Some matters are of particular importance to the providers of health services, some are of particular importance to clients and some are of wide general public interest. We believe that it is not possible to know in advance what kinds of interest will need to be composed to solve a particular problem but we do believe that such a complex system can never be administered in an authoritarian fashion and that both the efficiency and design of the use of the health services requires continuous consultation both as to what alternative solutions are possible and as to what alternative solutions are acceptable.

We believe that it is correct to fix the public accountability securely in the Department of Public Health and we believe it to be consistent with the existing community planning to establish for the Health Commissioner an adequate advisory mechanism. The City has and may continue to create citizens advisory bodies for its operating units including District Health Centers. The purposes of this recommendation will not stand in the way of this process and in fact the body of highest advice to the Commissioner should include representatives of the local Councils. It would be understood that the Health Commissioner is not bound by the advice of the Health Services Council but in each instance of the making of public policy he would include the specific recommendations of this Council as an essential part of his findings.

PART III - PHILADELPHIA'S
EVOLUTION IN HEALTH CARE

As evolution in health care systems go, it is no surprise that the present Mayor's Committee on Municipal Hospital Services, in Philadelphia, was born of controversy. The events leading to the appointment of this committee were raised out of serious challenges to the existence of the present Philadelphia General Hospital as a proper place to care for the sick and injured.

The infernal controversy was sparked by a set of circumstances surrounding the death of a popular police captain in 1966, a day after an examination at the Philadelphia General Hospital for severe pain and a discharge with an innocuous diagnosis. Actually, the death probably only furnished the hone for already sharp feelings the Policemen and Firemen purported to hold against the hospital for the role this institution played in handling the compensation clinic functions for the employer - city.

But the aftermath was a period of damaging and revealing investigation--from the outside-- by City Council; from within by a Staff Committee. All related the hospital's shortcomings to a serious lack of funds, but none really looked at the Hospital and use of public health care funds in relation to the whole

health care system, which itself was also shaky--and costly--across the land.

The investigations of that stormy time were fed by glaring and troubling headlines. But no one looked at the lot of the rest of the patients who continued to depend on the Philadelphia General Hospital.

City Council moved to shore up the institution by doubling the funds paid under affiliation contracts, to three of the City's six medical schools, to render patient care at the Philadelphia General Hospital. Mayor James H. J. Tate moved to develop the leadership necessary to approach the problems of the hospital analytically by altering its Board of Trustees. He also ordered the study which has resulted in this report. He placed both activities under the Chairmanship of a well known businessman long active in hospital and health affairs-- Earl Perloff.

What is happening today in public health and hospital care, is happening in every area of essential human concern: Government, at all levels, is increasingly being asked to furnish the funds to meet and eliminate society's problems. In health the private sector has generally occupied itself with the more popular, more glamourous and more lucrative activities, leaving the public sector as the area of last resort. Although the role of public health is supposed to ensure the health of the whole community, traditionally public health services have been more the province of the poor, the elderly, and needy mothers and infants. In other words, those who must make do with whatever is doled out to them. Because of the neglect this implies, or the end results of disarray and fragmentation in the system, this often also means - too little - too late. This is the most costly brand of care.

This prescription is not what the doctor ordered. It provides neither the quality nor the quantity of medical care to the people who need it most. It does not sufficiently consider the health of the whole public. It does not consider the special problems of the poor and marginal, who in Philadelphia number 15 - 20% of the 2 million population. Nor has it successfully taken into account many of the problems of black people, who comprise about one-third of the population.

However, the City of Philadelphia demonstrates a history - and conscience - in the provision of health care that is not without hope. It has provided certain things longer -- or first -- before any other city. It has used the incisive process of public - private study for planning and policy making. Where there has been the decisive leadership to back the findings of these processes, results that have improved health care for all have clearly emerged.

For the last twenty years community need in Philadelphia has been met through a Public Health Department regarded as one of the best in the nation. It is formally organized under the City Charter to administer policy and program in behalf of preventive care for all, and some "emergency care" for the indigent. With strong leadership from the Mayor's and the Health Commissioner's offices, the City has tried to increase its services, either through expanding its own system, or through purchases from private hospitals' ambulatory resources. While not all of the decisions made during the progressive period that began in the 1950's were fruitful, public health in Philadelphia developed a general and apt sense of planning, organization and policy leadership.

With the advent of federal funds, through Medicare and Medicaid, as well as through other grants to states, or directly to the City,

the public health program has begun to have an impact upon both public and private institutions. But the additional funds poured into the existing system have not satisfied the current demand for service. The system has not been reorganized so that the delivery of care is economical, equitable, and of a uniform quality. In fact, new programs have only whetted the institutionalized appetites for more.

Moreover, because demand has increased, public responsibility has also increased, but something is still not working. In Philadelphia those programs operating under the central administration of the Public Health Department, have generally improved. But the performance is uneven. Conditions at the 239-year old, municipally owned Philadelphia General Hospital have triggered investigations and considerable debate. The rest of the hospital system is viewed by some as defaulting on certain responsibilities.

Neither the good--the unevenness--or the bad-- have occurred overnight. Over the past 200 years there are a number of trends that are worth describing--both to illustrate the bases of the City's present quandry--and the strengths upon which it can build.

The Past - 18th and 19th Centuries

Philadelphia has a medical ambience grown out of its fine hospitals, schools and research

centers. Its tradition is rich in concern for medical care for all people. Quaker ethic coupled with the infusions of people and ideas from other sources--sparked innovation and produced liberal government that considered humane ideals an important cornerstone of public policy. The result was the early establishment of institutions like the Philadelphia Almshouse founded in 1729, which as it began to dispense medical care, became the seedbed for the Philadelphia General Hospital. As this institution grew it was a marvel for its willingness to feel a responsibility to all people...black, white, Catholics, Jews, Protestants...paying and non paying. A French hospital expert visiting in 1788 said that PGH was surpassed by none in the world, except perhaps, for the one in Besancon, France.

Quite early the City began to cover the medical expenses of the poor. By ordinance of City Council, Pennsylvania Hospital was to receive reimbursement for the treatment of indigents who might otherwise have been ejected for failure to pay. And, creative as a community, Philadelphia moved progressively in its attempt to control disease. In 1794 it established a Board of Health.

Through most of the latter half of the nineteenth century, however, and the first half of the twentieth century, innovation died and the government of the City became moribund,

unable to provide minimal service, scandalously corrupt and unmanageable. In these years, what little movement there was, was a blowing with the winds of national trends. In effect, the City usually followed New York's lead.

In 1904 Philadelphia formally established a municipal Department of Public Health and Charities. This was the same year Riverview, the Home for the Aged was founded. By 1920 health and charity parted company in municipal government as the Department of Public Health and the Department of Welfare, each assumed its own identity. Public health services continued to be spotty and most of the activity was confined to the private sector with a number of clinics and specialty hospitals opened throughout the City. If public care suffered from the inaction and fiscal conservatism of local government, there were a few saving graces too. Philadelphia was saved from committing itself to New York's fate--a huge city with an expensive stockpile of municipal hospitals.

The gnawing recognition that neighborhood services might be a worthy goal is almost of antiquity in Philadelphia. By 1948 funds were made available for the purchase of seven health center sites, as well as for an increase in preventive medical care. Like everything else planned by the city at this time, the health centers were makeshift renovations of old structures and not necessarily suited to the

medical needs of the people they were supposed to serve. And despite the growing willingness of the City to assume some of its health responsibilities, efforts were largely futile because the day-to-day operation of the Public Health Department and its centers was not only misdirected, but chaotic.

The Late Forties - Time For a Change

By the end of the 1940's the ferment for change in government had reached its boiling point. Studies of all facets of operations in Philadelphia's City Hall were producing demands for improvement and for the codifying of governmental structure. Part of the concern generated was in the area of public health. In this period, with a new dedicated city administration, bolstered by the reform Home Rule Charter, public health in Philadelphia entered a new era.

For the City, the 1950's marked the beginning of planned orderly government administered by professionals with proven competence. In this atmosphere there was an attempt to define goals and to reach them. The last twenty years have been marked by constant redefinition of those goals, by the emergence of an increasingly more humane, well-balanced philosophy. In short, the City has committed itself to providing quality public health services to all people, with special emphasis on those

at higher risk of ill health--which certainly includes the poor.

Landmarks of the 1950's and 1960's

Part of the progress of the last two decades is attributable to the number of studies and commissions which built a consensus and direction for taking specific actions. What has emerged is a Philadelphia pattern. An idea is proposed. It is circulated for a while. Then it is suggested in another report, more emphatically. It is finally adopted. This is the scenario for action in Philadelphia. It began with the first significant study, the Philadelphia Public Health Survey taken by the private non-profit Health and Welfare Council. In this case, one key recommendation called for the formal development of ten district health centers. The idea had been proposed six years earlier, and it had been partially acted upon by the City Administration. The net effect of the 1949 survey was to refine and to detail the City's obligations and operations. It also pinpointed criteria for medical care, emphasizing preventive services. But these services were to be limited to the indigent. All such health policy was to be carried out in accordance with a comprehensive plan to be adopted by the City Planning Commission. In effect, the survey was the first rational determination of what the City had to do to meet the needs of its citizens.

The survey, which required six months and

included a two day conference of community leaders and outside experts, was a verdict on the condition of the system. And the verdict called for action. In bold terms the survey charged the Public Health Department with harboring "insufficient or incompetent personnel at various levels"... It saw "overlapping services and chaotic conditions". In the most effective understatement, the survey argued, "Minimal administration on an expedient basis, cannot result in well rounded programs based on the total needs of the people". This report paved the way for the health center construction which is presently nearing completion with a new center, the City's tenth, in the Northeast. This will leave the City with eight fine new buildings, and only two renovated hold-overs from the past (Districts 7 and 8) to replace.

The adoption, by the voters in 1951, of the Home Rule Charter obligated the City, not only to developing the health centers, but to concerning itself with the health needs of all its people. The Charter enumerated the powers of the Department of Public Health with the following language:

Section 5-300 - Functions

- a/ "Protection of Public Health. It shall administer and enforce ordinances and regulations relating to public health..."

- b/ "Health programs. The Department shall institute and conduct programs of public health and medical research and programs to promote public education in all matters concerning public health."
- c/ "Health facilities. The Department shall establish, maintain and operate health centers, stations and clinics, laboratories and other health facilities."

When put to the test of legal interpretation, the Charter also made the Hospital (PGH), a part of the Public Health Department. It placed it under a vague, policy-making supervision of the Board of Health over which the Health Commissioner presides. The Board of Health also was to determine the Hospital's admission policy. The Charter also specifies that there would be a Board of Trustees of the Hospital responsible for the "daily operation". In other words, PGH was as free as any voluntary hospital to run itself. However, it had to work within the confines of a municipal budget determined by the City Public Health Department, and it was supposed to work within the policies for health care administered by the Health Commissioner.

Foundations of Able Public Administration

When Democrat Joseph Clark took over City Hall after 67 years of Republican rule, he made it a clear point of departure with the past that he would run his administration in "a goldfish bowl". In each area of government the idea was to operate a highly professional department, to recruit the finest talent to fill top positions. He also wanted to make good on his campaign promise to change the picture of public health in Philadelphia.

Clark's new Health Commissioner, Dr. James P. Dixon worked with the Health and Welfare Council to appoint a Technical Advisory Committee to study and compile data on the cost and service rendered at health centers and to determine the extent to which the 1949 health survey was being implemented. The object was to aid the Board of Health in steering a course for the City's health centers program. The Mayor himself was critical of the actual operation of existing centers. At the dedication of one planned and executed before he took office in 1952, he said he was ashamed of the effort. He promised better centers in the future.

Hubbard Report

This new policy recommending committee of 1952 was chaired by Dr. John Hubbard, of the Board of Health. Its recommendations formed the foundations for medical care policy in the City, and for the implementation of a philosophy of fine health care for all citizens.

Key recommendations of the Hubbard Committee called for expanding health center services in the following way:

1. Comprehensive service for all
"... The term 'health center' then becomes not so much a structure of bricks and mortar as a vital community activity rendering direct health services to people in accordance with local need."
2. Health maintenance for the family unit
"...extension of health maintenance to all members of the family, looking upon the family as the focal point of community services."
3. "No sharp distinction can be drawn between public health and medically indigent... (and this) involves problems of public responsibility (which) cannot be ignored and will have many implications for health center programs..."

This remarkable report then proceeded to spell out, almost two decades ago, what today is favored and promoted as policy and program. It recommended that District Health Centers carry out a broad spectrum of direct comprehensive services for all. The cornerstone of programming should be health maintenance for the whole family. It suggested that every effort be made nationally and locally to rationalize financing of care so that there would be no double standard, "no bargain base-ment care for the indigent...while a better quality of care is reserved for the well-to-do".

Public Policy's First Rebuke

Despite the progress resulting from tighter organization of the Public Health Department, one institution defied the science of public administration employed by the Clark administration. That was the Philadelphia General Hospital. And to this day it continues to confound policy makers in their attempts to control or reorganize it, or even to make it a rational part of a health care system.

During his campaign Clark expressed interest in improving the quality of medical care at the Hospital. In 1952 his advisors were urging

him to bolster services to patients and to improve teaching for medical students by relating the hospital's medical staff more closely with the City's five medical schools. Their idea was to purchase services from the schools. Little did the new Mayor's advisors realize the extent of the storm that would be centered over the concept of contracts with the medical schools.

After more than a year of wrangling, Clark found that his hand picked board of hospital trustees were following his advice to be independent. A split board successfully gunned down his proposal. And the City medical staff which waged the successful battle against the contracts remained as suspicious as ever of interference from City Hall. In Clark's eyes "a small group of disgruntled physicians on the staff"... stood in the way of his "building from the ground up, for the first time, a really high class medical and administrative service at PGH". "They," he noted, "wanted to turn back the clock and maintain the medical empire they had built up under the previous administration".

Thus the proposal for affiliation lay dormant for another five years. Then, under the new Mayor, Richardson Dilworth, the idea was revived, and so was the controversy. There were terroristic claims by the doctors that patients would become "human guinea pigs". But most of the old champions of total independence for

PGH were dead and the contracts were signed.

Despite its difficulty in piercing the armor of PGH, the Clark administration was able to make a few dents. In late 1954, Health Commissioner Dixon contracted with architect Vincent Kling to determine the City's need for the facilities of PGH's stepchild, the Northern Division, an institution spread over considerable acreage in North Philadelphia. It was, by the 1950's, clearly under-utilized and largely unusable. For years, however, plans covered the drawing boards to expand the facility at a cost of \$16 million to the taxpayers.

The Kling Report

When it was published in late 1955, the Kling Report recommended the conversion of the Northern Division to a tuberculosis hospital, one preferably run by the State. Space freed at Blockley, the historic name for the main hospital, by the transfer of tubercular patients, could be used to pioneer an attack on the problems of other chronically ill people. Not only was this suggestion for the Northern Division a threat to amputate a limb from one of Philadelphia's sacred cows, but the whole study was a disquieting report card on the City's medical failures.

This report used previous studies to remind the public that it was failing to meet the needs of the City's young. It firmly suggested that munic-

ipal care was more and more becoming the province of poor blacks who had to accept what they received. It dispelled the popular theory of "overcrowding of hospital beds". By documenting the existence of 21,000 public and private beds, the Kling Report left the City free to place its money for health care elsewhere. It even warned that the possibility of "overbuilding is greatly increased because seventeen voluntary hospitals are planning to spend \$40.5 million sometime in the future to build 2,000 new beds". Although Kling argued that no new additions were needed at either Blockley or the Northern Division, he stressed that treatment of the chronically ill was a staggering problem in Philadelphia because 65,000 persons are disabled each month by disease.

What was unmistakable was the growing disuse of the Northern Division. Spread over a 58-acre tract, this half century old branch of PGH was a victim of modern medicine. Though it was capable of housing 483 patients, by 1954 it served only 268. Fully one fifth of its beds were dilapidated. And the diseases it treated were themselves dying out--these were tuberculosis, polio, smallpox and diphtheria. More and more it was the City's resting place for the aged, chronically ill. And their average stay was 57 days.

The fact that inpatient care at both branches of PGH was declining, having dropped 12% from 1931 to 1954, helped to weaken the political

resistance to shuttering the Northern Division. In effect the Kling Report paved the way for the next study, the Duane Report, which had a profound effect on public responsibility for medical care in Philadelphia.

Duane Report

When in 1957, Mayor Richardson Dilworth appointed the blue ribbon Policy Committee on Medical Care for the Needy, to be chaired by attorney Morris Duane, he was in effect consolidating all the gains of the past few years and pointing the way to the future. The Duane Report was the major watershed in the development of the City's public policy. It not only broadened the responsibility for the health of all citizens, but it was the first report to result in early and direct action. It benefited from the ground breaking efforts of past studies. Its two specific recommendations were heeded within a year: 1) the prickly question of affiliation with five medical schools was resolved when contracts with all five (though two dropped out within the year) were signed authorizing them to handle a portion of the PGH caseload; and 2) closing the Northern Division was stressed again, and consummated.

The Duane Report also opened the City's door to free or low cost medical care for a sizeable portion of the population. It saw the move as a logical extension to more than 100 years of expending municipal funds and supply-

ing care to the needy in all categories of medicine. "Promotion of public health and the prevention of disease is a prime duty of every civilized community", it stated.

It extended coverage by the City beyond hospitals and public health centers into the home and recommended the consolidation of visiting nurse agencies so that this could be done. And it stated that the Department of Public Health was given the freedom to take into account the type and the extent of care needed, the size of the family and its financial resources. In specific areas it urged that the State assume the cost of long term mental care, the City to assume short term responsibilities that tuberculosis care be shifted to the State (allowing for the closing of the Northern Division); that care of the acutely ill among the needy be apportioned to private hospitals as well as to PGH (which led to the concept and program of contracts with hospitals for the purchase of emergency care). This program of medical care for the needy was given to the Commissioner of Public Health, with day-to-day responsibility at PGH given to the Hospital's Board of Trustees and its director, "all of which are part of the Department of Public Health".

With this gentle nudge, the Duane Committee was attempting to resolve the problem never surmounted since the reorganization of health services in the language of the Reform Charter; namely the absorption of PGH into the system

and operation of the Public Health Department. "Slowly and after careful thought", the nature of inpatient care should be altered by segregating the chronically ill from the acutely ill. The hope was to send the chronically ill to a new rehabilitation institute where their state of health could be raised to the point where they could return home, and be followed by home care programs.

The health center program, growing since the early 1950's also came in for scrutiny by the Duane Committee. By 1957, four of the ten planned centers were completed. They were located in both North and West Philadelphia. Capital budgets were approved for the construction of the remaining six centers. But according to the study the operating budgets of the existing centers required a substantial boost from \$2.3 million in 1955 to \$3.8 million by 1957, if comprehensive programs of care were to be feasible.

The Duane Committee detailed the City's need for prenatal, postnatal and follow up care, as well as specific areas of child health requiring attention, and the care and treatment of contagious diseases. Adults were not only to benefit from coverage in the recommended programs, but "community participation", the watchword of the sixties, was described as a vital part of the answer to improving the health of the poor.

While the Duane Report had some difficulty in determining the exact local expenditure on the medical care of the needy, it was suggested that \$24.6 million was a good approximation. Almost half that figure however, was to be consumed by the Philadelphia General Hospital.

In other areas of finance, the Committee pointed to inadequate funding. Because hospitals in Philadelphia were impairing their capital position to meet the cost of care to the needy, \$1.6 million was recommended for five voluntary hospitals for the handling of these cases. It was recommended that the State place itself in a position to realize federal matching grants for indigent bed care by passing needed legislation. And thus the rising demands in various levels of government were joined.

Red Car Cases, Dollar Shortages, and More Reports

The Duane Report produced accomplishments and acts. It also spawned a prolific rash of further studies which clearly pointed to impending crisis, but did not produce action.

Emergency services need better defining, it said, and so a study committee was created under Charles Paxson. This proved Philadelphia like the rest of the nation was giving great numbers of non-emergent services in its hospitals--the substitute family doctor for the poor. Nationally, urban emergency room

utilization had increased by 400% from 1940 to 1955. In Philadelphia it was not as dramatic--but there was a 129% increase. The most marked growth was in cases transported by the Police Red Cars--in just two years, 1955-1957--the jump was 61%, and many more of these were sick people than traumatically injured.

By now, 29 hospitals were participating in the City's purchase program, handling 85% of the Red Car cases, PGH taking 15%. The report said loud and clear that the hospitals, even with the contract funds, were suffering deficits. While such efficiencies as the closing of the Northern Division saved the City some money, newer programs were creating greater demands on tax dollars. The modest budget for affiliation contracts, \$600,000 grew to two million in four years, and this amount was constantly upheld as inadequate payment.

What also became apparent was the failure of the grafting on of new medical school services to alter the internal operation of PGH. Autonomous, uncontrolled, a battleground for rival services from the medical schools, a place with no guidelines, overall policy or standard operating procedure, PGH in the 1960's could no longer meet the demands of the population it was supposed to serve. The misty legend that the institution housed the finest equipment and offered the expertise of the finest specialists and the best educational atmosphere for interns, could not vie with the firm reality of a

superannuated, unventilated, underfunded institution fighting a demoralizing battle within itself and under its multitude of "bosses".

Thus, in November 1963, Fred Corleto, Managing Director, and Dr. Norman Ingraham, Health Commissioner, revived the concept of providing ambulatory medical care in the District Health Centers. In a report to City Council, a half-million dollar appropriation was requested to handle 100,000 visits a year for services "similar to those furnished in a physician's office". PGH, they said, received about 243,000 outpatient visits, but this was only 2% of the City's needy receiving care. Voluntary hospitals were estimating their cost for caring for the other 71% at \$6.9 million (in 1962), of which \$4.1 million was deficit. Thus an annual contract appropriation of \$2,000,000 was recommended. It was anticipated that the more comprehensive use of the health centers would close the gap.

In 1964 the Mayor's Advisory Committee to Study and Recommend on Hospital Care of the Needy, headed by the late Al Paul Lefton, was appointed to try to make that year's contract negotiations with the hospitals coherent. Again, an increase in the allocations to the hospitals, now 30 in number, was recommended. The hospitals were not satisfied with the amount suggested.

The basic theme of the Lefton Report was not a new one. "The amount of medical care rendered to needy individuals", it stated, "must be related to the need for such care and to the resources available to the City to provide for it. . . . of \$14.2 million for all ambulatory services, the City paid \$4.8 million, including \$1.6 million for emergency care. And while the report complained about the shortage of funds for care, it also pointed to a shortage of information on which to base decisions about the contract arrangement.

Meeting the demands of an increased patient load among the needy was just one problem plaguing medical institutions in Philadelphia. According to the Hospital Survey Committee, the hospitals in Philadelphia had to face down a \$500 million question--in order to finance expansion and new programs in the next decade. PGH, with only 25% of its plant meeting U. S. Public Health Service Standards, was included in this appraisal. It alone could consume \$50 million in replacing obsolete equipment to bring the hospital up to par, if indeed this were deemed a necessary part of good planning.

But by 1966 something buried in the utilization figures was beginning to make a difference even among the needy. In 1960, PGH reported 1,858 beds of which 1,370 were fully in use for short-term care, the rest were allotted to long-term

care. By 1966, PGH was using fewer beds - 1,676 as reported and 1,115 of these were for short-term patients, while the number of a variety of long-term patients occupying beds had risen to 561.

What was making the difference must have been Medicare and to a lesser extent Medicaid -- Titles 18 and 19 of the 1965 amendments to the Social Security Act. Medicare was the first time beginning in the United States of a social insurance system to ensure health care as a right. The hastily added Title 19, was merely an effort to consolidate the reimbursement systems for a number of welfare medical aid programs. Medicare also made bare beginnings at tying payments to some measure of the quality of institutions. Medicaid, left to a diversity of state plans, did not. Nevertheless these financing programs now appeared to give some margin of free choice, at least, to segments of the population. Clearly the last resort utilization of the city hospital, was shrinking.

This small, but growing evidence, led the Hospital Survey Committee's report to a most basic question about the Philadelphia General Hospital and its future. The Committee asked: "A major question facing this community in developing longer range hospital plans and needs is the future of PGH. Should it be rebuilt to meet modern standards or should it be phased out and other institutions throughout Philadelphia increased in size to provide the services now provided by PGH?"

Unfortunately for the defenders of PGH, the question was raised at the very time that the police captain's death and the resulting investigations occurred.

Still another Crisis

The Hospital Survey Committee's report of 1967 was most optimistic in its predictions for the impact of Medicare and Medicaid.

Ward patients will disappear. "These acts entitle indigent and medically indigent patients to semi-private hospital accommodations at the hospital of their choice, out patient services, full diagnostic and treatment services, and treatment by physicians of their choice."

Medicare, by 1968, was covering 25% of hospital patients, but Medicaid was only providing \$4 for an out patient visit, when the city's hospitals reasoned that \$13 a visit was nearer to their cost. PGH, despite its own collections from these third party payment sources, was asking the City for still another \$8 million just to cover its escalating operating costs. Was the situation becoming uncontrollable?

Then, in the summer of 1969 the optimistic dream came apart. The State, declaring a severe fiscal crisis of its own, and a budgetary estimate for welfare costs alone short \$50 million dollars of another look at realities, issued an Executive Order to cut the eligibility standards for Medicaid ("Pennsycare"). The City had already reduced

its hospital contract funds by a million in a budgeting crisis of its own. The Pennsycare cut back alone, it was estimated, would eliminate from \$3 to \$5,000,000 from Philadelphia Hospitals, including PGH.

Dramatically, ten of the hospitals under contract to the City to render emergency and ambulatory care, threatened to shut their emergency rooms, which, they said, were a prime source of unreimbursed admissions. The City's contracts, of course, had never covered inpatient care. The old story of deficits in meeting the costs of caring for the needy was heard again.

This prompted a City Council investigation which spanked the hospitals for their callousness, but did focus, perhaps for the first time in the history of the City's struggles to underwrite health care as a right, on the problem of the high costs of hospitals and the nonsense of counting on the hospital as the only basic resource for ambulatory care.

The City Council Report pressed the Health Department to assume a policy leadership and planning role over the whole system, since it did not find this exercise of responsibility in the public interest in the private sector. The report clearly stated the assumption that the City would continue to purchase some care, but stressed that this must, at long last, be predicated upon a systematic plan.

In the midst of the City's agony, the mounting costs of care, the declared deficits by providers, and the articulate expressions from dissatisfied consumers, there were two bright spots. One did not hear very much about them, but they were both small activities on the way to the "better plan".

A committee of the Board of Health reporting in June 1968, revived the concept of providing ambulatory care in District Health Centers. And finally action occurred!

In Health Center #5 at 20th and Berks in North Central Philadelphia, the leading home of PGH's outpatients, the program began to convert, in September, to family care. The device was relatively simple--categorical services ceased, and the patients were enrolled in a total care program instead. In the first four months 2,331 patients enrolled. In the first year the Department of Health merely rearranged its own resources to support these changes, but for fiscal 1970--some new budget will be provided.

A small dent was also being made, at City expense, in improving arrangements for the care of the needy aged and chronically ill. These deserving human beings, if otherwise unplanned for, often fill expensive acute hospital beds for long stays. At PGH such patients often occupy as many as 400 beds.

Riverview, the city's home for the aged since 1904, was entering a brighter period, with vastly improved programs for the medical care of its residents and the promise of improved facilities. A report in 1968,

by the Pennsylvania Economy League took note of this start in new facilities at Riverview as a hopeful sign for improved quality of care.

Two years earlier Riverview was severely criticized by the Commonwealth for its poor facilities, inadequate staffing, and inattention to the medical care problems which abounded in most of its residents. Leadership again was the key, and by 1968 the master building plan for Riverview was underway, patient load had been cut to a manageable 850 persons, and both medical care and some patient transfers were being handled through a variety of purchase agreements that seemed to be working well. Riverview also increased its own staff, including for medical direction.

Summary

The conscience of Philadelphia has always included a concern for the health of all its citizens. It was the first city in the country to publicly support the care of the needy in the voluntary Pennsylvania Hospital, and it was historically a leader in converting its Quaker Almshouse to a medical care institution.

It did not however, organize and support a sophisticated Department of Public Health to oversee the public portion of the health care system until it reformed its entire governmental structure by Charter in 1951. Even then it did not completely resolve the problem

of where the municipal hospital fits in relation to public health policy.

The spirit of the City which produced the Reform Charter, also created a climate for public-private planning and studies that has been remarkable for productivity. When the leadership provided by political decision makers was sufficient to cut through selfish interests, many progressive advances have been made in health care.

The City produced a system of aesthetic and adequate Health Centers, tried to reorganize its public hospital to provide better care, entered into support and purchase of care from other resources, and continually increased its support to the Department of Health.

But in its many studies, only two stand out as having viewed the whole health care system, and the impact that the public role could have on its genuine service to Philadelphia's citizens. These are the Reports of the Hubbard Committee and the Duane Committee. Other hard-working committees have looked at only a piece of the problem: the inadequacies of the public hospital; the deficit financing of care by other hospitals for the ambulatory needy; the problem of emergencies--whatever that meant; the role of the Health Centers.

Unless the public role is related to the whole system, well intentioned recommendations may only serve to dig the City deeper into an impossible situation.

PART IV - PHILADELPHIA'S HEALTH CARE
SYSTEM TODAY

A. Philadelphia Today And Tomorrow - A
Short Demographic Description

1. Introduction

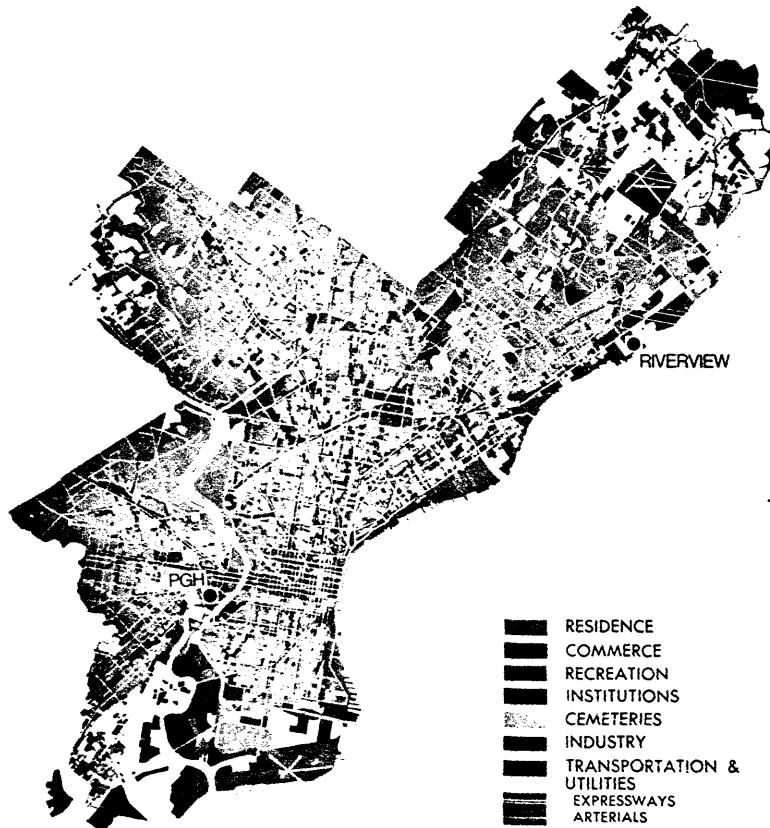
The success of any planning process is determined in part by the quality or accuracy of the demographic information available to the planners. In the United States most of the basic information necessary is derived from the U. S. census taken each decade. Unfortunately, we were at the end of a census period while conducting this study and a great deal of the information contained in this report is obviously in need of revision. However, the committee feels that the information used is the most accurate available and in general provides a fair estimate of the present situation in Philadelphia.

2. The City Plan

Another factor which influences the planner's ability to predict future trends is the presence of a viable plan to serve as a guide for the future

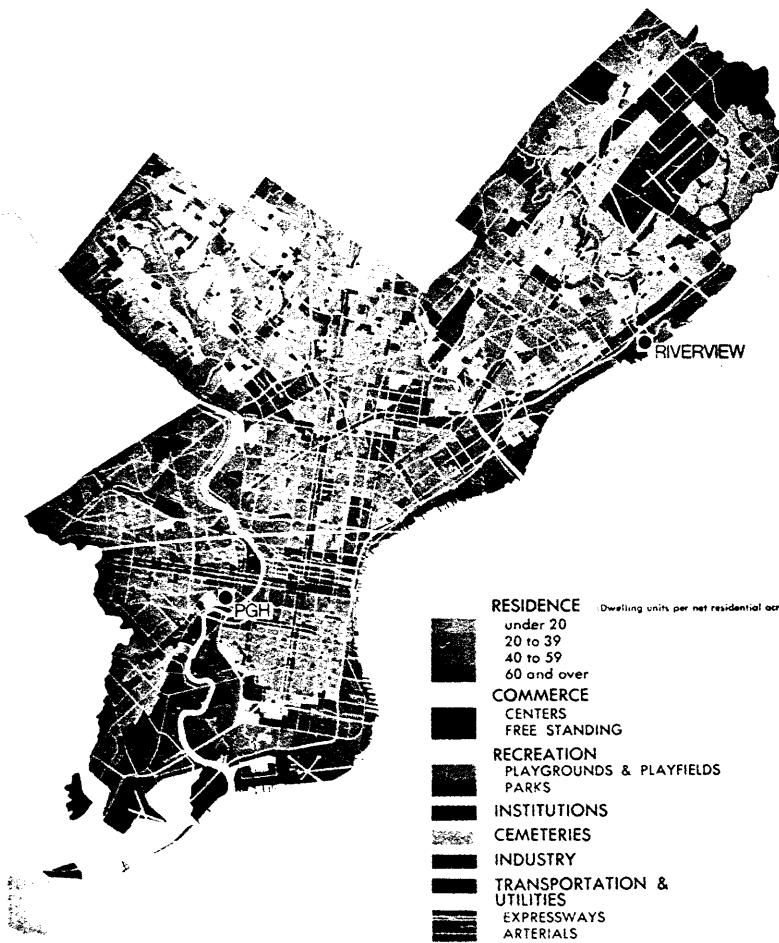
growth and development of the City. Fortunately a very good plan for Philadelphia exists and has already had an important influence on all aspects of urban developments. One can say that a tradition of planning exists in Philadelphia which in itself will help prevent any real planning disasters from occurring.

Although the City Planning Commission points out that the planned and actual use of some city land has not been in strict accordance with the plan, they feel that in general Philadelphia will continue to follow the basic principles established and one is quite safe in using the plan as a guide to the future city.



Map #1, prepared by the City Planning Commission, describes the present use of land in Philadelphia. One can see that in many cases incompatible land use has led to the decline of many areas of the city as desirable places to live or work. This situation is particularly evident where heavy industrial and residential uses conflict.

1 EXISTING LAND USE



Map #2 shows the proposed plan for land use in the city. Here one sees the potential results of a rational plan for development. Conflicts are minimized by the separation of incompatible uses while access to necessary services is enhanced. It is this plan that must serve as a basic guide to the future plan for health services in Philadelphia.

2 COMPREHENSIVE PLAN

3 PLAN FOR TRANSPORTATION

56

- EXPRESSWAYS
- ARTERIAL STREETS
- RAPID TRANSIT LINES
- COMMUTER RAILROAD LINES

Map #3 shows the Philadelphia Master Plan for Transportation. Again, the success of any new health service planned will depend in part upon ease of access for the potential users of the service, public or private. The existence of the transportation plan will help assure that this will be the case.



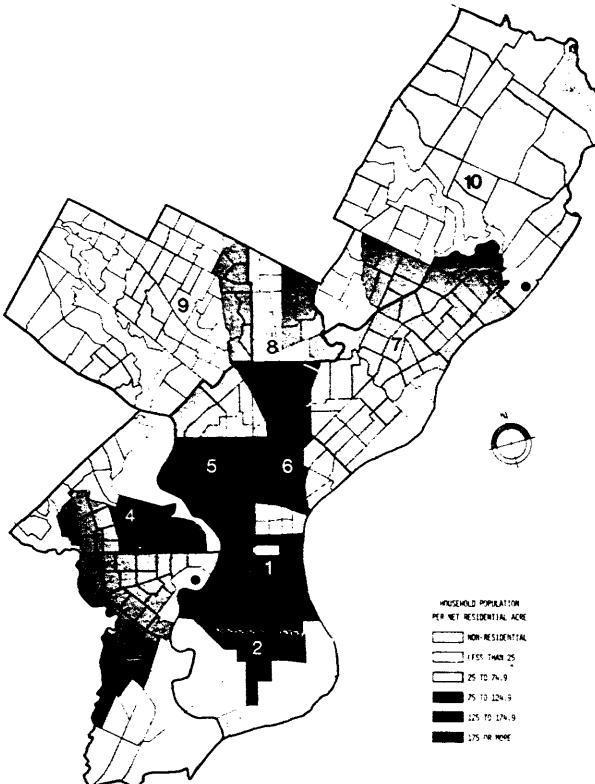
1333

3. Population Estimates

The City Planning Commission estimated the 1967 population of Philadelphia to be 2,041,700 persons. Of this total, the nonwhite population was estimated to be 641,000 or 31.4%.

The greatest concentrations of people are presently found in Center City, lower North Philadelphia, southwestern Kensington, the northern part of South Philadelphia and the southeastern part of West Philadelphia. These heavily populated areas are also, in general, the neighborhoods where the nonwhite population of the city lives.

Map #4 shows the distribution of the total estimated 1967 population of the city in terms of persons per net residential acre by planning analysis sub-section.



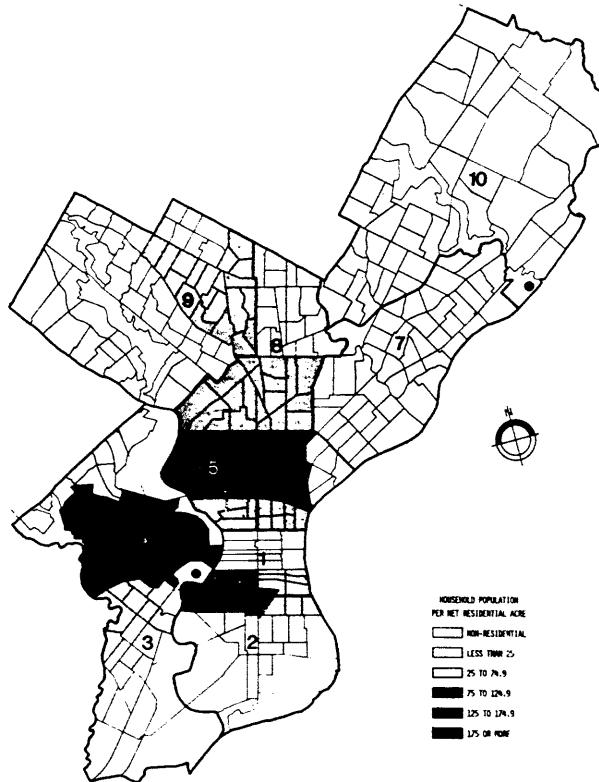
POPULATION DENSITY
TOTAL 1967

4

1334

Map #5 shows the distribution of the estimated 1967 nonwhite population of the city in the same terms.

A comparison of the above maps will confirm the statement previously made that the high density areas of the city are also the nonwhite areas.

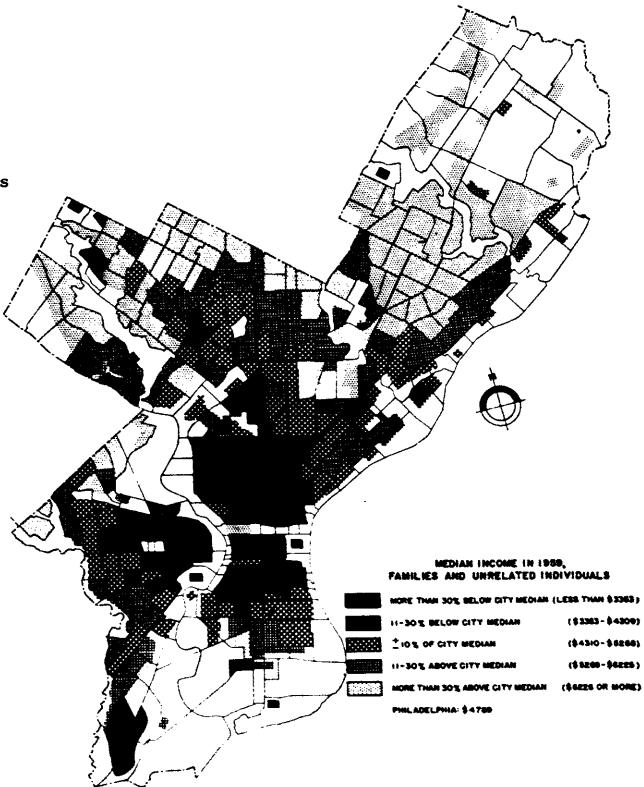


POPULATION DENSITY
NON-WHITE 1967

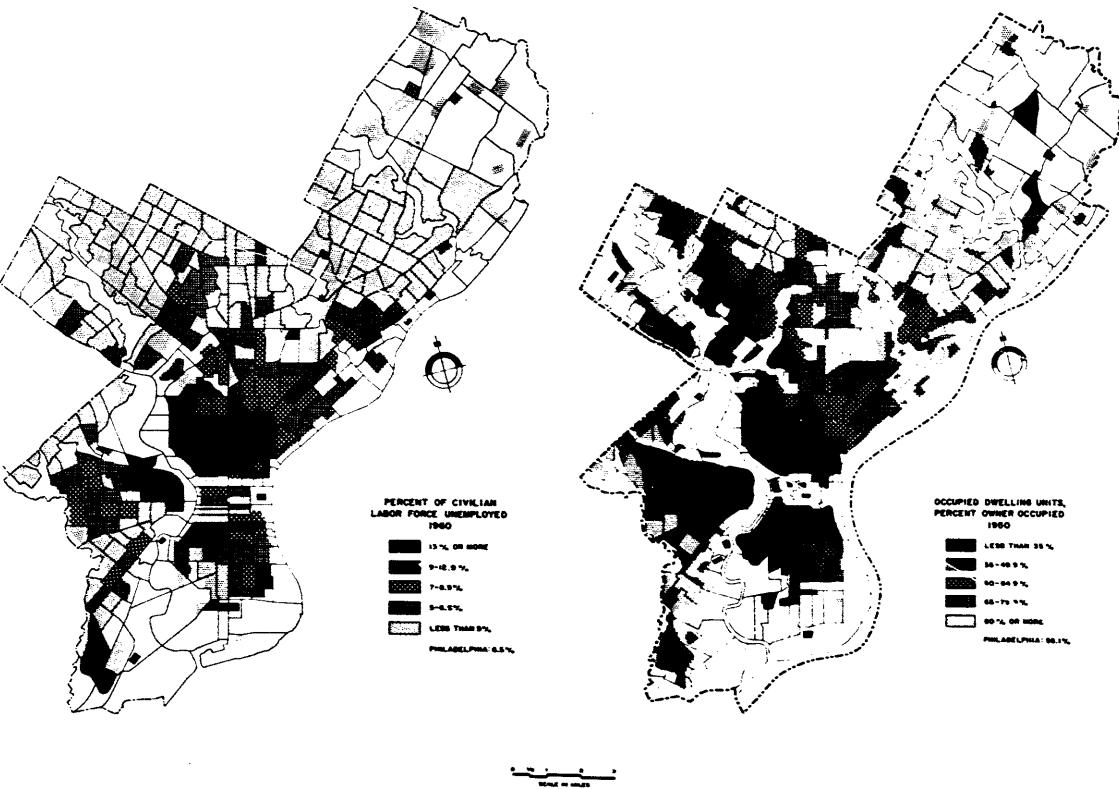
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Maps #6, #7 and #8 describe the distribution of income, unemployment, and owner occupied dwellings in the city. A comparison of the population density maps with the maps of these characteristics will indicate that a very high correlation exists between these factors. Others have shown that the incidence of contagious diseases, infant mortality, homicide, air pollution, low educational achievement and life expectancy also correspond very closely to high population density, low income and high unemployment rates. The implications of the above for health planning are obvious.

In part IV-B of this report it will be seen that various agencies and institutions tend to serve particular sections of the city. Reference to the above maps will enable the reader to classify, to an extent, some of the characteristics of the users of these services.



INCOME DISTRIBUTION
1960

UNEMPLOYMENT
19607 OWNER OCCUPANCY
1950

80

4. Future Trends

The Delaware Valley Regional Planning Commission estimates that in 1985 the population of Philadelphia will be about 2,023,000, a slight decline from the present population. The City Planning Commission estimates that the 1980 population of the city will be about 2,250,000 with a slight decline thereafter. However, both agencies agree that there will be substantial increases in the number of aged Philadelphians, particularly those over 75 years of age. This is of special interest inasmuch as Philadelphia is undersupplied with facilities to care for the chronically ill and it is this age group which makes the greatest use of this type of facility.

Table #1 summarizes the known and projected population of aged Philadelphians.

Table 1 - Projections of Philadelphia Age 65
And Over Population 1970 and 1980

	<u>65-69</u>	<u>70-74</u>	<u>75-79</u>	<u>80-84</u>	<u>85+</u>	Total Age 65+
1960 Actual	84,500	60,271	36,008	17,930	10,094	208,803
1965 Estimated (Dept. of Public Health)	81,400	65,800	41,300	21,600	11,300	221,400
<u>1970 Projected</u>						
White						
Male	28,445	21,503	14,133	6,915	3,347	
Female	36,806	31,037	20,756	11,816	6,734	
Nonwhite						
Male	10,086	6,357	3,577	1,714	1,087	
Female	12,036	7,978	4,525	2,417	3,191	
Total	87,373	66,875	42,991	22,862	14,359	234,460
<u>1980 Projected</u>						
White						
Male	25,659	18,472	12,458	6,623	3,781	
Female	34,785	28,089	19,544	12,446	7,821	
Nonwhite						
Male	11,659	7,205	5,738	2,835	1,926	
Female	15,478	10,613	7,943	4,276	3,769	
Total	87,581	64,379	45,683	26,180	17,297	241,120

B. Existing Health Related Services and Institutions

Philadelphia's hospitals, teaching centers, nursing homes, and public health centers form a complex and largely uncoordinated network of delivery points for personal health services. This section briefly highlights the characteristics of the institutions within that network.

1. Hospitals

In gross terms, the City (and County) of Philadelphia is served by 13,000 hospital beds. These beds are distributed among 44 institutions in the following fashion: about 7900 are identified as short-term general acute care hospital beds; another 4500 are located within the institutional framework of the City's six Medical Schools, and an additional 550 are in specialty institutions. The Philadelphia General Hospital is identified as a component of the first group mentioned—that of the community short-term general hospital facilities.

In summary, the main organizational features and deficiencies of this hospital universe can be identified as follows: the facilities and their beds are reasonably well distributed within the city at the present time; short-term beds are present in greater numbers than are needed; other patient-care deficiencies are present. Many of the existing beds are being operated in facilities that are unsafe or unsuitable for hospital functions. The relatively great proportion

of hospital services identified as university operated, or with specialty designations, makes articulation among all components of the hospital system very difficult.

The first three of these general characterizations were presented as early as 1962 by the Hospital Survey Committee. These judgments were made in a study designed to provide a projection of hospital facility needs for the Philadelphia Metropolitan Area into the 1970's. The deficiencies which they noted have not been significantly improved upon during the past decade. The problems remain as a challenge for those who would seek to rationalize or improve the operations of this particular segment of the health care system.

At present, Philadelphia proper contains slightly more than half of all of the hospital services present in the greater metropolitan area. This represents a continuation of long-standing trends. In addition to housing many hospitals requiring more equitable relocation and extensive physical upgrading, the city hospital system can be distinguished from its suburban counterparts by lower levels of occupancy and longer length of patient stay.

The lower occupancy levels are largely a result of a greater degree of clinical specificity in bed allocations. Units where patient access is limited to a particular diagnostic classification, are unable to support consistently high occupancies. The fact that many of the institutions in the city are smaller than the general hospitals in the suburbs,

also accounts for lower than average occupancy rates.

Longer average patient stays represent a combination of factors: specialty institutions and teaching hospitals attract more complicated cases which lead to longer episodes of hospitalization; the presence of a large number of total hospital beds reduces the pressures for early discharge which might otherwise be present if bed spaces were tight; large numbers of beds may also increase the pressure on physicians to over-use the hospital resources. Also contributing to the longer hospitalization within the city is a striking absence of facilities for less intensive care of long-term patients.

Thus within the total universe of 13,000 hospital beds, the medical school institutions and the specialty institutions account for more than one-third. Within the terminology of the Hospital Survey Committee, the following institutions are identified as university-medical school operations: Woman's Medical College Hospital, University of Pennsylvania Hospital, Jefferson, Temple, Hahnemann, Presbyterian, Graduate, Pennsylvania, and Osteopathic College (both the Barth and Spruce Divisions). Of the specialty institutions, two are pediatric in nature--St. Christopher's and Children's Hospital. The other two specialty institutions are Wills Eye Hospital and the Oncologic Hospital. There are institutions which specialize in medically directed rehabilitation and chronic diseases care not included in these figures.

Of the general community hospital beds, Philadelphia General Hospital currently accounts for approximately 1577. This represents a declining total number of beds operated at PGH, but still a significant percentage of the non-specialty and non-university operated facilities. Part of the decline in the operating complement of PGH can be traced to attempts to conduct its operations more efficiently through concentration of patients. It is also, in the face of a declining total number of patient days of care rendered, a representation of the fact that other segments of the local hospital system have picked up some of PGH's former acute care needs. But PGH has been assuming the responsibility for the care of the more convalescent or even custodial patient. Another factor is the reorganization relative to medical school affiliation--with only three institutions now being responsible for PGH services in place of the five which were formerly active there.

Map #9 shows the location and bed complement of the City's hospitals. A comparison of this map with Map #4 will demonstrate that, on the whole, Philadelphia hospitals are now located in the areas of greatest population concentration. However, the population of the city has been migrating to the north for several years and this movement is expected to continue. Therefore, it appears that the far northeast and northwest areas of the city will be poorly served in the future unless there is a redistribution of services.

Table #2 lists Philadelphia hospitals according to bed complement as reported in 1969. The existence of a large number of small institutions--14 hospitals of less than 150 beds and 16 more with bed complements of 151-300--accounts for a good part of the inefficient utilization of resources in the city. In statistical terms it can be shown that a small number of large institutions can adequately serve a population with fewer total beds than a large number of small institutions. This is due to the fact that the necessary reserve capacity to provide for variations in census as a percentage of normal requirements is reduced as the providers of service become fewer and larger. Obviously there is a point where other considerations such as ease of access by users and practical administrative concerns militate against too great a concentration of resources.

Table 2 - Philadelphia Hospitals Ranked by Bed
Complement - 1969 1./

Under 150 Beds

St. Vincent's	30
Physicians & Surgeons	41
American Oncologic	50
Center City (Wolfe)	60
Kensington	60
Stetson	68
Spruce (Phil. Col. of Osteopath. Med.)	69
Oxford	102
Broad St.	104
Oliney	107
West Park	123
Doctor's	136
Parkview (Osteopathic)	145
St. Christopher's	150
14 Hospitals	1,245

151-300 Beds

Children's	164
Jeanes	169
Mercy-Douglass	184
Wills Eye	185
St. Joseph's	200
Mem. of Roxborough	201
Frankford	205
J. F. K. Memorial	220

151-300 Beds cont'd.

Northeastern	220
Chestnut Hill	225
St. Mary's Franciscan	226
Barth (Phil. Col. of Osteopath Med.)	229
Metropolitan (Osteopathic)	230
Woman's Med. Col.	233
St. Agnes	247
Methodist	249
16 Hospitals	3,387

Over 300 Beds

Graduate	326
Germantown	331
Presbyterian	334
St. Luke's	338
Nazareth	352
Episcopal	361
Misericordia	398
Pennsylvania	425
Hahnemann	530
Temple	759
Jefferson	770
Univ. of Penna.	914
Einstein (No. and So. Divisions)	972
Phila. General	1,577

14 Hospitals 8,387

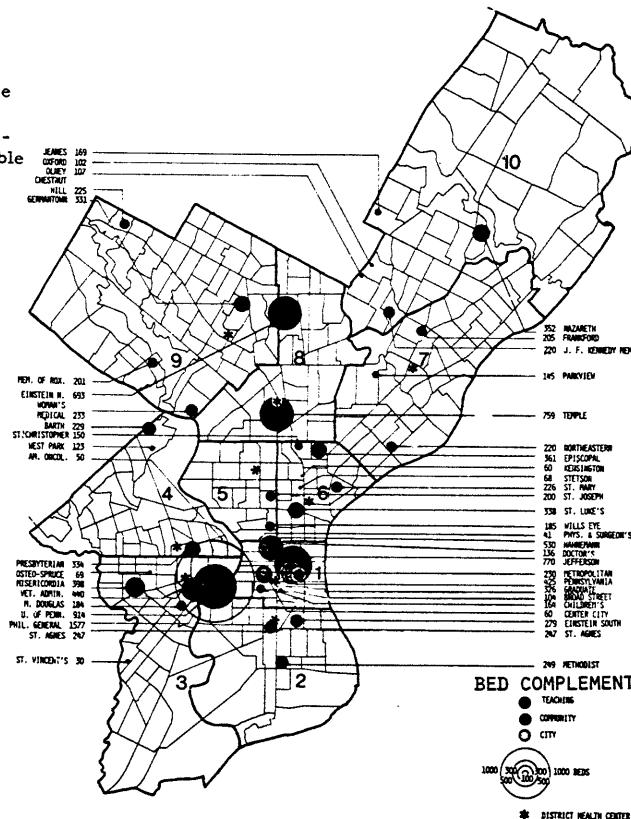
Total

44 Hospitals 13,019

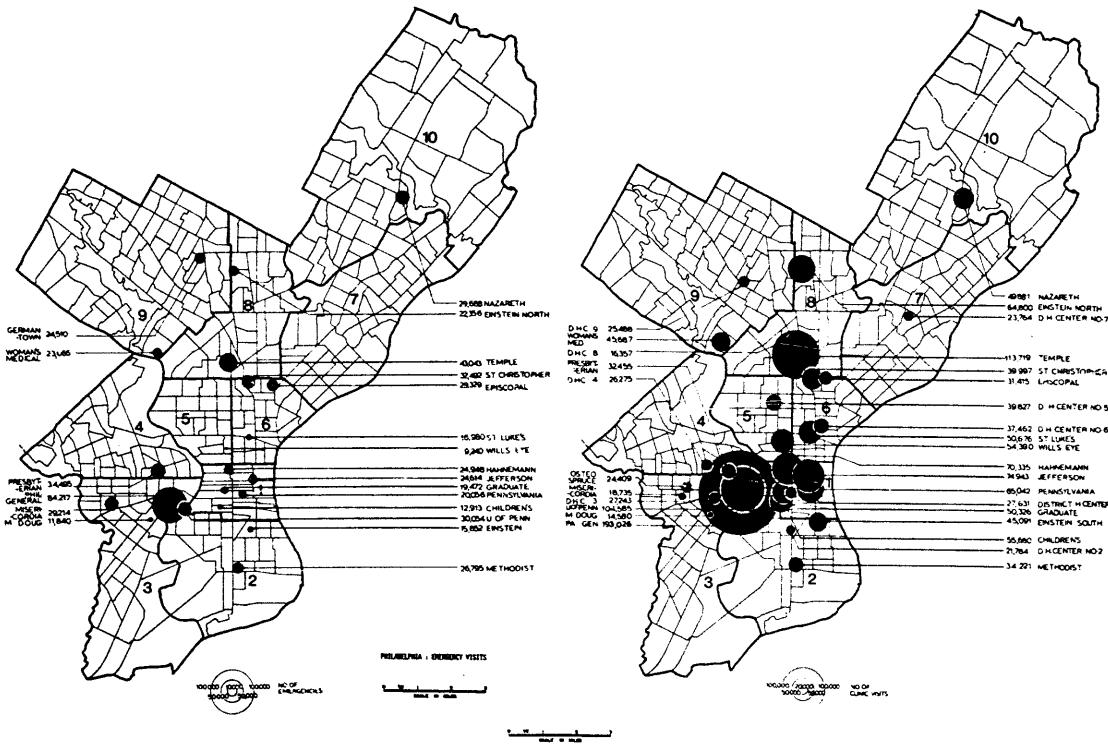
1./ From JCCHA - Guide Issue 1969, and Philadelphia Hospital Survey Committee

In addition to the above, the need to amortize expensive equipment, the difficulty in obtaining personnel and the tremendous expense of replacing obsolete plant will no doubt make it necessary for many small institutions to merge their efforts in the future. Others may find it necessary to close their doors. If the Philadelphia hospitals are to provide the best possible patient care at the lowest possible cost, this process will have to be accelerated.

In summary we find that in 1969 Philadelphia had 44 hospitals with a total bed complement of 13,019, a ratio of 6.5 beds per 1,000 population. The average length of stay in 1968 was 11.4 days compared to a national average of 8.4 days. The bed occupancy rate in Philadelphia was 78.5% compared to a national rate of 78.2% in 1968.



PHILADELPHIA: ACUTE
GENERAL CARE HOSPITALS



PHILADELPHIA: HOSPITAL
EMERGENCY ROOM VISITS
1968

10

PHILADELPHIA: HOSPITAL
OUTPATIENT DEPT. VISITS
1968

11

Where Does the Philadelphia General Hospital Fit?

Of the total universe of about 13,000 hospital beds within the City, the Philadelphia General Hospital today accounts for approximately 1577. Maps 9, 10 and 11 showing location, size, and number of visits for the City's acute beds, emergency rooms and outpatient care facilities, include PGH and relate it to this universe. It is evident then that PGH still operates a major share of hospital bed spaces, and also shares to a considerable degree in providing emergency and outpatient services.

However, the PGH share of the City's hospital beds has been declining. The number of total beds available in the City has grown. PGH has also reduced its bed complement as occupancy has declined.

- . In 1960, PGH reported 1858 beds
- . In 1966, PGH reported 1676 beds
- . In 1969, it reported 1577 beds
(includes 527 beds in long-term unit)

This reduction in total bed complement has been accompanied by an even more dramatic decline in overall patient days of care rendered at PGH, and an increase in the proportion of beds assigned to long-term care and "special problems".

The characteristics of users of the Philadelphia General Hospital, and the nature of the "special problems" it houses, will be described below.

However, analysis of these patients' characteristics, interviews of medical and administrative staff, and review of hospital records, has led to the conclusion that on any one day of current use, the hospital is probably caring for about

- . 600 patients characteristic of acute, short-term medical-surgical services;
- . about 500 patients who have special problems that may or may not need care in an acute hospital bed, but to whom the rest of society seems to have denied any form of help.

Analysis of the Existing Physical Plant of Philadelphia General Hospital

Several appraisals of the facilities of the Philadelphia General Hospital have been made in the past. The last major survey was included in the "Kling Report" of 1956. Since that year no major new construction has taken place at PGH. However, adjacent land has been used for the development of several facilities that could have an effect upon the future of PGH.

Since 1956, profound changes in concepts of hospital planning and design have occurred. These have been brought about by rapidly changing philosophies of medical care and new developments in the management of hospital patients including the employment of technologies that did not exist 10 years ago. The scarcity and expense of all types of hospital personnel and the rapid increase in the cost of land and construction have also spurred new design philosophies.

Several other factors have also influenced the criteria used to evaluate the viability of medical facilities including: a general upgrading of state and federal hospital standards, new methods of paying for the care of patients, rising expectations on the part of the consumers and a public awareness of the fact that the hospital is only one element in providing good health care.

PGH facilities have been evaluated in the light of all these present day criteria. It is the opinion of the facilities consultants that, if in-patient hospital services are to be provided by the City of Philadelphia in the future, the present facilities of PGH, with the possible exception of the Mills Building, have no further usefulness for housing such services and must be replaced.

The above conclusion was not reached until a thorough examination of the possibilities of bringing the hospital up to modern standards through addition and renovation had been carried far enough to convince the committee that such an approach would be nearly as expensive as new construction. Moreover renovation still would not provide a solution to the basic problem of hospital logistics. Remodeled facilities would not help solve the staffing problems which have plagued the institution for years, but would compound them because of a drastic reduction in the bed capacity of the buildings made necessary by current code regulations. (In general, it is no longer in conformance with standards to build an open ward facility such as PGH. At this time a maximum of four patient beds to a room served by adjacent toilet facilities is permitted and the trend is toward even smaller rooms with some hospitals now having only single patient accommodations. Institutions which have built such facilities are finding that increased utilization has been sufficient to overcome the

modest increase in construction cost. Better and more efficient patient care also results.)

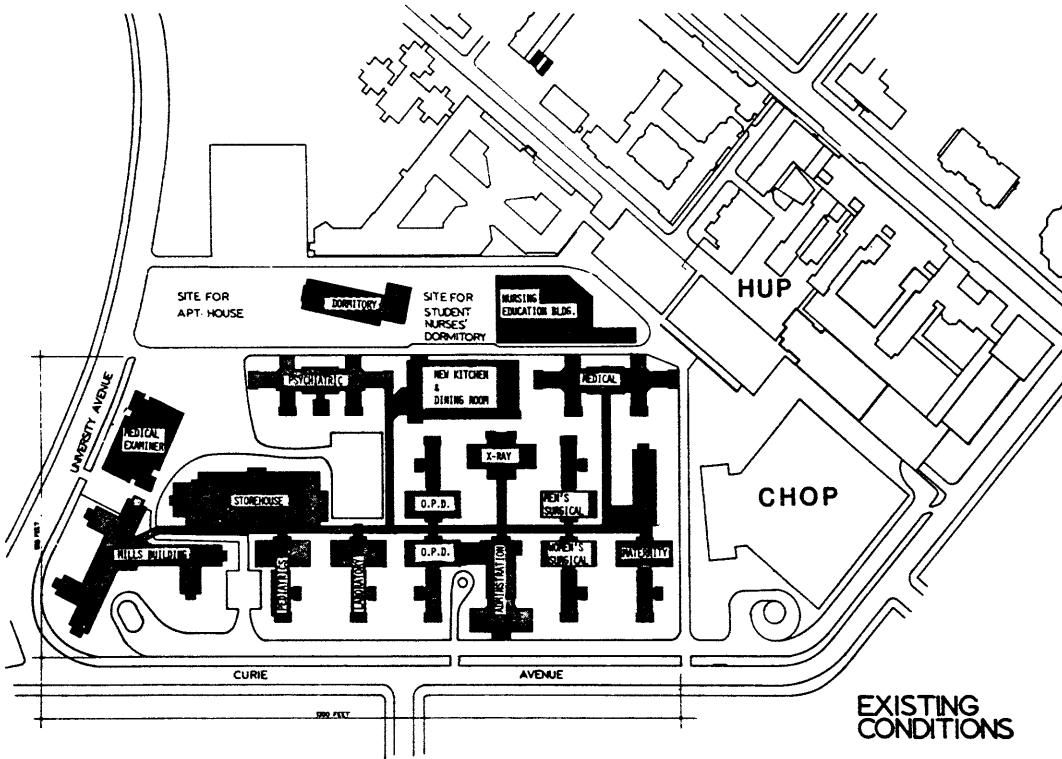
Several other factors were considered by the committee in reaching the general conclusion that PGH must be built anew. One involved the type of construction of the existing buildings, particularly the inpatient pavilions. These are not brick masonry as they appear, but rather consist of reinforced concrete bearing walls clad with a brick veneer. In addition, the floor slabs are reinforced concrete spanning the space between the exterior walls. This type of construction is exceedingly difficult to remodel due to the great difficulty in altering exterior wall openings or piercing the floor slabs. This would be necessary in order to renovate. Another major consideration is the condition and adequacy of the existing mechanical and electrical systems. In general all such systems at PGH are totally inadequate and obsolete and would have to be completely replaced in any renovation scheme. At the present time, over one-half of the cost of new hospital construction is accounted for by these systems. The increased difficulty of installing them in renovated buildings makes them even more expensive. These are some of the basic reasons why remodeling existing buildings would cost nearly as much as new construction.

The following drawings are included to illustrate the points made above. Drawing 1 is site plan of the existing hospital. The general layout of

of PGH is a pavilion plan which is patterned after European models and was prevalent in the United States as a scheme for new construction until the 1930's. It should be mentioned that the architectural concepts of hospital function and design had already gone beyond this general scheme at the time the preliminary plans for PGH were being drawn, making the hospital one of the last major expressions of a concept that was considered obsolete over 40 years ago. In 1951, Gustav Birch-Lindgrin made the following observation with respect to the pavilion type of hospital in his book Modern Hospital Planning. He actually had particular reference to PGH when he said:

"With the development of medical science, care has become much more complicated, entailing a considerably increased transportation of the patient to surgery, x-ray, laboratory tests, diathermy, baths, rehabilitation, etc., as well as the transportation of goods, laboratory specimens, records, food and the like. Furthermore, medicine has become specialized. It is no longer possible for a doctor to master more than a small section of medical science. Consequently, cooperation between specialists and different departments has become imperative, which makes it necessary that they all be within easy reach of one another.

Lastly, care has expanded greatly in scope. The increased demand for hospitalization



PHILADELPHIA GENERAL HOSPITAL
SITE PLAN

SCALE IN FEET

necessitates greater and greater establishments which, in turn, make coordination of the various elements and means of communications within a hospital highly important. It is evident that a block building with considerably reduced distances permits a simplified communication system which is more satisfactory than those found in spread-out structures.

The difficulty of obtaining labor and its increased costs make efficient utilization a necessity. An effort is made, therefore, to eliminate useless work, such as unnecessary or unnecessarily long transfer of patients and equipment. The lively traffic within the walls of a hospital makes it an obvious advantage to concentrate the building system.

Other factors, such as saving of building and operation costs through centralization, and the difficulty of finding a sufficiently large building site, especially for big hospitals in the city, have also contributed toward the realization of the concentrated system."

If anything, these observations of twenty years ago are more than ever true today.

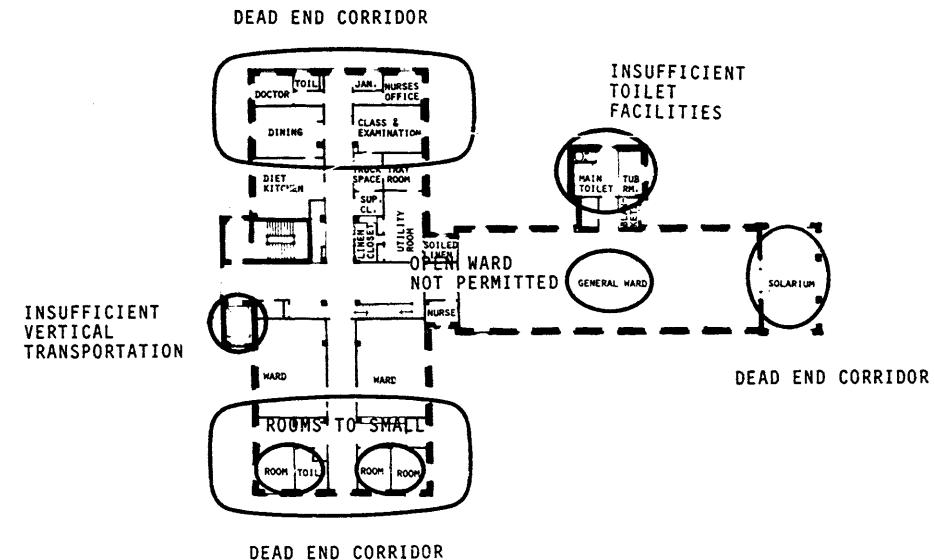
Table 3 at the end of this section identifies the major functions contained in the various structures at PGH. An analysis of a few critical

functional relationships will serve to demonstrate the severe logistical problems inherent in a plan of this nature. The emergency room, diagnostic radiology department and surgical suite are located in three different buildings. The surgical suite, and a pathology laboratory, to be located in the new Medical Examiner's Building, are at opposite ends of the site. The kitchen and inpatient beds are so dispersed that it is virtually impossible to provide attractive or warm meals to patients. The relationships between inpatient beds and diagnostic radiology, the clinical laboratory and the pharmacy are such that patients, specimens and drugs all must be transported great distances resulting in excessive expense, discomfort and delay. These are problems that no scheme for renovation, no matter how skillfully conceived, could solve.

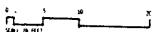
As noted, above, several schemes for renovation were considered, those considered by the committee to be best are included below.

Drawing 2 shows the plan of a typical inpatient pavilion floor as presently organized. The major deficiencies as defined by applicable codes are noted in red.

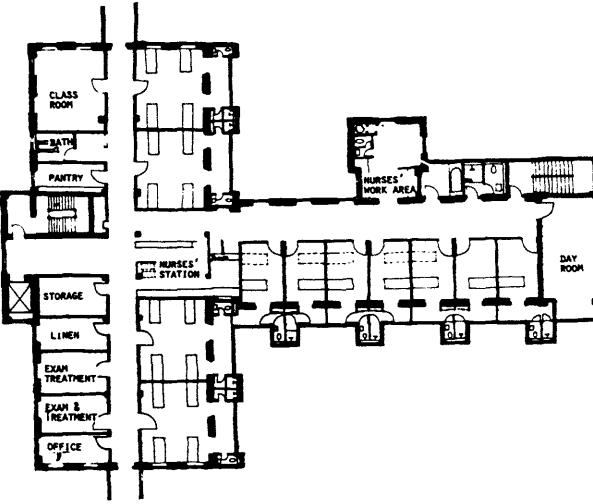
Drawing 3 shows a scheme for remodelling a typical floor for use as a short term acute care nursing unit. At present, a typical floor consists of between 42 and 46 beds served by inadequate support facilities. The scheme for remodelling



TYPICAL FLOOR PLAN
EXISTING INPATIENT PAVILION



2



TYPICAL FLOOR PLAN OF EXISTING
INPATIENT PAVILION REMODELED FOR
ACUTE SHORT TERM CARE

1:1
SCALE IN FEET

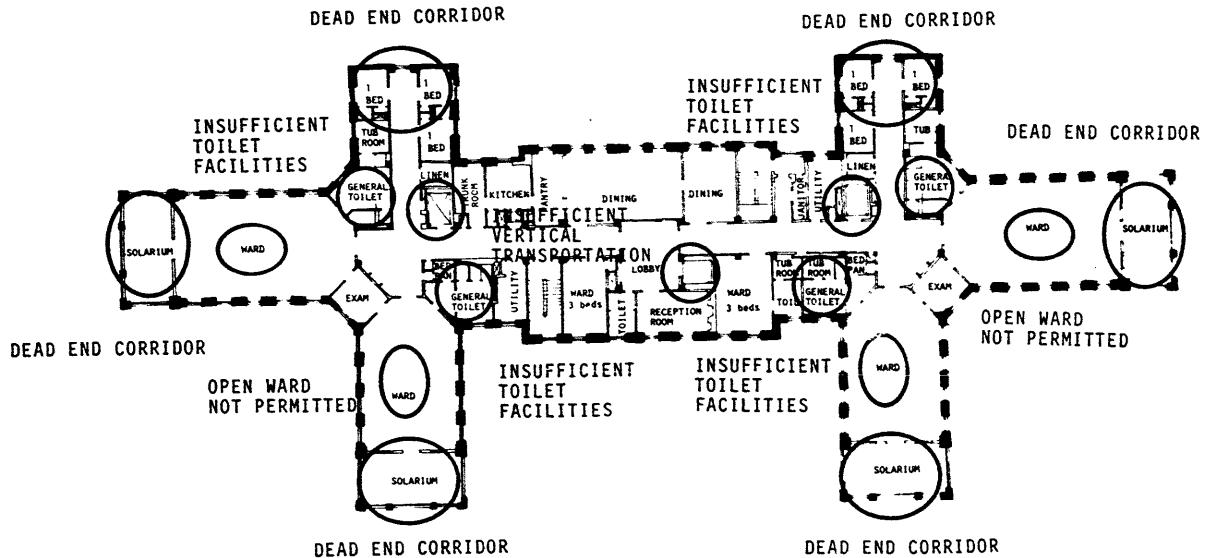
which would comply with present regulations and practices would have been between 23 and 30 beds depending upon the number of single patient rooms included. This is too small a bed complement for efficient use of nursing staff, particularly during evening and night shifts.

1353

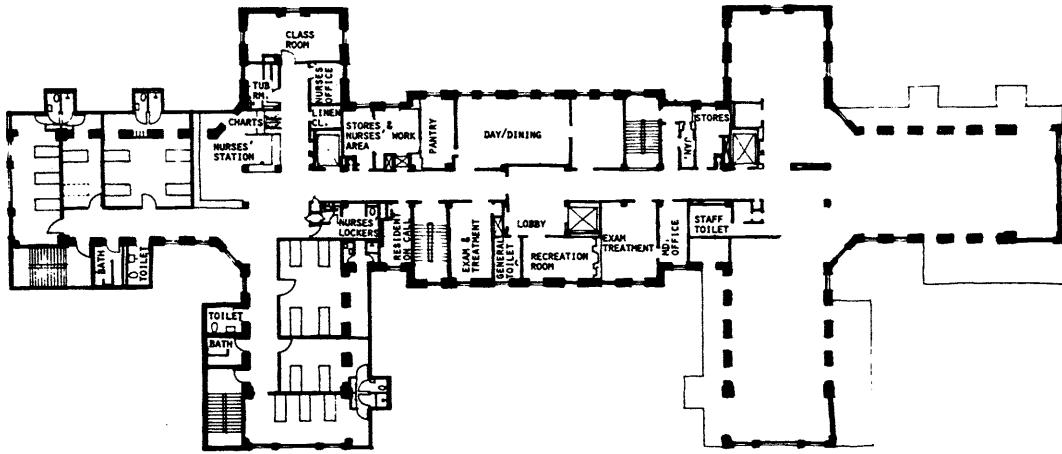
Drawing 4 shows a typical floor of the Medical Building as presently organized. Major code deficiencies are noted in red.

Drawing 5 shows a typical floor of the Medical Building for use as an extended care facility. In this instance, the bed capacity of a building floor would be reduced from approximately 72 beds at present to from 36 - 38 beds if adequate support facilities and patient amenities were included. Again an uneconomical unit results.

A situation similar to those above obtains with respect to the Mills Building. However, due to the relative newness of the building and a slightly better plan it may be possible to extend the life of the building by remodelling it. At best, less than ideal patient care facilities will result if the decision is made to use the building for that purpose. Other possible uses such as the development of a school of allied health professions would be more compatible with the building. Any recommendation concerning the disposition of the Mills Building must be postponed until the future of PGH is determined and the task of developing a detailed master plan and program for the hospital is undertaken.



TYPICAL FLOOR PLAN
EXISTING MEDICAL BUILDING



TYPICAL FLOOR PLAN OF EXISTING
MEDICAL BUILDING REMODELED FOR
EXTENDED CARE

TABLE 3 - Functions Performed at the Philadelphia General Hospital by Building (Also See Drawing 1)

59-6610-71-pt. 6
3

BUILDING 21 - MATERNITY

5th Floor:	40 Gynecology Beds 13 Jefferson, 13 Penn, 13 Hahnemann, 1 float
4th Floor:	31 Gynecology Beds 10 Jefferson, 10 Penn, 10 Hahnemann, 1 float
3rd Floor:	22 Obstetrical Beds 19 Hahnemann, 4 Jefferson 12 Bassinets
2nd Floor:	12 Prenatal Beds 4 Hahnemann, 4 Jefferson, 4 Penn 12 Postpartum Beds 4 Hahnemann, 4 Jefferson, 4 Penn 60 Bassinets 18 regular, 42 premature
1st Floor:	32 Obstetrical Beds 12 Jefferson, 18 Penn, 2 float

BUILDING 29

2nd Floor:	Labor and delivery suite
1st Floor:	Central Sterile Supply

BUILDING 22 - WOMEN'S SURGICAL

6th Floor:	Hahnemann research laboratory
5th Floor:	Operating suite and recovery room
4th Floor:	44 Orthopedics Beds 15 Jefferson, 15 Penn, 14 Hahnemann
3rd Floor:	46 General Surgical Beds 14 Jefferson, 16 Penn, 16 Hahnemann
2nd Floor:	46 General Surgical Beds 23 Jefferson, 23 Penn
1st Floor:	23 Urology Beds; Penn Blood Bank

BUILDING 17 - MEN'S SURGICAL

5th Floor:	Operating Suite
4th Floor:	6 Otolaryngology Beds; Jefferson 5 Oral Surgery Beds 1 Oncology
	2 General Surgical Beds; Jefferson 28 Orthopedics Beds 10 Hahnemann, 9 Jefferson, 9 Penn

3rd Floor: 32 Intensive Care Beds
 10 Hahnemann, 10 Penn,
 10 Jefferson, 2 float
 14 Eye Beds; Penn

2nd Floor: 11 Detention Beds
 23 General Surgical Beds; Hahnemann
 5 Oral Surgery Beds
 6 Otolaryngology; Jefferson
 2 Oncology Beds

1st Floor: 31 Urology Beds; Penn

BUILDING 23 - ADMINISTRATION

4th Floor: Administrative Offices
3rd Floor: Administrative Offices
2nd Floor: Administrative Offices
1st Floor: Emergency Room and Admitting Office

BUILDING 16 - X-RAY

2nd Floor: Diagnostic Radiology
1st Floor: Diagnostic Radiology

BUILDING 24 - OUT PATIENT DEPARTMENT

5th Floor: Medical Records
4th Floor: Medical and Surgical Clinics
3rd Floor: Medical and Surgical Clinics
2nd Floor: Medical and Surgical Clinics
1st Floor: Nuclear Medicine, Radiotherapy

BUILDING 14 - STOREHOUSE

General stores, Linen Service, Inhalation therapy
 Paint and Carpenter Shops

BUILDING 15 - OUT PATIENT DEPARTMENT

5th Floor: Pediatrics Clinics
4th Floor: Dental Clinic
3rd Floor: General Medical and Surgical Clinics
2nd Floor: 32 Beds; Police and Firemen
1st Floor: Pharmacy

BUILDING 25 - LABORATORY

5th Floor: Pediatric Research
4th Floor: Clinical laboratories
3rd Floor: Clinical laboratories
2nd Floor: 8 Beds; Clinical research
1st Floor: Clinical laboratories

BUILDING 26 - PEDIATRICS

5th Floor: Pediatric Research
4th Floor: 52 Medical Beds
 Rotate among Penn, Jefferson
 and Hahnemann

3rd Floor: 21 Medical Beds
 Rotate among Penn, Jefferson and
 Hahnemann

2nd Floor: 10 Beds; Pediatric intensive care
 26 Surgical Beds
 Rotate among Penn, Jefferson
 and Hahnemann

1st Floor: 36 Communicable Disease Beds
 Rotate among Penn, Jefferson
 and Hahnemann

BUILDING 10 - PSYCHIATRIC

6th Floor: C.M., H.C. offices
 5th Floor: C.M., H.C. offices
 4th Floor: Research Laboratories
 3rd Floor: Research Laboratories, Collections
 2nd Floor: Research Laboratories, Nursing Education
 1st Floor: Day care for employees children, Compensation Clinic, Nursing Education Office

1st Floor: Psychopharmacology Research, CMHC Clinic and offices
 Basement: P.M. and R. Treatment Facilities Gym, Auditorium
 Sub-Basement: Employee Facilities, Furniture and Upholstery Shops, Janitorial Service

BUILDING 27 - MILLS

9th Floor: Community Mental Health Center
 Day Hospital
 8th Floor: 72 Psychiatric Beds; Penn
 7th Floor: 81 Psychiatric Beds
 54 Hahnemann, 27 State Reception Center
 6th Floor: 32 Psychiatric Beds; Jefferson
 73 Rehabilitation
 5th Floor: 81 Neurology Beds; Temple
 40 Neurosurgery Beds
 4th Floor: 122 Neurology Beds
 60 Penn, 60 Jefferson, 2 float
 3rd Floor: 123 Pulmonary Beds
 2nd Floor: Stroke Research Center,
 Physical Medicine and Rehabilitation

BUILDING 8 - MEDICINE

7th Floor: Staff Offices
 6th Floor: 21 Beds; Student Health Service
 5th Floor: 6 Coronary Care Beds
 15 Intensive Care Beds
 4th Floor: 71 Medical Beds; Hahnemann
 3rd Floor: 73 Medical Beds; Jefferson
 5 Dermatology Beds; Penn
 2nd Floor: 73 Medical Beds; Jefferson
 5 Dermatology Beds; Penn
 1st Floor: 14 Dermatology Beds; Penn
 Basement: Mechanical and Electrical Maintenance Shops

The Philadelphians Who Use The Philadelphia General Hospital

Throughout this section, the focus will be upon drawing a descriptive profile of Philadelphia General Hospital: its patients, its programs and the dynamics of its operation. The principal point of comparison will be aggregated figures on users of major hospitals in Philadelphia, so that Philadelphia General Hospital can be seen in contrast to those institutions. Its role in the overall health delivery system, therefore, can be more clearly defined.

Inpatients

A midnight census of inpatients at PGH and at 22 other Philadelphia hospitals was taken in mid-September, 1969. The sample hospitals account for the majority of short-term general hospital beds in the City. Information was solicited that would describe social, demographic, medical, and other characteristics of these patients. Data from an inpatient census conducted in 1960 was made available for comparative purposes. On the day of the inpatient census, incidentally, 1087 of the reported 1577 beds at PGH were occupied.

What patient population is cared for on the in-patient services of Philadelphia General Hospital? How does this population differ or agree with the general patients served by other hospitals in the City? Where do the inpatients being treated at

PGH come from? Some institutions have become neighborhood fixtures. Others care for patients from the city-at-large. Others have become regional centers. (See Table 4 and Map 12)

PGH is none of these. It is only in part a neighborhood hospital in that in 1969, 20% of its inpatients were from Health District #4, a district to the north of it. But it is not a city-wide hospital either. It needs to struggle out of its questionable role as a charity hospital. Its inpatients today come from a strip of the City that is synonymous with dense population, blackness, pockets of low-income. In fact, the greatest single percentage of its inpatients (22% in 1969) come from east of the Schuylkill River - Health District #5. (Table 5)

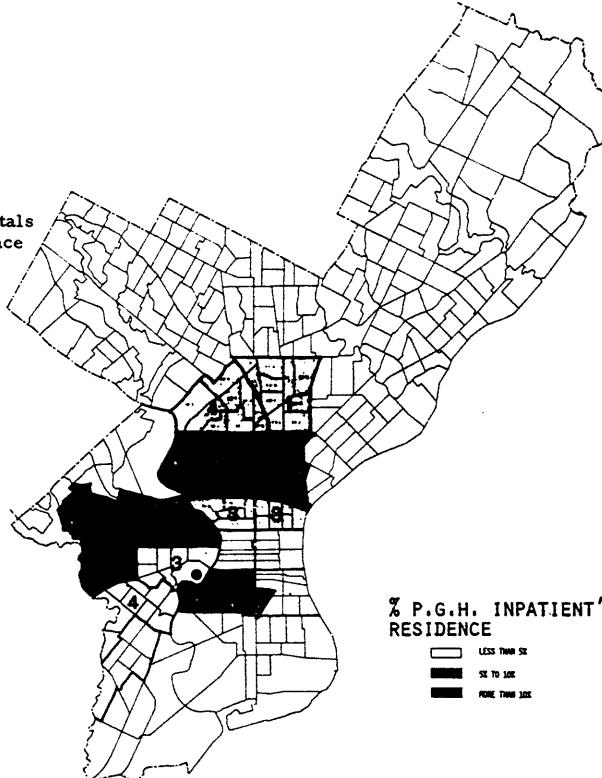
This is the heart of North Central Philadelphia where a network of citizens involved in health services planning under the Model Cities program clamored and pushed more ambulatory service nearer home.

TABLE 4

Distribution of patients by Health District of residence for inpatients at time of Census, Philadelphia General Hospital and other Hospitals sampled in 1969.

Health District	% of PGH Patients Residence	% of Other Hospitals Patients Residence
Out of City	4	22
1	9	7
2	10	8
3	13	8
4	20	7
5	22	7
6	9	6
7	3	7
8	5	9
9	4	9
10	1	4
Not determined	0	6
	100%	100%

Notes: On the inpatient census day, Children's Hospital had the largest percentage of out-of-city patients (69%); St. Christopher's, also a pediatric hospital - 44%; the Hospital of the University of Pennsylvania reported 45% of its inpatients from residences outside the City; Jefferson - 41%. The smallest percent of patients from outside Philadelphia were reported by PGH at 4%, and Mercy-Douglass, Northeastern and Misericordia at 3% each.



P.G.H. INPATIENT
ORIGIN - 1969

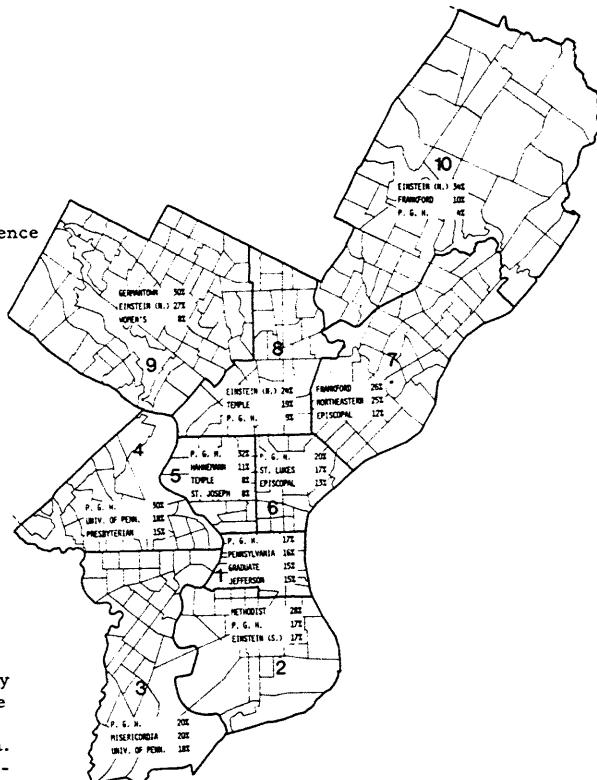
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TABLE 5

Distribution of place of residence by Health District for Philadelphia General Hospital inpatients at time of census in 1960 and 1969.

Health District	1960 % Patients Residence	1969 % Patients Residence
Out of City	0	4
1	9	9
2	8	10
3	12	13
4	20	20
5	20	22
6	13	9
7	5	3
8	4	5
9	4	4
10	5	1
	100%	100%

An analysis of the residential origin of inpatients on the census day by hospitals most used (Map 13 and Table 6) shows that only residents of Health District #5 were using PGH more than other hospitals to a statistically significant degree. Twenty percent of patients living in Health District #3, the neighborhood of PGH were in PGH; another 20% were in Misericordia in the same geographic area. Facts such as these may be important in determining location of a new public hospital.



PHILADELPHIA: HOSPITAL BED UTILIZATION BY HEALTH DISTRICT
1969

TABLE 6 - Residence of Users of Hospital
Inpatient Departments

<u>Residence of Patients By Health District</u>	<u>% of Inpatients From the Dist. in PGH</u>	<u>Other Hospitals Most Used By Residents of District</u>	<u>% of Inpatients From District</u>
1	17%	Pennsylvania Graduate Jefferson	16% 15% 15%
2	17%	Methodist Einstein (So. Div.)	28% 17%
3	20%	Misericordia University of Pennsylvania Mercy-Douglass	20% 18% 11%
4	30%	University of Pennsylvania Presbyterian Misericordia	18% 15% 10%
5	32%	Hahnemann Temple St. Joseph's	11% 8% 8%
6	20%	St. Luke's Episcopal Temple	17% 13% 12%
7	6%	Frankford Northeastern Episcopal	26% 25% 12%
8	9%	Einstein (No. Div.) Temple Woman's Medical	24% 19% 7%
9	6%	Germantown Einstein (No. Div.) Woman's Medical	30% 27% 8%
10	4%	Einstein (No. Div.) Frankford	34% 10%

Age distribution of PGH inpatients differed little from the hospital universe of which it is a part.

- . About 10% of PGH inpatients were under 15;
- . About 11% of other hospitals' inpatients were in the pediatric group.
- . 47% of PGH inpatients were over 50;
- . 53% of the patients in other hospitals were over 50.

TABLE 7 - Age distribution for inpatients at Philadelphia General Hospital and other Hospitals.

<u>Age Group</u>	% of Patients At PGH		% of Patients At Other Hospitals	
	1960	1969	1960	1969
Under 1	4	5	2	5
1 - 4	5	2	3	2
5 - 9	2	1	2	2
10-14	1	2	2	2
15-19	3	6	3	4
20-29	11	12	10	10
30-39	13	12	12	9
40-49	10	13	14	13
50-64	24	22	25	24
65 and over	22	24	23	29
Not determined	5	1	4	0
	100%	100%	100%	100%

In terms of other characteristics - sex and race, Philadelphia General Hospital differs considerably.

- . 57% of PGH inpatients were male;
- . 55% of other hospitals' inpatients were female.
- . Approximately 1/3 of inpatients in all other hospitals sampled on the census day were nonwhite;
- . Almost 3/4 of PGH's patients were nonwhite on the same day.

Though the Philadelphia General Hospital had by far the largest number of nonwhite inpatients on the census day, it by no means accounted for the entire number of black and other minority patients hospitalized throughout the City. On the census day, 4742 patients listed as white, and 2171 patients listed as "other", were either in PGH, or one of the sample 22 short-term hospitals.

The hospitals with the highest percentages of patients who were not white (based upon number as percentage of total beds) were:

Mercy-Douglass	88%
PGH	73%
Hospital of Woman's Medical College	62%
St. Luke's	51%
Presbyterian	49%

When examined in terms of absolute numbers, PGH accounted for 785 nonwhite patients; the Hospital of the University of Pennsylvania, 236; Temple, 228; Jefferson, 180. Other nonwhite patients were distributed in smaller numbers in other hospitals. Therefore, as a whole, more nonwhite patients were hospitalized in other hospitals in the City on the census day, than at PGH.

On the other hand, a number of institutions had inpatient populations in excess of 90% white. This was true on the census day of Northeastern, Frankford and Methodist Hospitals.

The long stay nature of inpatient hospitalization at PGH is made very clear by material displayed in Table 8. The characteristic emphasized is not "length of stay", which can only be calculated in relation to discharge statistics. Rather, this is a snapshot at a point in time of how long a particular group of patients have been in the hospital.

By this definition, Philadelphia General Hospital differs significantly from other hospitals in the area. On the day of the patient census, in other hospitals, 68% of the patients had been there less than two weeks. But at PGH, 55% of the patients had been there longer than two weeks. In fact, 22% had been there longer than three months.

Throughout the 1960's, Philadelphia General has consistently been the City's long stay hospital. In 1960, 37% of the patients had been there more than one month. In 1969, the figure was 39%.

Needless to say, one of the reasons for the long stays of many patients at PGH, is the simple but stark fact they may have no other place to go when there is any vestige of medical care still necessary. Or they may merely have no place to go! But short-term beds are expensive to run, and require program and staff complements that are not necessarily at all appropriate to the needs of long-term patients and the homeless.

TABLE 8

Distribution of time in hospital at census for Philadelphia General Hospital patients and other hospitals sampled in 1960 and 1969.

<u>Time in Days</u>	<u>% of Patients by Days in Hospitals</u>			
	PGH 1960	Others 1960	PGH 1969	Others 1969
Under 7	25	47	29	46
7 - 14	17	26	16	22
15 - 20	10	10	7	11
21 - 30	11	8	9	8
31 - 55	11	5	17*	7*
56 - 90	8	2		
90 or more	18	2	22	6
	100%	100%	100%	100%

The time in hospital at census was calculated by determining the day of admission and subtracting the date of admission from the date of census. These figures should not be confused with length of stay which is determined at the time of discharge.

*For age groups 31-55 and 56-90 combined.

The care of inpatients in the hospitals participating in the 1969 census was financed in the following ways.

Blue Cross	41%
Medicare	22%
"Pennsycare"	11%
Commercial Ins.	11%
"Free"	2%
Workmen's Comp.	1%
Other	12%

Because this item allowed for only a single response in the questionnaire schedule, it does not reflect the normal dynamics of hospital financing in that a patient may utilize a number of sources once primary sources of financial responsibility have been exhausted. This general assignment to one category of payment, therefore, may differ somewhat from the description of total expenditures for inpatient hospitalization derived from actual rather than survey sources.

It is not possible to discuss source of payment for the patients of the Philadelphia General Hospital. This information is not available. This is to be deplored, for such knowledge can be a key factor in planning and financing both ambulatory care programs and inpatient services.

It is always of interest to the City to consider how it is spending its own funds for the purchase of certain personal health services. It does not now apply local money to providing inpatient care other than through the operation of beds at the Philadelphia General Hospital.

It does provide outpatient and emergency care directly at PGH, and also purchases some of these services, by contract, from a number of the community's hospitals. In 1968, 596,612 total emergency room visits were reported to the City by 30 hospitals participating in the emergency room purchase program. The City paid in full or in part for 257,953 of these visits. Under the 1968 contracts, \$993,377.77 of local funds went toward reimbursement of these emergency visits.

Another \$2,006,481.23 covered some of the costs of outpatient department visits in 34 hospitals. Averaged over the visits for which the funds were presumed to pay, the emergency room visit was reimbursed at \$3.85, the OPD visit at \$4.02.

Emergency Room Users at
Philadelphia General Hospital

The profile of emergency room patients at PGH was drawn from records of visits during the period July 1, 1968 to June 30, 1969. The sample of emergency room use in other hospitals was taken from records which these hospitals participating in the Emergency Medical Services Contract program submit to the City of Philadelphia. The city purchases emergency and ambulatory medical care through this mechanism.

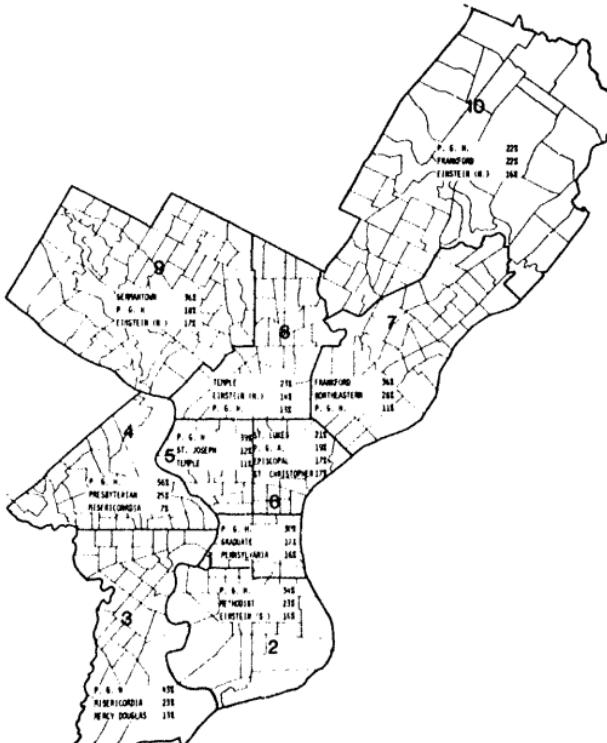
The receiving ward at PGH has a dual function. It is an admitting office and also operates as the traditional emergency room. The data for this study was collected in such a way as to separate the activities of this facility. In all instances where the emergency room at PGH is the term used, it is only this function of the receiving ward that is being described.

Where do the patients come from who use the emergency room at PGH? The information in all samples of emergency room users was

analyzed by residence of the patients by Health District. A greater percent of patients residing in several Health Districts were recorded as using the PGH emergency room more than others, though it was hardly the exclusive "family care" resource in any Health District. Residents of Health Districts #1, 2, 3, 4, and 5 showed greater use of PGH than any other single emergency room.

It is also interesting to note that even those patients who would appear to be high utilizers of the emergency room at PGH did not always go to PGH at all times in the year when they sought this sort of "instant care". Patient interviews were conducted amongst persons arriving at the receiving ward. Nearly 54% of these patients said they had used the PGH emergency room or outpatient departments before in the past year, but of this number, 23% said they had also used a private physician at least once in the same year, and 17.6% had also sought care in another emergency room or OPD. Thus, there was a clear pattern of the multiple use of resources, none of which, of course, share information on the whole patient.

Map 14 and Table 9 will show the residence by Health District of emergency room users in 1968, and the percent of these appearing in the PGH sample, as well as the pattern for the other hospitals most frequently visited.



PHILADELPHIA: EMERGENCY ROOM
UTILIZATION BY HEALTH DISTRICT
1968

1 MILE = 1 KM

TABLE 9 - Residence of Users of Hospital
Emergency Rooms

<u>Residence of Patients By Health District</u>	<u>% of Patients From the Dist. in PGH</u>	<u>Other Hospitals Most Used By Residents of District</u>	<u>% of Emergency Room Users From District</u>
1	30%	Graduate Pennsylvania Children's	17% 16% 11%
2	34%	Methodist Einstein (So. Div.)	23% 16%
3	43%	Misericordia Mercy-Douglas	23% 13%
4	56%	Presbyterian Misericordia	25% 7%
5	39%	St. Joseph's Temple Hahnemann Woman's Medical	12% 11% 9% 9%
6	19%	St. Luke's Episcopal St. Christopher's	21% 17% 17%
7	11%	Frankford Northeastern	36% 28%
8	13%	Temple Einstein (No. Div.) St. Christopher's Woman's Medical Episcopal	23% 14% 11% 11% 11%
9	18%	Germantown Einstein (No. Div.) Woman's Medical	36% 17% 8%
10	22%	Frankford Einstein (No. Div.)	22% 16%

In general terms, the users of the emergency room at PGH are young, black and very evenly balanced between male and female. They present a great variety of conditions, mainly medical, which bring them to the emergency room. The general youthfulness of the PGH emergency room users (wherein almost fifty percent are less than thirty) is close to the average age of emergency room users in other hospitals. Patients who are under thirty constitute just less than 60% of the emergency room users of the other hospitals in the study.

Similarly, the even male-female distribution of PGH emergency room users is reflected in other Philadelphia facilities. Unfortunately, information about the comparative racial composition of emergency room populations throughout the City is not available because records from which this sample were derived do not consistently record this information.

TABLE 10

Age distribution of patients seen in the PGH Emergency Room and at all other hospitals sampled.

<u>Age in Years</u>	<u>% of Patients At PGH</u>	<u>% of Patients At Other Hospitals</u>
Under 1	3	4
1 - 4	7	10
5 - 9	6	9
10 - 14	4	7
15 - 19	8	8
20 - 29	20	21
30 - 39	13	13
40 - 49	11	10
50 - 64	10	9
65 and over	7	8
Not determined	11	1
	100%	100%

RACE -- PGH was 18% white and 82% other. Not available for the other hospitals.

SEX -- Male and female were evenly divided at PGH and other hospitals.

We know that today the emergency rooms, though still conceptually based on the traditional rationale of providing 24 hour care for life threatening conditions, have become a helter skelter mix. They attempt to meet whatever crisis is brought to their doors, but they are also serving as the primary source of care for episodes of illness, malaise, and uncertainty. The emergency room has taken on the role of the general practitioner's office.

This mix of effort in emergency rooms impedes the best standards of either care. It is both expensive and often impractical for every hospital, large or small, to be equipped and staffed 24 hours around the clock to care for the surgical aspects of trauma, the medical aspect of life-threatening illness, and the immediate intensive care required by both. If the predominant problems presenting to emergency rooms are family needs, the expensive stand-by services of surgeons, head injury and burn specialists, trauma teams and such are wasted, and inappropriate. Internists, pediatricians and obstetricians might better meet the needs in some areas.

We tried, therefore, in this Study to distinguish between general family medical use of emergency rooms, and more severe conditions, such as trauma. Even this effort had its imperfections. The entries on the records submitted by the participating hospitals made it necessary to include a broad range of minor to major trauma in our use of this term. All accidental injuries from

minor lacerations and sprains to fractures, to the complex injuries resulting from motor vehicle accidents are classified as trauma. Some of these subclassifications, such as injury resulting from a vehicular accident, were recorded and can be retrieved at a later time. It would be even more serviceable for future planning for the city to redesign its reporting forms with the help of specialists versed in trauma management and medical emergencies.

With these deficiencies of definition in mind, it is still possible to state that the data for 1968 shows that in all participating hospitals combined, 38% of the cases seen in emergency rooms fell into our very broad classification of trauma. Therefore, the predominant use of emergency rooms can be said to be for non-emergent cases. This is most consistent with nationwide trends.

Even so, it is surprising that at PGH only 10% of the users of the emergency room were there for treatment of any kind of traumatic injury.

This statistic is further backed by information obtained from interviews of 155 emergency room users at PGH. These interviews were conducted during each of the seven days of the week and also during all hours of a 24 hour span. The number of interviews for each day of the week, or for the hours of the day were picked to give an accurate sample of actual emergency room use. Only 8.1% of these patients were in the PGH emergency room because of accidents. This

figure again indicates that this emergency room functions as another clinic rather than as a center for the care of true emergencies. There is one interesting fact to add which appeared frequently in the emergency room; young white patients are using PGH emergency room for detoxification or treatment of drug effects "because it is free and anonymous".

If trauma was responsible for only about one in ten of PGH's emergency room users, what were the other reasons that brought people into the emergency care facility? Thirty-two percent of the total PGH emergency room users presented symptoms of "flu", colds, upper respiratory ailments, gastro intestinal problems, skin rashes or superficial infections. (See Table II) These are emergent in the sense of causing distress to the patient. But these are also problems which are more generally considered to be the province of office practice. The fact that patients often come a considerable distance to the PGH emergency room for the care of such conditions underlines the need for more readily available resources for front line medical care within the neighborhood areas.

A number of hospitals exceeded the citywide average of thirty-eight percent trauma cases in their emergency rooms. However, further examination of the data reveals that many of these cases were trauma of a minor nature -- lacerations and cuts, sprains and such. At the low side, one is not surprised to find about a fifth of emergency room users at Children's

Hospital and St. Christopher's related to traumatic injury. In no case did any other hospital have a figure as low as PGH's ten percent.

One of the other significant points at which PGH's emergency room population differs from other hospitals is in the greater number of Ob-Gyn. presenting episodes. Thirteen percent of PGH's emergency room patients vs. three percent in the other hospitals fell in this category even after making adjustments for emergency room visits which resulted later in normal deliveries. Since the present number of deliveries at PGH is quite small for the number of beds assigned to Obstetrics, this data was reexamined. A majority of the emergency room users presenting as Ob-Gyn. cases, were found to be gynecologic conditions -- bleeding not related to childbirth and inflammation and pain.

Psychiatric cases also present to the PGH emergency room more often than at other hospitals. Ten percent of the users of the PGH emergency room are listed as psychiatric patients, only 3 percent in other hospitals.

This information points to a need for certain kinds of care in neighborhood based centers. Further study might also help define the best methods for the initial prevention of some of these episodes.

TABLE II

Medical complaints of cases seen in the Emergency Room at Philadelphia General Hospital and other hospitals sampled.

<u>Complaint</u>	<u>% of Cases At PGH</u>	<u>% of Cases At Other Hospitals</u>
Trauma	10	38
Flu, Colds, Ear, Nose & Throat, Respiratory	22	17
Upper Gastrointestinal	4	5
Skin Rashes and Infections	6	5
Musculo-skeletal	3	4
Cardiac	5	4
Obstetrical-Gynecological	13	3
Genito-Urinary	3	3
Psychiatric	10	3
Allergic Reactions	5	2
All Others	<u>19</u> <u>100%</u>	<u>16</u> <u>100%</u>

How do the Patients come to the emergency room at PGH? In all manner of ways. The largest number, 35% of the total, came by private car. Twenty percent arrived via bus or subway. In the sample of over 1,000 patients the Police Red Cars accounted for almost 25% of the total transportation. Of those persons transported by police, 90% were admitted to the hospital after being seen. Further, the cases brought to PGH by Red Car, seem to be most representative of the special or complicated problems in which the hospital has come to inadvertently specialize. Almost two-thirds of the records of Red Car cases showed such special notations as: alcoholic, drugs, suspected psychosis.

Of particular significance in understanding the part PGH plays in the hospital system is the role of the emergency room in the dynamics of admitting patients to hospitals. The proportion of emergency room users who were eventually admitted does not significantly differ between PGH and other hospitals (being twelve percent at PGH vs. nine percent at all other hospitals). However, at PGH sixty-five percent of total admissions to inpatient care come originally from the emergency room. In other hospitals, the proportion of inpatients originating through emergency rooms is between twenty and thirty percent. This means that in other hospitals, whether it is all it should be or not, inpatient care is apparently part of a plan for 70%-80% of the patients using these hospitals. Admission

occurs in a management spectrum wherein someone who has been following the patient determines the recourse to inpatient care. At PGH, if statistics describe the system, the situation is reversed. Sixty-five percent of all inpatients find their way into beds from their unplanned presentation to the emergency room.

Outpatients at P.G.H.

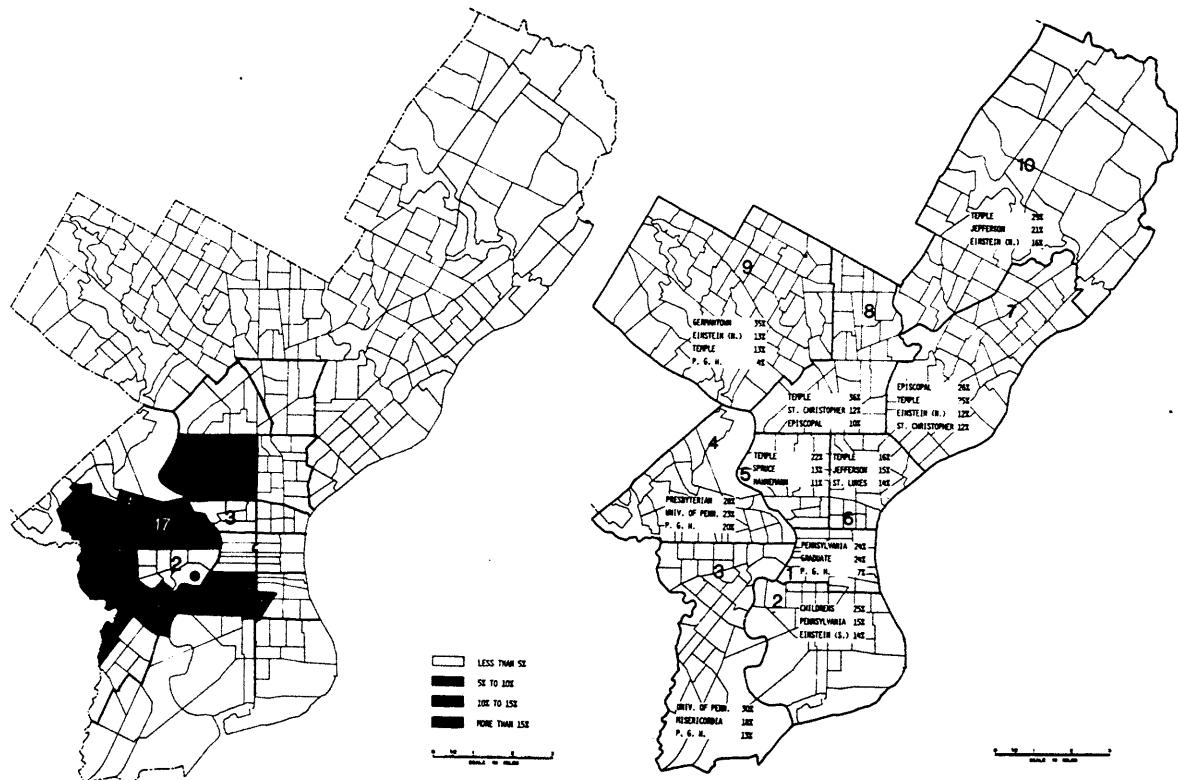
This report has taken the position that a hospital is best placed in the spectrum of health care, if it serves as a back-up resource for ambulatory and preventive services. The latter, in turn, to be most serviceable toward the goal of keeping people well, should be in neighborhood based, highly accessible facilities. If a community's health services are well planned, one would then expect to see the following:

- . Inpatient care distributed between "neighborhood hospitals", with neighborhood inpatients in the majority, and hospitals with patients from throughout the community - or region - because of some special characteristic of the hospital.
- . Emergency rooms serving the true emergencies of designated regions of the city.
- . Outpatient departments or health centers that are clearly the ambulatory care foci for the neighborhood; other hospital-based outpatient departments would demonstrate their back-up relationship to the neighborhood centers for specialized ambulatory work.

The analyses of the origin of patients in all services at PGH, illustrates that presently the system, and this hospital within it, does not show the logical patterns to which good planning might lead. PGH's inpatients are not from the total community. Where financing permits a choice, there is the implication that the hospital is avoided as an inpatient care resource. PGH's emergency room users do come from every Health District, but not for true emergencies. Police Red Cars figure prominently in the transport of patients to the ER of PGH, and their terse notes imply the nature of these emergencies--the problems other hospitals may wish to avoid: acute drug or alcoholism episodes, psychiatric emergencies.

An analysis of the origin of users of the outpatient services at the Philadelphia General Hospital illustrates that these services, as now constituted, fit least of all into a logical system.

Table 12 demonstrates that the outpatient clinics of the Philadelphia General Hospital are in no way the primary source of ambulatory care for residents of any Health District, including those (3 and 4) immediately geographically related to the Hospital. In almost every instance, the hospital outpatient departments most used are in those facilities which are in a conveniently located part of the area. Perhaps the only exception is the use of Jefferson in 1968 by 21% of the residents of Health District #10. (Also See Maps 15 and 16.)



P.G.H.: OUTPATIENT DEPT. AND
EMERGENCY ROOM PATIENT ORIGIN
1968

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PHILADELPHIA: HOSPITAL
OUTPATIENT DEPT. UTILIZATION
BY HEALTH DISTRICT - 1968

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TABLE 12 - Residence of Users of Hospital
Outpatient Departments

<u>Residence of Patients By Health District</u>	<u>% of Patients From the Dist. in PGH</u>	<u>Other Hospitals Most Used By Residents of District</u>	<u>% of Outpatient Clinic Users From District</u>
1	7%	Pennsylvania Graduate	24% 24%
2	13%	Children's Pennsylvania Einstein (So. Div.)	25% 15% 16%
3	13%	University of Pennsylvania Misericordia	30% 18%
4	20%	Presbyterian University of Pennsylvania	28% 23%
5	9%	Temple Osteopathic (Dispensary) Hahnemann	22% 13% 11%
6	3%	Temple Jefferson St. Luke's	16% 15% 14%
7	4%	Episcopal Temple Einstein (No. Div.) St. Christopher's	26% 25% 12% 12%
8	4%	Temple St. Christopher's Episcopal	36% 12% 10%
9	4%	Germantown Einstein (No. Div.) Temple	35% 13% 13%
10	0%	Temple Jefferson Einstein (No. Div.)	29% 21% 16%

Though PGH clinics are not the major ambulatory care resource for residents of any Health District, total clinic visits in 1968, taken at face value, would cause PGH to appear to lead in numbers served. There were 218,181 clinic visits in 1968. Two other hospitals provided the next largest number of clinic visits:

Temple University	176,990 visits
University of Penna.	157,558 visits

Deeper examination qualifies even these statements about PGH clinic users. The figure for total clinic visits includes 31,237 visits by 6,082 City Compensation Clinic patients. When these special outpatient visits are subtracted, PGH clinics accounted for 176,944 visits --just slightly less than total visits to the Hospital of Temple University.

Further, the patients (excluding Compensation Clinic) seen at PGH had an unusually high clinic utilization rate--an average of 8.5 visits per year. This means that the actual number of clinic users was probably about 20,800 persons. The users of clinics at Temple, for example, are believed to appear for care more nearly at the average national rate of 5 visits per year. This would mean that these clinics served nearly 35,400 individual patients in 1968.

The clinic population of PGH may be described as mainly female (65%) and black (90%). At other hospitals the clinic users were also mainly

female (63%). No information is available on the race of users of other clinics in the city. Over half the clinic patients at PGH (56%) are over 40, while 47% of the users of clinics in other hospitals are 40 or above. (See Table 13)

TABLE 13

Age distribution for patients attending clinics at Philadelphia General Hospital and all Other Hospitals Sampled.

<u>Age</u>	<u>% of Patients At PGH</u>	<u>% of Patients At Other Hospitals</u>
Under 1	2	4
1 - 4	3	6
5 - 9	3	8
10 - 14	3	6
15 - 19	8	7
20 - 29	13	13
30 - 39	12	9
40 - 49	13	11
50 - 64	28	16
65 and over	15	20*
	<u>100%</u>	<u>100%</u>

* Estimated figure based upon previous local study and national figures available. Only one-third of visitors to clinics were eligible for reimbursement of their care by the city's funds.

A comment should be made about the source of this information. The sample of users of outpatient clinics other than at PGH was drawn from data furnished under the emergency medical care contracts with the City of Philadelphia. This sample represents only about one-third of the total visits to clinics in 1968. Persons included in the sample are those who are fully or partially paid for by the City, and who do not have payment from another source such as Medicare or "Penn-scare". Under the city contract fund, about 60% of the cases seen in emergency rooms were eligible for city reimbursement, but only one-third of the clinic users received care paid for by local funds.

Nevertheless, it is possible that the data illustrates the following: where the city has chosen to assume the responsibility for the personal health care of some of its citizens by a mix of direct provision of services (at PGH), and the purchase of care, this system would appear to foster more access to convenient neighborhood resources. This statement appears to apply, at least, to the use of outpatient clinics. It does not apply to the special role the emergency room at PGH appears to play in absorbing the illness episodes of the "unwanted".

If clinics are well organized, with appointment systems, and some continuity of physicians, there is more opportunity to relate to the needs of patients comprehensively, and to work with them in such a way as to maintain health and keep people out of expensive hospital beds. If

this trend away from the use of PGH clinics and toward the choice of clinics in the neighborhood is meaningful, it should also imply some readiness of patients to use the neighborhood-based ambulatory care resources which this report recommends the City stimulate vigorously.

The interviews with patients using the Philadelphia General Hospital adds some further insight into the reasons for the use of clinics at PGH. The interview sample was planned to cover a representative number of total users entering the Hospital's resources, both through the emergency room portion of the receiving ward, and through the outpatient clinics. Therefore, a statistical sample number of users of the following clinics were interviewed during clinic sessions -

Medicine, Pediatrics, Physical Medicine and Rehabilitation, Surgery, Gynecology, Dental, Eye, Pre-natal and Dermatology

Even in clinics, about one-half of the patients said they had come because they were "feeling sick". A little over one-third actually had appointments indicating the more desirable aspects of some continuity of care.

A majority (86.4%) of clinic or emergency room users knew of other hospitals in their residential neighborhoods. This is in close correspondence to the 80.9% who, though waiting to be seen at PGH, answered that it

was not the nearest hospital to their residence.

But knowledge about the existence of other sources of health care does not really indicate extent of this knowledge, or degree of use of these facilities. The interviewers attempted to discover why patients came to PGH rather than other hospitals that might be nearer to them. After these other resources were named by patients, they were asked their opinions on the comparison between certain characteristics of PGH and these other hospitals. At this point, it became evident that 65% of the patients being questioned really had no experience with the other resources, even though they knew vaguely that they were there.

While most of the OPD patients did know of other hospitals with clinics in their neighborhoods, only 55.3% knew of any private doctors in their neighborhoods, and only 54% knew of health centers, including the comprehensive family care centers. This means that 15% of the ambulatory users of PGH knew of no other resource for their care, and a full 43% did not know of the existence of physicians or health centers.

These results can be interpreted in two ways:

- . Doctors are not well distributed in certain areas. (This will be documented in a section to follow.)

- . The flow of information about available health care programs is grossly inadequate.

Patients were also asked where they might choose to go for medical care if there were no financial, time or transportation constraints upon them. Three-quarters of those interviewed (74.8%) said they would still come to PGH. Their further explanations indicate the deeply ingrained "habit" PGH has become for some of the City's residents. 13.4% simply said they came "out of habit". Another 18.2% of the patients referred to past experiences with the Hospital and also regarded these as good experiences. Another 27.3% felt familiar with the doctors and considered them capable. But 13% said they would choose a private physician because they would "receive better care".

In the series of questions wherein patients were asked to compare PGH with other resources, even deeper reasons for the "PGH habit" emerged. Over and over again interviewers heard the direct expression of the belief that PGH was the only place poor people were "supposed" to go, and therefore, perhaps the only place where they were uniformly welcome for care. Thus 68% of the patients felt "poor people are treated better at PGH". But only 36.6% of those interviewed (92% of whom were black), felt that "black patients are treated better at PGH".

The attitudes of most ambulatory patients at PGH, including those coming from the E.R. - the major source of inpatients, imply a trust of the public hospital that must be carefully nurtured to carry over to any alternative programs for care. This trust cannot be easily maintained if these particular patients are not both counselled and consulted in the change.

Also implied is a deeply set and habitual pattern of use. Even though more than half of these patients had used other resources in the prior year, there was a clear picture of return to PGH when there was any lack of money, or fear of reception in other centers of care. There was no grim expression of dissatisfaction with PGH, even as it is. There was recognition by some (25%) that PGH is dirtier than other hospitals. Only 31% of the patients interviewed felt care was better at PGH, while most of them felt it was the same as at other hospitals

And in the end, most of the patients (an average of 65%) would still choose PGH for a variety of conditions. The more specific the condition, the more likely they would be to continue to choose "their hospital". For example 66.6% would come to PGH if they needed an operation. 57.6% would bring a sick child to PGH. Only 40% would continue to use PGH if they "just didn't feel well", but many of the rest might treat colds, the "flu"

and the other more ordinary ailments of life by going to a drug store or applying favorite home remedies. Very few (15%) would go to private physicians.

Therefore, there is no great aspiration for "middle class medicine". Two important beliefs emerge as essential to any successful alteration in the City's program:

- . It would be frightening to present users of PGH to sweep it away "overnight". A comfortable and trusted pattern must be slowly and carefully replaced.
- . Massive education of the current users of PGH must occur. Their health rights must be explained to them, as well as the benefits of more primary and preventive care at more accessible location.

The Special Responsibilities of the Philadelphia General Hospital

The data collected concerning PGH and other facilities in Philadelphia, indicate that a major function of PGH today is the treatment of special problems rather than acute, short-term general medical and surgical care. This section will examine these special uses to which beds and facilities at PGH are put. It will be evident throughout that when beds are available ways are found to fill them. It will be equally evident that such uses of beds do not necessarily result in solutions to the health and social problems placed there.

An earnest effort has been made, from an examination of statistics of many kinds of health care institutions, to determine the relative place of PGH in the total universe of facilities available for such care. It is possible, at PGH, to obtain a relatively accurate idea of numbers of special problems treated, but in other parts of the health care system, there is often either denial that such patients are treated, or no statistics are available. Therefore, any statement of the PGH share of these special problems may still under represent the rest of the system.

Six special services are located nowhere else in Philadelphia at this time. Table 14 identifies and summarizes the scope of these services.

All of these services are now exclusive to PGH, and their use, in total, represents about 20.7% of all admissions to the Hospital's beds. However, no one of these services must be housed at the Philadelphia General Hospital.

TABLE 14 - Special Services Performed
Exclusively at PGH

Name of Service	# Beds	#PGH Admissions or Cases Treated (1968)	% Total PGH Admissions	Average Days of Stay
Police and Fireman's Ward (for injuries on duty)	33	741	3.4%	10.3
City Employees' Compensation Clinic	40	31,327 patients 672 admissions <u>1/</u>	3.1%	7.9
Prisoner's Ward	11 <u>2/</u>	169	0.8%	11.1
Rape Cases	-	428	-	-
Communicable Diseases	48	408	1.9%	8.0

NOTE: 1/ Number of admissions shown are conservative since figures were available only for admissions from the clinic itself, not from the receiving ward.

2/ Number of beds, and admission figures, are only for male prisoner's ward. Female prisoners are admitted without special chart notation and distributed to wards throughout the hospital.

In addition, 32 beds are set aside in the Mills Building for the only State psychiatric receiving service in Philadelphia. Cases are held only from 24 - 72 hours while disposition is being arranged. No drug cases are received. Because of the arrangement for rapid turnover, 2,497 patients were admitted to this service, in 1968 and therefore represent 11.5% of PGH's total admission for that year.

The Police and Fireman's Ward, and the Compensation Clinic program, both could be relocated, under contract, to any acute general hospital or occupational ambulatory care service that met standards the city would specify.

Providing selected hospital staffs were willing to engage in the medico-legal aspects implied, rape cases could be examined at other institutions. It is currently thought that a juvenile rape case, for example, is best handled where both pediatric and child psychiatry services are available.

Advances in isolation techniques have made it unnecessary to totally segregate communicable disease cases. If such patients require hospitalization, normal criteria can determine which institution should be used to provide the necessary care. The 48 beds now assigned to communicable diseases cases at PGH would be insufficient to cope with an epidemic so other hospitals need to be prepared to deal with this problem in any event. Day to day utilization of the available capacity and expertise in the total system can relieve PGH of this task.

Psychiatric receiving arrangements, in modern practice, are also best handled in relation to programs specializing in psychiatric emergencies and their disposition.

The small prisoner service might present the most unusual problems in relocation, since special

security measures are sometimes required.

Some of the six services now located only at PGH do represent traditional public health or governmental responsibilities, because, in part, they may involve or endanger more than one individual. However, it would appear that Philadelphia has not progressed with contemporary thought in selecting the most appropriate locations and resources in which the necessary public health protection methodologies might be applied.

Two of the services are simply employee health programs over which the employer needs to exercise some control. Many industrial employers have found that better protection for the health of their employees can be provided under contracts with groups specializing in the control of the occupational hazards and general compensation review. In addition, the city may find that decentralization and purchase, under contracts, of these services will result in cost savings.

A large number of patients occupying beds at PGH have problems in the following categories:

- Alcohol and drug addictions
- Mental Disorder
- Rehabilitation
- Tuberculosis
- Chronic Diseases or disability

Care for these problems in Philadelphia is not exclusive to PGH. Some services are available

in modest amounts at other general hospitals, but the majority of care is provided in specialized facilities. Even these institutions are generally not adequate to meet the estimated need. It is a fact that the services necessary to deal with some of these problems exist in larger proportions at PGH than at other general hospitals in the City. Further, many of these patients do not belong in acute hospital beds. Why do these services appear at PGH in sufficient proportions to make it, in truth, a complex of specialized care programs? Is the public hospital in Philadelphia used today as a dumping ground for diseases and conditions that are hardest to treat, cure or manage simply because the private sector has been allowed to assume responsibility only for the treatments they desire or find most profitable?

The following is an attempt to analyze the role that PGH plays in relation to other institutions in caring for patients with special problems:

Psychiatric Beds

There are 162 psychiatric beds at PGH provided for the services, including their community mental health catchment areas, of three medical school services. These beds accounted for 1,308 admissions in 1968. The average stay is about one month.

There are many other psychiatric beds in Philadelphia:

350 in 12 general hospitals of which 88 are in medical school teaching hospitals.

7,266 beds in various state and private psychiatric institutions.

Therefore, about 2% of the psychiatric beds in Philadelphia are at PGH.

Treatment of Alcohol Problems

There are no specific beds at PGH for detoxification, or the handling of acute illness episodes in alcoholics. However, in 1968 there were at least 1,030 inpatients whose basic medical problems were related to alcoholism. There are four alcohol treatment programs in the city which provided for 12,292 outpatient visits in 1968. Sixty in-patient beds are associated with these programs. Ten voluntary general hospitals indicated they may have had about 330 inpatient alcohol cases in 1968.

Numbers are an insufficient measure of the adequacy of treatment programs for this severe health problem in our society. However, based on numbers alone, PGH appears to be handling about 75% of alcoholic patients who are actually in some phase of treatment on an inpatient basis.

Drug Addiction

In 1968, the methadone treatment center program at PGH handled 155 patients on an ambulatory basis. These were users of "hard drugs" only. Treatment locations, using a variety of methods, in eleven other hospitals served about 2,100 patients. Thus the service housed at PGH handled about 7% of those drug addiction cases under hospital based treatment. The city also has eight community-based treatment programs whose statistics are indefinite.

Long-term Care

PGH keeps about 350 beds filled with a variety of long-term care patients. In 1968 these beds sustained 692 admissions (3.2% of the Hospital's total admissions) and the average length of stay was 100.9 days.

The executive director of the hospital estimates that more than half of these patients could be more appropriately treated in other types of institutions if beds were available in acceptable facilities.

Rehabilitation

There are 80 beds assigned to the physical medicine and rehabilitation service at PGH. These beds accounted for 180 admissions with an average stay of 81.5 days in 1968. Six specialized rehabilitation hospitals in Philadelphia have an

additional 490 beds. Five medical school hospitals provide another 52 beds. Thus 12.9% of the rehabilitation beds in the city are at PGH. Only 0.8% of the Hospital's admissions, however, were rehabilitation patients.

Tuberculosis

PGH and the Landis State Hospital share the responsibility for tuberculosis care. PGH assigns 110 beds to respiratory and tuberculosis patients. In 1968 this service admitted 749 patients or 3.5% of the total annual admissions of the hospital. Landis Hospital has a bed complement of 486 which served 981 patients in 1968. There is considerable difference between PGH and Landis Hospital in the management of tuberculosis cases. The average stay at PGH was 45.9 days. At Landis it was 182 days.

PGH, then presently cares for 43.3% of the tuberculosis patients in the city during the inpatient phase of their management.

Does the "soak-up" or "dumping-ground" phenomenon of PGH meet the need or does this sometimes inappropriate use of a hospital cause obstacles to coordinated and comprehensive efforts at prevention and more successful care?

Psychiatric services at PGH are merely housing for the state's disposition facility or back-up beds for the less desirable or more intractable patients from remote catchment areas. Two of the three medical schools involved do not appear to be including general hospital psychiatric beds within their catchment areas in their current planning.

Alcoholism and drug addiction are not accorded hospital treatment to any significant degree anywhere in the city. PGH does house and treat these patients, though usually for some acute medical aspect of their underlying problem. The PGH Utilization Review Committee estimates that fully 33% of the beds are occupied by alcoholics. Accurate statistics cannot be given because a diagnosis of their "real" disease is not normally entered in their medical record. The attempt of PGH to handle the medical aspects of alcohol related disease is probably a minute portion of the care needed. The police arrest about 27,000 persons a year for drunkenness. Less than 1% of these are referred for treatment. In 1968, ten "drunks" died in jail after hospitals refused admission. The application of national statistics to Philadelphia indicates that there are probably about 100,000 alcoholics in the city.

Approaches to treatment exist with medical care in a hospital as one part of a broad spectrum of possibilities. Detoxification centers are needed. Combined medical and psychological services provided on an ambulatory basis, rehabilitation programs, public education and community reintegration all could help to solve this problem without resorting to hospitalization.

Drug addiction treatment is almost non-existent in Philadelphia. The police make 3,000 drug arrests per year and only take arrestees to a hospital if they suspect an overdose. One estimate has placed the number of drug users in Philadelphia at 15,000. Treatment for drug addiction, as with alcoholism, should exist in several forms simultaneously and be geared toward the population most in need.

The average age of PGH drug addict patients is 27.6 years; 82.7% are male, 15.8% female, 63.9% nonwhite, 36.1% white.

Addictive diseases by their nature have always been considered socially undesirable with no known cures and therefore are almost completely ignored by the private sector. For this reason, these problems have become part of the public responsibility. They do not really belong in hospital beds, but should be treated on a neighborhood basis at a level that deals with the social and environmental conditions leading to addictive disease. Hospital beds are needed only to treat acute episodes that result from the

constant use of addictive drugs or alcohol, but should not be used as an excuse for treating the momentary manifestation of disease while ignoring the underlying problems.

Rehabilitation is a long and expensive process. PGH's service is, therefore, of most value to the indigent population who cannot afford private programs. Tuberculosis care is a traditional public health function which is therefore divided between the state hospital and the municipal hospital. Shorter stays at PGH would indicate the value of the modern practice of having tuberculosis treatment associated with a general hospital.

Conclusion

The data in this report would support the conclusion that it is a misuse of acute care beds to hide in or dump on PGH

chronic patients
addictive diseases patients
psychiatric patients

It is an appropriate use of properly planned beds to relate the special care of

tuberculosis patients
rehabilitation patients
acute illness episodes in addictive and chronic diseases patients

to general hospital care, including in the public

hospital

This means, however, that care for all of these problems must be a part of a carefully planned array of services. Bed care alone is never the answer.

No one of these statements is intended to deny public responsibility. The fact that many such patients are in PGH and seldom are treated in other settings must be viewed as placing responsibility in public hands for some years to come.

The recommendations of the committee ask that the responsibility be implemented in relation to reality. More long-term care facilities are needed. Beds for patients who are in need of extended skilled care may need to be built under public auspices. More rehabilitation services should be related to general hospitals. Flare-ups of acute illness in chronic patients should be carefully programmed into acute hospitals with appropriate follow-up.

More care for addictive diseases must be offered, but as often as possible on an ambulatory basis. The hospital should be the back-up resource only. The same thinking applies to tuberculosis. Short stays in general hospitals are often necessary, but ambulatory management can be emphasized thereafter. Psychiatric beds are a necessary back-up to comprehensive mental health programs but the major emphasis should be on preventing hospitalization. Beds in a municipal hospital, isolated from the rest of the system, are not appropriate.

Comparisons - Philadelphia General Hospital
and Other Large Public Hospitals in the U. S.

We have compared PGH with other similar hospitals to provide a picture of how well - or poorly - it does when placed beside its counterparts. There are 35 hospitals in the U. S. that bear a generic relationship to PGH. That is they are all city or city-county owned. They are large--500 or more beds. They are classified by the American Hospital Association as short-term general hospitals.

Table 15 gives data on four other well known municipal hospitals, as well as PGH. None is exactly like PGH in bed capacity, patient load, or personnel complement. The table highlights the under-use at PGH of beds and bassinets, compared with some of the other hospitals. Personnel ratios appear to be lower at PGH than in the other four institutions. Expenses per admission are second only to Bellevue in New York. Expenses per bed are derived by relating total operating expenses of the hospital to the number of beds. It is a way of expressing the costs, related to bed capacity, of all the things to which the City budget applies: interns and residents' salaries; costs of the medical school affiliation contracts; city support of the research laboratories, equipment and staff of the physicians from both the medical schools and the PGH complement; educational costs.

In some instances, where hospital stay is shortened by an intense concentration of patient care effort, this will also reflect as a high expense per bed. This is the case for Los Angeles County General Hospital where the expense per bed is the highest of any of the hospitals reviewed. However, note that the product of the intensive care is short stays--only 7.3 days per admission. This enables rapid turnover of patients--45 admissions per bed per year. Therefore, costs per admission are kept low and many more citizens receive appropriate hospital care services.

Table 15 - Comparison of Five Large Municipal Hospitals, 1968

	<u>Philadelphia General Hospital</u>	<u>Wash. D.C. General</u>	<u>Los Angeles General</u>	<u>Bellevue New York City</u>	<u>Baltimore City</u>
Beds	1,577	675	2,105	1,932	1,091
Admissions	18,665	17,250	95,398	33,564	14,093
Average daily census	1,015	589	1,905	1,618	NA
Occupancy rate	64.3	87.3	87.5	71.3	-
Average stay - days	19.8	11.7	7.3	10.7	-
Bassinets	114	129	251	50	45
Births	2,817	4,781	12,108	1,244	2,976
Personnel	2,875	1,780	6,314	4,690	2,259
Total Expense	\$23,576,000	\$18,661,000	\$75,406,000	\$49,024,000	\$15,456,000
Expenses per bed	14,950	27,645	35,822	25,374	14,166
Expenses per admission	1,263	1,082	790	1,461	1,096
Admissions per bed	11.8	25.6	45.3	17.3	12.9
Births per bassinet	24.8	37.1	48.2	24.8	66.1
Personnel per bed	1.82	2.64	2.99	2.43	2.07
Personnel per 100 daily census	283	302	331	290	NA

Source: All data from Guide Issue, Hospitals, August 1969

2. Health Care Centers

City of Philadelphia District Health Centers

For the past two decades, the City has been in the process of building health centers in each of the ten health districts in Philadelphia. At this time, nine centers are in operation with Districts 7 and 10 sharing an older renovated building physically located in District 7. Funds for building a new District 10 health center are included in the proposed 1972-73 Capital City Budget.

For the most part, past programs in the District Health Centers have been categorical in nature rather than comprehensive. This has resulted in a low level of both facility and personnel utilization and as could be expected, a rather high cost of operation when considered on a per visit basis. Even so, when the services being offered are considered in the light of the potential demand for them, it is surprising that the citizens of Philadelphia have not made greater use of the services available. Why this is so, is difficult to say. A combination of factors may be responsible: lack of consumer knowledge of the available services, unfavorable public opinion of the quality of service, and a low personal priority for obtaining certain kinds of medical care on the part of consumers. The inappropriateness of categorical services

to today's health needs, and the fact that the centers seldom operate evenings or weekends must also be considered.

Late in 1969, the City began a comprehensive family care program in Health District 5, and expects to start a similar program in District 6 in 1970-71. The experience to be gained from these operations will provide invaluable information for planning future programs. The committee hopes that these programs will be viewed as real opportunities to experiment with innovations in the delivery of personal health care.

Table 16 summarizes the activities of the District Health Centers for the year 1967-68 and is included more as a benchmark than a statement of present activities. Important changes in the operation of the district centers have recently taken place, and many more changes are contemplated in the near future. The net result of these changes should be a considerably more active and vital health program and more efficient use of personnel and facilities.

TABLE 16 - Visits to District Health Centers
July 1, 1967 - June 30, 1968

<u>Clinic or Activity</u>	HEALTH CENTER										<u>Total</u>
	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7 & 10</u>	<u>8</u>	<u>9</u>		
Adult Screening	-	-	-	-	-	170	-	-	-	170	
Cancer Detection (Pap test)	763	492	477	169	362	489	629	88	539	4,008	
Chest Clinic	5,107	3,546	5,649	5,115	6,487	5,622	4,087	3,846	3,408	42,867	
Child Health Conference	3,625	5,698	5,813	7,454	6,600	3,779	2,947	3,904	6,266	46,086	
Dental (Incl. PHR)	3,149	10,359	6,117	5,977	9,627	13,277	11,004	5,500	10,169	75,179	
Social Health	13,915	-	3,882	-	5,307	-	-	-	-	23,104	
X-Ray	867	1,191	3,459	4,076	2,527	4,177	2,023	1,348	1,694	21,362	
Walk-In Immunization and Tests	205	498	1,846	1,311	2,732	1,941	3,074	1,671	3,412	16,690	
Project Human Renewal	-	-	-	-	4,099	2,923	-	-	-	7,022	
Medical & Mental	-	-	-	-	-	3,322	-	-	-	3,322	
Parasitosis	-	-	-	-	-	-	-	-	-	6,021	
Pre-natal	-	-	-	2,173	2,086	1,762	-	-	-		
	<u>27,631</u>	<u>21,784</u>	<u>27,243</u>	<u>26,275</u>	<u>39,827</u>	<u>37,462</u>	<u>23,764</u>	<u>16,357</u>	<u>25,488</u>	<u>245,831</u>	
Other Services											
X-Ray Survey	83,255	-	1,665	-	3,965	-	-	-	-	88,885	
Passport Validations	-	972	1,005	382	28	392	2,631	655	3,597	9,662	
Biological Requests	418	103	380	120	78	231	226	229	221	2,006	
X-Ray Mobile Unit	-	-	-	-	-	-	-	-	-	63,984	
										<u>164,537</u>	

Physical Analysis of District Health Centers

The seven new buildings (District Health Centers 1, 2, 3, 4, 5, 6, and 9) are, in general, well-conceived, designed and built. The renovated houses that comprise the buildings for District #7 and 8 are obsolete and bear no further discussion. The newer centers are easily accessible, either by public transportation or by automobile. In Districts 2, 3, 4, and 6, land is available for expansion of the facilities. In the cases where land for expansion is not available, it appears that it could be purchased at a reasonable price if this were done quickly. With the exception of District 10, which presently has no health center (the building is being planned), the health centers are well-located with respect to the total population of the City. The health centers are physically large enough to house the services now being provided. If the contemplated move toward comprehensive, first-line medical care for large numbers of Philadelphians is made, this will require that the existing centers be expanded or somewhat altered on the interior. Additional centers larger in size than any in existence may need to be built. If the demand for this service approaches that experienced in other cities, such expansion will be absolutely necessary.

At the present time, the health centers are not being used to capacity. The utilization analysis indicates that more intensive use of the facilities can provide for a substantial increase in the number of patient visits per year without expanding the existing buildings. Further discussion of this point will be found in Part V of this report.

Table 17 summarizes the general condition of each of the District Health Centers and some basic operating data. That rather wide variations in the utilization of space and staff exist is clear. However, even the best utilized centers still present substantial opportunities for improvement in operation.

The publicly owned District Health Centers have a potential which is just beginning to be properly exploited. It is the extension of their programs to cover the ambulatory care needs of families in the adjacent areas that this committee recommends as a priority public activity.

TABLE 17 - Summary of Physical Condition
and Operation - District Health Centers

District Health Center	Gross Useable Area	Date Opened	General Condition	Land for Expansion	Relative Design Quality	Clinic Operating Hours Per Year (hrs. /week x 48)	Total Visits/ Year	Visits/ Clinic Hour	Visits/ Sq.Ft. / Year
1	18,200 Sq. Ft. ^{1 /}	1960	Good	No	Good	10,992	27,631	2.5	1.5
2	18,600 Sq. Ft.	1963	Excellent	Yes	Excellent	12,048	21,784	1.8	1.2
3	38,100 Sq. Ft.	1960	Excellent	Yes	Good	10,656	27,243	2.6	.7
4	21,800 Sq. Ft.	1966	Excellent	Yes	Excellent	10,896	26,275	2.4	1.2
5	23,200 Sq. Ft.	1963	Excellent	Possible	Good	14,784	39,827	2.7	1.7
6	19,600 Sq. Ft.	1958	Excellent	Yes	Good	18,532	37,462	2.0	1.9
7 & 10	6,900 Sq. Ft. Conversion 1955		Poor	N/A	Renovated	12,672	23,764	1.9	<u>2 /</u>
8	11,300 Sq. Ft. Conversion 1953		Poor	N/A	Renovated	9,648	16,357	1.7	1.5
9	17,800 Sq. Ft.	1958	Excellent	Possible	Good	9,360	25,488	2.7	1.4

1 / District 1 building has a total area of 66,400 sq. ft. of which 18,200 sq. ft. is used for clinic purposes.

2 / No accurate estimate possible due to large number of off-site visits included in records.

In addition, there are a number of health center program resources operating under other auspice that deserve mention. Their existence and the community support behind them points to the need for the Health Department to include these programs in any master planning for a network of neighborhood health centers. Depending on the adequacy of the centers, and the needs of various areas, varied public-private combinations should be considered. The goal is to blanket the City of Philadelphia with well-organized family care centers whose chief aim is to keep citizens well, productive and out of hospitals.

There are three OEO funded Neighborhood Health Centers serving portions of north central Philadelphia, and southeast Philadelphia. The auspice for two of these (Nicetown-Tioga, and Comprehensive Group Health Services) is Temple University Hospital and its pediatric affiliate, St. Christopher's. The other center - Southeast Philadelphia - is sponsored by Pennsylvania Hospital whose physicians all hold appointments at the University of Pennsylvania School of Medicine.

Each of these centers has buildings, or temporary facilities pending renovation. Each must serve patients who fall within the current eligibility requirements set by OEO. Thus, patient enrollees must not only live in the target area, but must have incomes that are presently no greater than those set by the State's criteria

for eligibility under Pennsycare (Title 19). As federal guidelines shift, eligibility by income may fall to an even lower standard. Thus by current standards, the centers may only care for a certain number of people within their boundaries. Within the concepts of this report, planning would need to occur so that the needs of the rest of the residents of the area, including those who might pay something for their care, could be met.

- Nicetown-Tioga is in an area within which about 27,000 low income Philadelphians live. By current standards permitted by OEO, this center estimates it may serve about 18,000 of these citizens. It presently reports budget sufficient to offer a wide range of care and social and vocational services to this many persons, but has 4,100 patients enrolled (after 18 months of operation). They are giving 8.9 services per patient per year.
- This is a creative operation presently functioning in construction trailers while an adjacent eight story building is being remodelled. The Health Department shares in the salary of the medical director of this center, and he in turn functions also as a medical advisor and coordinator in the operation of the nearby public District Health Center 8.

- . Comprehensive Group Health Services has OEO funds for adult care, and Children's Bureau, Children and Youth Project funds for child care. This center insists that all 16,000 persons within its target area are eligible for care, but has taken budget in this fiscal year to care for 10,700. There is a reported enrollment of 9,200 patients, 5,000 of which are under the C and Y Project.
- . Southeast Philadelphia Neighborhood Health Center, in operation for only six months, estimates there are 30,000 persons within its geographic boundaries. About 10,000 are probably eligible for care at the Center. Eight hundred patients have enrolled in the first six months.

It may be too soon to ascertain whether such comprehensive ambulatory care programs have had the desired result of reducing or preventing hospitalization. However, the centers which have kept such statistical information presently report very few hospital admissions, and these predominantly for obstetrical care.

There are also at least four community-sponsored self help health centers in Philadelphia. One, in a multipurpose setting, has ties with Hahnemann Medical College and Hospital. These centers currently suffer from lack of funds, and

cannot supply much data on enrollment or range of services. Some are depending largely on volunteered physician time. They are noted, however, because each represents strenuous and dedicated effort on the part of consumers to meet their own health services needs.

There are four programs, all with facilities, operated by funds derived from union health and welfare benefit plans. Two of these are closed services available only to union members and spouses. the Sidney Hillman Center of the Male Apparel Industry, and the ILGWU Center. (At least one other union has a contract with this center for care of its members.) Together they serve several thousand Philadelphians.

A variety of AFL-CIO local unions have arranged for prepaid care of members --through a center at Broad and Vine Streets in Center City. Still others prepay care in the John F. Kennedy Center and Hospital program. There is a downtown ambulatory center, and another in the northeast physically associated with a new hospital. The hospital is also available to patients of physicians in private practice in the area. This center, then, has experimented with arrangements for the care of other than union enrollees.

In addition to the Children and Youth Project housed with the Comprehensive Group Health Services project, the other four medical schools in Philadelphia also sponsor C and Y Projects. Fund allocations and management for all five

projects are vested in a joint corporation - CompCare. Hahnemann and Woman's Medical Colleges C and Y programs use the facilities of their outpatient clinics. The other medical schools are in outpost neighborhood settings. The program of the University of Pennsylvania is operated by Children's Hospital. These programs record the enrollment of about 14,000 children and adolescents.

There are also a variety of setting for Community Mental Health Center programs. The Mental Health and Mental Retardation component of the Department of Public Health serves as the planning and administrative office, under the State plan. These programs are in many stages of development toward the full spectrum of services required by the legislation. One of the notable absences in most of them, in view of the need in Philadelphia, is the inclusion of services for victims of addictive diseases. The City is also presently almost completely lacking in beds for the acute hospitalization of emotionally disturbed children. A few such beds are planned in the construction program of the new Children's Hospital, on PGH grounds. Presently, 9 of 12 catchment areas into which the city-county is divided have partially functioning or evolving programs. Three other catchment areas have not yet made staffing grant applications, and community mental health services are minimal in these neighborhoods.

It has already been mentioned that beds at PGH are still used to meet the bed requirements for three of these plans: Hahnemann, Jefferson and the Hospital of the University of Pennsylvania have designated some of their psychiatric service beds in the Mills Building for the Community Mental Health Centers with which they are associated.

Map 17 gives the locations in Philadelphia of these various present or potential ambulatory care centers. Some of the Community Mental Health Centers have subsidiary "trouble center" locations and the like, so only administrative headquarters, and perhaps some associated bed locations are reflected.

It will be a true test of the art of cooperative planning to guide the integration of these programs into the network of neighborhood based comprehensive family care programs which this report measures as imperative to the health of all the city's citizens.

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HEALTH CENTERS



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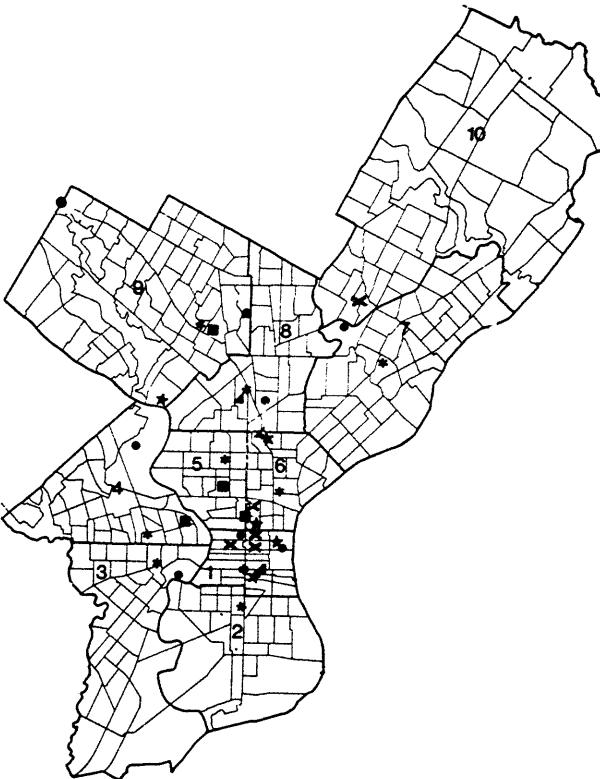
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17

3. Physician Manpower

A question often asked, especially when changes are being projected in the health care delivery system - is - "But where do we get the doctors?" The implication of the question is that there are not enough physicians. In some areas, this is so, and in others numbers are not the problem, but rather the distribution of physicians, or the manner in which they practice.

Therefore, in planning for Philadelphia, it is important to look at the characteristics of available physicians, their specialties, their institutional affiliations, how they are distributed in office locations.

The City of Philadelphia has a multiplicity of health care institutions, and an unusually high concentration of medical schools. This seems to be reflected in the fact that, in general, the City is well served by physicians. This is true both in absolute numbers and in proportion to the population base.

The presumed adequacy of physician supply, however, does not assure that all needed personal health care programs can be staffed by the existing reservoir of Philadelphia physicians. There is a high degree of hospital-based practice. Office locations concentrate in the Center City commercial area. There is heavy emphasis on clinical specialization and subspecialization. These

are all constraints which limit the equitable access by all Philadelphians to the physicians residing in the City.

The Philadelphia Metropolitan Area - when compared with the Boston, St. Louis and Pittsburgh Metropolitan Areas, has a relatively high ratio of practicing physicians to population base. The category "physicians in patient care" includes interns and residents and may, therefore, overstate the supply of physicians who are available to the general public for direct personal health care. However, ratios based on this figure are more accurate measures of physician availability than those derived from a total enumeration of all physicians which would include those in categories such as administration, research, full-time teaching. Of the metropolitan areas compared, Pittsburgh, with 1.28 patient care physicians per 1000 population, most closely approximates the national 1967 figure of 1.25 patient care physicians per 1000 population. St. Louis has 1.31 medically trained doctors per 1000 population. Boston's figure of 2.2 is higher than the others, reflecting the even more intensive concentration of training and research institutions in Boston. Philadelphia alone (as separate from the remainder of its metropolitan area) had approximately 5500 physicians of whom 86% or approximately 4700 were classified as being in active practice. National statistics from which these figures are taken, do not include osteopathic physicians. If these were included, the ratio per population would be even higher. But in Philadelphia, it is still 2.32 M.D.'s per 1000 persons.

A series of subtractions must now occur. By adjusting the figures for known numbers of physicians in administration, basic research, or physicians in training on house staffs, one finds approximately 3500 physicians within Philadelphia boundaries, who are the primary providers of patient care in offices, clinics, and hospital settings.

This estimate of the universe of practicing physicians is corroborated by a count in the commercial directory, *Dorlands*, of physicians and osteopaths in the Philadelphia area.

What are some of the characteristics of these physicians? (See Table 18)

- . There is a high degree of specialization. Over half hold Board Certification in some specialty area of medical practice. Another 25% list their practices as devoted full-time to a specialty. This leaves 25% of the practicing physicians as self-proclaimed generalists.
- . They are, on the average, older than one would expect for a major metropolitan area. (This is based on year of graduation from Medical School. Over half graduated before 1944.)
- . One out of nine of the practicing physicians in Philadelphia is an osteopath.

. One out of eight has no hospital base for direct referral of his patients, or formal institutional appointment. Thirty-six per cent are affiliated with only one institution.

. The remaining half have two or more hospital affiliations, and one in ten are affiliated with four institutions.

The lack of affiliation in the American system, is regarded as synonymous with the physician's lack of certain qualifications, or discrimination against him, or both. Conversely, multi-hospital use by physicians, while not unusual in a region with a great many hospitals, can bespeak of excessively busy and fragmented medical practices.

. Almost 94% of the practicing physicians rendered care out of a single office location. Of those who operate secondary offices, these were within the City of Philadelphia two out of three times.

An inspection of the secondary office location of physicians who practice primarily in the surrounding suburbs, showed very few who operate these offices within Philadelphia. These facts indicate that the pattern of outward migration to suburban office locations has not yet developed to any great extent in the Philadelphia region.

TABLE 18 - Characteristics of Practicing Physicians, Philadelphia, 1969

<u>Characteristic</u>	<u>Number</u>	<u>Percent</u>
All Practicing Physicians 1 /	3,993	100
M. D.'s	3,548	88.9
D.O.'s	445	11.1
Hospital Affiliations:		
None	482	12.1
One, two, or three	3,132	78.4
Four or more	379	9.5
Office Location:		
Single Philadelphia Office	3,735	93.5
Two or more Philadelphia offices	172	4.3
Two or more offices with secondary in suburbs	86	2.2
Year of Medical School Graduation:		
Before 1940	1,380	34.5
Between 1940 and 1950	1,072	26.8
Since 1950	1,541	38.7

1 / Defined by inclusion in Dorland's Medical Directory.

Though there is this evidence of a sufficient ratio of practicing physicians to population, there is also evidence of their maldistribution within the City. Map 18 showing the location of the offices listed in Dorlands, clearly highlights this fact. The midtown Market Street axis, extending across the Schuylkill River past the University of Pennsylvania/PGH complex, is the corridor which houses major concentrations of health care institutions and where the practicing doctors are most heavily located. Many of the inequities in the local health care delivery system derive from and reflect this pattern.

What can be said of these community-wide characteristics of physicians in practice, when smaller areas of the City are studied and compared? The characteristics of physicians practicing in Health Districts 4, 5 and 6 have been analyzed in this way. (See Table 19).

Health District # 5 houses approximately 9% of Philadelphia's population, but contains the office locations of only 4% of practicing M.D.'s and osteopaths. A greater percent are osteopathic physicians than in the rest of the community.

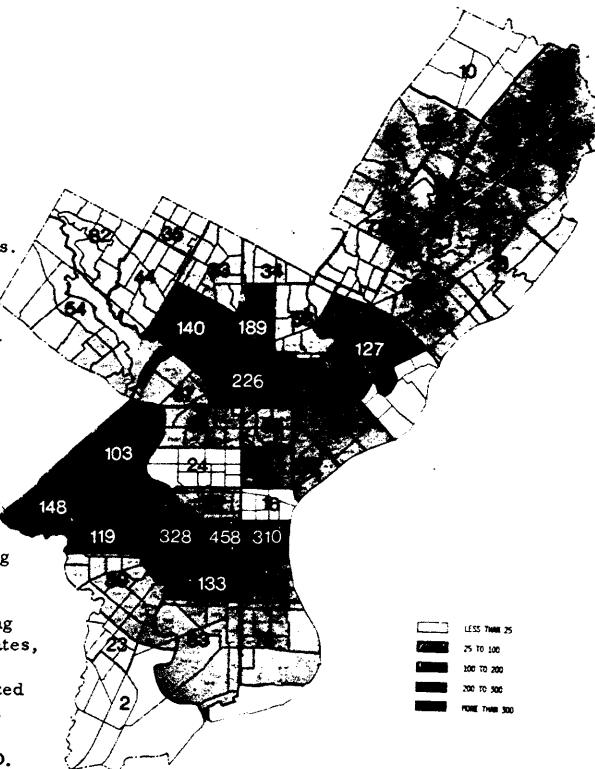
These physicians are older, more limited in their practice patterns, less specialized, more isolated from formal hospital affiliations. (Three out of 10 practicing in Health District # 5 have no hospital affiliation as compared to one in eight city-wide.)

Health District #6 with about 6.5% of the City's population, contains more physicians than Health District 5, and these physicians more closely approximate the city-wide distribution of characteristics.

But this area is still less well served than the City as a whole, in terms of the number of specialists, the ages of physicians and their access to institutions.

A zip code approximation 2/ of Health District #4 necessitated taking in the geographic area that includes the Hospital of the University of Pennsylvania - PGH complex. This results in a geographic area of the City with an excess share of physicians in relation to its population, relatively few osteopaths, and a greater share of post-World War II medical graduates. Almost 60% of these doctors are Board Certified.

- 2/ The profile data on physicians is based on the zip codes of their office locations. All mapping by the Mayor's Committee research staff was based on groups of census tracts collected in "subanalysis units" as used by the City Planning Committee. These in turn, in various aggregates, are generally components of health districts. Certain zip code areas thus closely approximated the units which equal Health District #5 and #6. But in trying to approximate H.D. #4, it was necessary to take in a larger area (part of H.D. #3).



PHILADELPHIA: DISTRIBUTION
OF PHYSICIAN'S OFFICES BY
POSTAL ZONE - 1969

These facts, in summary, highlight the challenge of medical care programming in Philadelphia. It lies more in the area of overcoming the factors which contribute to the maldistribution of physicians than it does in increasing the supply. For those physicians who do perceive their mission as patient care, the incentives and climate of progressive new delivery systems must be provided to attract younger men to remain in the service of Philadelphia. The hospital must be placed in its proper relationship to the practice of care. It need not and should not be the womb from which the doctor cannot be delivered, but it should be an institution backing the care he renders to families where they are - and where they need their doctors to be.

For older physicians who have, for a variety of reasons, been denied a hospital to serve their patients, someone may need to take further responsibilities. Programs of continuing education may need to be devised to qualify them. But where they are qualified, and the reasons for their lack of access to hospitals are more obscure, public pressure and support must be brought to bear to provide them this access.

In Philadelphia, the public sector may do this in a variety of ways ranging from providing such physicians the necessary back-up hospital in return for their designated services to Philadelphians, to making the access of qualified physicians a condition of contracts and the furnishing of funds to institutions.

TABLE 19 - Selected Characteristics of Physicians
in Philadelphia and Indicated Health Districts

ITEM	ALL PHILADELPHIA	HEALTH DISTRICT			#6
		#4	#5		
Number of Physicians ^{a/}	3,993	698	146		157
Percent Distribution	100%	17.5%	3.7%		3.9%
Percent of Physicians With:					
No hospital affiliation	12.1%	9.8%	28.8%		12.7%
four or more hospital affiliation	9.4%	6.7%	4.1%		5.7%
Board Certification	52.2%	63 %	25 %		36 %
Percent of Physicians Who are Osteopaths	11.1%	6%	25%		17%
Percent of Physicians Who Graduated from Medical School Prior to 1940:	48%	42%	56%		52%

a/ Includes M.D.'s and D.O.'s.

SOURCE: Dorland's Directory of Physicians - Tabulations by
Staff of Mayor's Committee on Municipal Hospital Services.

4. Institutions Providing Long Term Care And Related Services

Although there is a surplus of acute short term hospital facilities in Philadelphia, the situation with respect to facilities providing long term care has been approaching a crisis for several years. Not only is there an absolute shortage of long term care facilities in the City but many of the existing institutions are of sub-standard quality. Furthermore, most of these institutions, good and poor, find it impossible to provide services at the present public assistance rates thus making it difficult for many Philadelphians to obtain the care they need. One result of this situation has been the general over use of the acute care hospitals to provide extended care for those people who are unable to find a bed in a less costly and more appropriate facility. Another result has been the increasing length of the waiting list for admission to the City owned and operated Riverview Home for the Aged.

In 1968, the Pennsylvania Economy League (Eastern Division) published their report No. 350, Caring for Philadelphia's Needy Aged, which concentrated on the needs of the older (over 65) population of the City. This very comprehensive study can and should serve as a major resource document for the future planning of programs concerned with long term care in Philadelphia. There is one area that was not covered thoroughly by the report,

convalescent care for otherwise self-sufficient persons recovering from an episode of acute illness who may need more intensive nursing and/or rehabilitation services than can be economically provided at home but do not require the services of an acute care hospital. At the present time many people in this situation are being kept in the City's acute care hospitals beyond the time that efficient use of these resources would dictate. This results in an over utilization of the City's hospitals as reflected in long lengths of stay and total patient days of care for the entire City population. The end result of this is excessive cost both to the individual and the community. Several Philadelphia hospitals have taken this problem into consideration as part of their master plans. These institutions should be encouraged in their attempts to provide high quality comprehensive care at the lowest possible cost.

The following table summarizes the inventory of beds for aged, handicapped and infirm persons in Philadelphia as of November, 1968. The information is derived from a directory published by the Office for the Aging (O.A.) and an unpublished Hospital Survey Committee (H.S.C.) survey made in May, 1967.

TABLE 20 - Number of Beds in Homes for Aged,
Handicapped and Infirm by Type of Home -
Philadelphia, Pennsylvania November, 1968

<u>Type of Home</u>	<u>Number of Facilities</u>	<u>Number of Beds</u>
Proprietary Nursing Homes	53	3,271
Non-profit Homes:		
Classified by nursing homes by O.A. and H.S.C.	11	1,579
Classified as nursing homes by O.A. and as homes for aged by H.S.C.	20	2,170
Classified as old age homes by both O.A. and H.S.C. (includes 226 in - firmary beds in 11 homes)	24	1,487
Riverview - includes 130 infirmary beds	1	850
Total	109	9,357

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The following table classifies the beds available in Philadelphia by type.

TABLE 21 - Number of Beds in Homes for Aged, Handicapped and Infirm by Type of Bed - Philadelphia November, 1968

<u>Classification</u>	<u>Number of beds</u>
Nursing care as classified by O.A. and H.S.C.	4,850
Infirmary in homes for aged as classified by H.S.C. (includes 130 beds at Riverview)	1,013
Other nursing care beds at Riverview	500
Subtotal - Nursing care beds	6,363
Other beds in homes for aged (includes 220 at Riverview)	2,994
TOTAL	9,357

All nursing homes in Philadelphia are required to meet minimum fire safety standards. If a home is not of fire-resistive construction it is judged as "non-conforming" by the State Department of Public Welfare with respect to long term needs. The ratings for nursing homes by the Hospital

Survey Committee are shown below:

<u>Type of Home</u>	Conforming		Non-Conforming	
	<u>Homes</u>		<u>Homes</u>	
	<u>#</u>	<u>Beds</u>	<u>#</u>	<u>Beds</u>
Proprietary	6	699	48	2649
Non-Profit	6	1062	5	418
Total	12	1761	53	3067

In September 1967, only one of the six conforming proprietary homes had any public assistance patients (10). The remaining 1040 public assistance patients in Philadelphia proprietary nursing homes were housed in non-conforming structures. It is not certain how many of the 1300 public assistance patients being cared for in non-profit homes at the same time were housed in conforming structures.

It is obvious that present levels of public assistance are inadequate for the purchase of care in the better facilities in Philadelphia. Nor will the construction of additional proprietary facilities benefit the typical recipient of public assistance except possibly through a limited and slow filtering down effect as some middle aged facilities find it necessary to accept public assistance patients to maintain a reasonable level of occupancy.

In addition to the non-conforming nature of a large proportion of the existing long-term care beds in the City, the projected increase in the aged population who are the principal users of these facilities will further aggravate the shortage of acceptable accommodations in the near future. (See Part IV- A)

The following is a summary of population projections made by the Pennsylvania Economy League using Delaware Valley Regional Planning Commission estimates as a base:

Estimates of Philadelphia Aged Population				%
<u>Age Group</u>	<u>1967</u>	<u>1980</u>	<u>Increase</u>	
65 - 74	151,400	151,900	0.3	
75 - 84	62,300	71,900	15.4	
85+	13,100	17,300	24.3	
Total	226,800	241,100	6.3	

In Chapter VI of the Pennsylvania Economy Report referred to above, a rigorous analysis of the estimated need for long term care facilities in Philadelphia was made. These do not include estimates of the demand for domiciliary beds and take very little cognizance of the rapidly expanding use of nursing homes as convalescent facilities for people under 65 years of age. It must be

pointed out that the above exclusions were not oversights on the part of the League but were beyond the scope of the study.

TABLE 22 - Projection of Occupied and Total Nursing Care Beds Needed in Philadelphia in 1980 Under Three Estimates of Utilization

	Average Daily Occupied Beds	Total Beds	Increase over 1967 #	Increase over 1967 %
1967	5,800	6,350	-	-
1980 Projected:				
Low Proj.	7,230	7,600	1,250	20
Med. Proj.	8,440	8,880	2,530	40
Hi. Proj.	9,640	10,150	3,800	60

The projected increase in the number of additional beds needed by 1980 is in the range of 1,250 to 3,800. If these beds were built in equal annual increments over the 10 year period from 1970 to 1980 between 125 to 380 beds would have to be added each year. In addition, about 3,000 existing non-conforming beds must eventually be replaced.

Various estimates of the need for hospital based extended care facilities have been made including one by the Hospital Survey Committee

in 1967 which projected a need for 500 such beds by 1970 and 600 beds by 1980. The H.S.C. based its planning on the assumption that about 5% of medical-surgical patient days of care could be provided in extended care units. More recent studies conducted in other cities indicate that this is probably a very low estimate of the potential demand for this type of accommodation.

At one time, home care programs were looked upon as an important means of relieving pressure on both acute and long term care institutions. However, experience in Philadelphia as well as other cities has shown that a proper type of institutional care is generally less expensive and results in the more appropriate use of personnel, particularly nurses. At the present time, it can be shown that, except for short term family crisis situations, it is uneconomical to consider home care as an alternative to institutionalization where the presence of a homemaker or home health aide is required for more than 20 hours per week. This is particularly true where the person or persons requiring care are elderly and do not have responsibility for other than themselves. A major study conducted in Cleveland, Ohio concluded that for people in this category appropriate alternate living arrangements were probably more economical at the point where the care required in the home exceeded about 10 hours per week of other than domestic assistance.

There are three basic categories of home care services:

1. Homemaker and housekeeping services
2. Home nursing services
3. Coordinated home care programs

The Philadelphia Department of Welfare Homemaker Service has found that one homemaker can serve slightly less than two cases per week at a daily cost including supervision and overhead of \$29. Based on a 5 day week and two cases per day, this experience results in a monthly cost of about \$314; about the same as the average cost of care in public nursing homes. A varying fee schedule has been established that can result in the reimbursement of up to about 2/3 of the cost of this service. Experience has shown that because most recipients are at the low end of the income scale and the service is not reimbursable under Medicare, only a small part of the cost of this service is recovered by the City.

In 1959 the Nursing Service of the Department of Public Health and the Visiting Nurse Society merged to form the Community Nursing Service (CNS). This service now works from the City District Health Centers and provides in-home nursing service. Services are reimbursable under Medicare Part B. At this time about 60% of the cost of this service is recovered by the CNS. As a general rule, the CNS has a three-month limit on services to an individual.

Beyond this, the family is expected to make some other long-term arrangement.

The most comprehensive of the services brought into the home is the "coordinated home care program". Such a program has been defined as "one that is centrally administered and that, through coordinated planning, evaluation and follow-up procedures provide for physician-directed medical, nursing, social and related services to selected patients at home". This program is almost always used as an alternative to continued hospitalization following an episode of acute hospitalization. A limited number of these programs are based at Albert Einstein Medical Center, Children's Hospital of Philadelphia, Jefferson Medical Center Hospital and PGH. The PGH program is limited to patients over 65 years of age who live near the hospital. All of these programs stress rehabilitation and are not intended to give long term service to patients with chronic illness.

The following table is an estimate of the number of Philadelphians receiving care at home made by the Pennsylvania Economy League. The lack of Philadelphia specific data made it necessary to apply national data to the City's population.

TABLE 23 - Estimate of Philadelphians Receiving Care at Home

	<u>75+</u>	<u>65-74</u>	<u>15-64</u>	<u>Total</u>
Number of persons in age group	75,000	150,000	1,300,000	1,525,000
Receiving constant care at home				
% of age group	5.3	1.0	0.2	-
Number	4000	1500	2600	8100
Receiving part-time care at home				
% of age group	3.5	1.2	0.1	-
Number	2600	1800	2000	6400
				14,500

The largest single component for care for aged and chronically-ill Philadelphians is the City-owned institution located on the Delaware River in Northeast Philadelphia. Although the site is potentially very attractive, there are serious problems connected with its location. The remoteness and lack of public transportation to the site make it virtually impossible for visitors and staff to get to Riverview unless they have private transportation. Unfortunately, the majority of potential visitors and even workers are in an age or income bracket which precludes automobile ownership.

Riverview, at present, provides service to 850 Philadelphians. Fifty-three percent of the residents are senile or retarded; 35% are more or less incontinent; 76 % are receiving some form of medical care, a percentage which is increasing. Recent changes in admission requirements have halted the former practice of using Riverview as a dumping ground for chronically-ill patients for which the institution is not prepared to care. This has resulted in a drastic reduction in the mortality rate and an increase in the average length of stay. Also contributing to the above is an expanded rehabilitation program and constantly improving arrangement with local hospitals for acute medical care. The success of these new programs at Riverview has been due to the dedication of the medical staff and the ability and commitment of the administration of the Welfare Department to bring the quality of care up to present day standards.

The present facilities at Riverview must be considered in two groups. The first group of buildings, built before 1931, is totally obsolete in all respects and is scheduled for demolition and replacement in accordance with the 1964 master plan. The second group of buildings, built since 1955, is generally well-conceived, but will require renovation in order to provide the type of facilities that the current program of Riverview demands and to bring the facilities into conformity with recent federal, state and local code requirements. The necessary modifications will result in a slight decrease in the number of available beds.

At this time, the City's capital program does not provide for the completion of the planned new facilities until after 1973, which is not completely unfortunate. We believe that now would be the proper time to reevaluate the Riverview Master Plan in the light of new programs at the institution and possibly revise them to reduce the number of beds planned for the site. At the same time, alternative sites for additional extended and custodial care facilities better related to the population to be served, to back-up medical services, and transportation should be investigated. The establishment of a comprehensive evaluation and referral service and investigations of other options for serving the needs of aged Philadelphians should be a part of any future planning for Riverview and related programs for chronic care.

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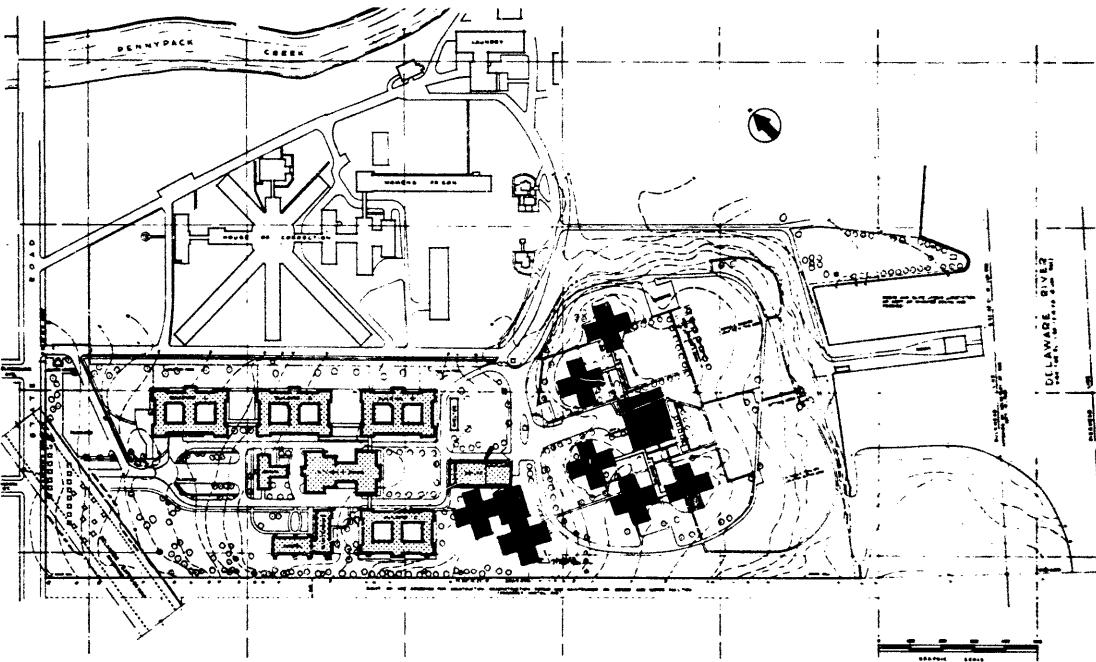
Maps #1, #2 and #3 in Part IV-A of this report show the location of Riverview with respect to land use and transportation in Philadelphia.

Drawing 6 is a site plan of the institution as it presently exists. Four hundred twenty-eight patients are housed in the older buildings and 431 in the post 1955 dormitories.

Drawing 7 is a site plan showing the intent of the existing master plan if it is carried to completion. The plan, as shown, will result in an increase in the number of beds at the institution to over 1000. The plan itself projects 1110 beds but new code requirements and the increased emphasis on medical care and rehabilitation programs will result in some reduction in this number.

A detailed analysis of the existing physical plant can be found in the Riverview Modernization Plan prepared for the City by Bellante and Clauss, Architects, Engineers and Planners in 1964. The following tables more fully describe the operation of Riverview and the characteristics of its patients.

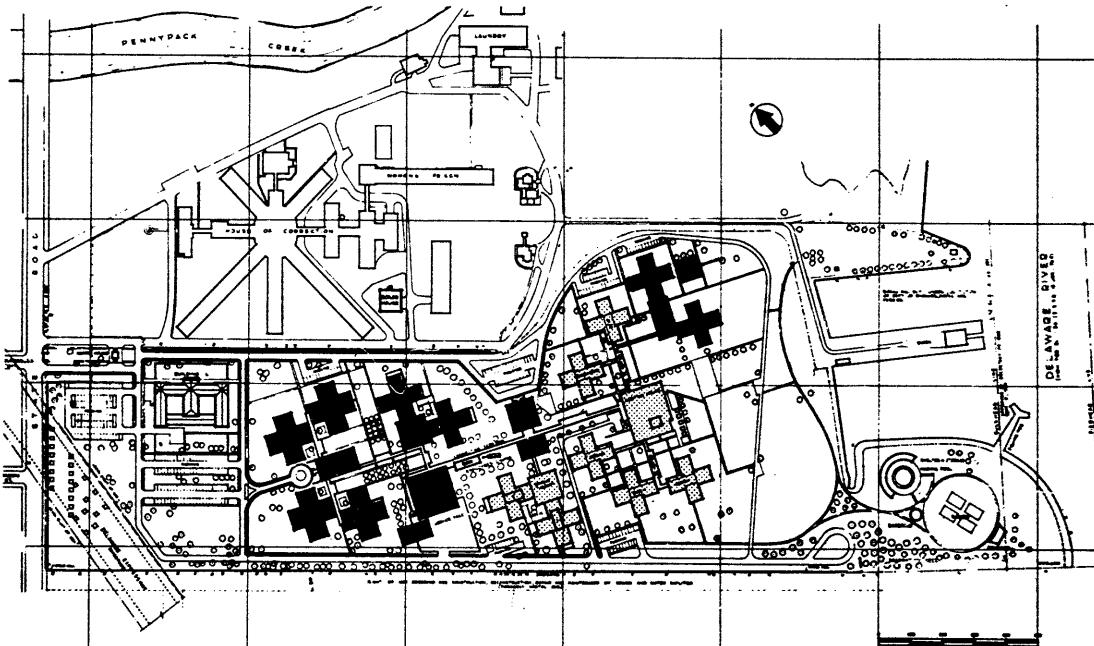
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POST 1955 CONSTRUCTION
PRE 1955 CONSTRUCTION

RIVerview
EXISTING SITE PLAN

6



RIVerview MASTER PLAN
PROPOSED SITE DEVELOPMENT

EXISTING PRE 1955 CONSTRUCTION
EXISTING POST 1955 CONSTRUCTION
PROPOSED CONSTRUCTION

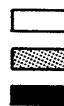


TABLE 24 - Historical Review of the Number
of Days of Care Provided at Riverview Nursing Home

Type of Care	1968	1967	1966	1965	1964	1963
Infirmary Care	40,295	41,014	47,549	50,188	51,298	50,079
Nursing Home Care	148,226	119,820	139,397	149,690	140,130	60,829
Custodial Care	106,721	160,874	184,233	194,295	215,386	283,497
Total Patient Days of Care Provided at Riverview	295,242	321,708	371,179	394,173	406,814	394,405
Average Per Diem Cost for All Types of Care	13.77	10.52	7.12	5.71	5.43	5.33

TABLE 25 - Riverview Nursing Home Patients - 1968

<u>Census</u>		<u>Age Distribution</u>		<u>Deaths</u>
		<u>Number</u>	<u>Percent</u>	
Male	426	21 Years to 50 Years Old	28	3.4%
Female	395	50 Years to 60 Years Old	109	13.3%
Total	<u>821</u>	60 Years to 80 Years Old	463	56.4%
		80 Years to 100 Years Old	221	26.9%
		Total	<u>821</u>	100.0%

<u>Reason for Admission</u>	<u>Percent</u>	<u>Length of Stay</u>	<u>Percent</u>
Indigent	4%	Less than 3 months	3%
Medical & Nursing	91%	3 months to a year	11%
Transients	2%	1 year to 3 years	27%
Mentally Retarded	1%	3 years to 10 years	36%
Other Reasons	2%	10 years to 20 years	20%
	<u>100%</u>	20 Years or more	3%
			<u>100%</u>

Source: Unpublished data from the Administration at Riverview Nursing Home.

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5. Education for the Health Professions

A critical look at the existing system for health care in any community must also review educational programs to provide manpower to staff these services. In the City of Philadelphia local tax dollars are helping to subsidize health professions education, largely through the training programs conducted at PGH. The committee deemed this reason enough for an intensive examination of health care manpower and training in Philadelphia.

Upper Echelon Professionals

Physicians and Dentists

It has been customary to explain inadequate delivery of health care in terms of physician and dentist shortages. However, there is not necessarily a positive correlation between the total number of these professionals and the provision of quality health care for all who need it. Even if one could prove a positive relationship, it would appear from the following data that locally there is little necessity to increase the total number of physicians and dentists.

In Philadelphia, with a population of approximately 2,045,000, there are currently over 5,500 physicians, a rate of 1 per 342 persons. The national average in the United States is 1 per

800 persons. The National Institute of Health indicates that 1 per 1,000 is adequate. In Philadelphia there are 1,368 dentists, or approximately 1 per 1,450 persons. The national average is about 1 per 2,000. NIH claims an adequacy rate of 1 per 2,000.

The problem, locally, does not center on total numbers but rather on the fact that physicians and dentists are disproportionately distributed throughout the city. Physicians are concentrated around medical centers or, like dentists, practice mainly in middle to high income, predominantly white neighborhoods. Another area of concern in the medical field points up the paradox of increased specialization that often results in superior health care, but can just as often hinder the coordination and continuity of health care.

Registered Nurses

Unlike the supply of physicians and dentists, the rate of registered nurses per population in Philadelphia is considerably lower than the national average. In the United States, the rate of professional nurses per population is approximately 1 per 330 persons. In Philadelphia, with 4,465 registered nurses, the rate is approximately 1 nurse per 575 persons. Philadelphia is faced with a registered nurse shortage. The Philadelphia chapter of the National League of Nursing, in 1967, estimated that at least 1,442 additional registered nurses were needed. Furthermore,

a continuing decrease in local nursing school enrollment suggest a persisting shortage.

Allied Health Manpower 1/

The more clearly recognized and longer established health professions of medicine, dentistry and nursing have received serious attention for a number of years. Only recently, however, has the broad range of other professional and technical functions essential to all types of health services been recognized for its significance. This group of occupations, so necessary for the expansion and quality of health services,

1 / The term allied health manpower, when used broadly, covers all those professional, technical and supportive workers in the field of patient care, community health, public health, environmental health and related health research who engage in activities that support, complement or supplement the professional functions of administrators and practitioners. Occupational categories in which personnel require only nominal orientation to become fully productive in the health industry are not included. The level of education necessary for employment is influencing the designations attached to job titles. Increasingly, those people trained in formal education programs that include theoretical and practical courses usually leading to a certificate or the associate degree are considered technicians; and those who are required to have at least a baccalaureate degree are referred to as technologists.

has been designated as the allied health occupations. It includes an extensive range of endeavors for which special training or education is required.

The occupational categories and functions of the allied health professions are undergoing rapid changes and are presently not well defined. Unfortunately, nationally and in Philadelphia, there is a considerable lack of information about the numbers of people serving in these professions, their distribution, their education and training, the ways in which their skills are used, and the directions that should be taken for better utilization of their skills in the variety of personal and community health service settings which exist or are contemplated in the future.

Because appropriate allied health manpower planning and means of data collection do not now exist in Philadelphia, we could not accurately analyze present and projected needs in this area. However, if the needs based on national figures are an indication of essential requirements locally, there is an acute shortage of allied health personnel in Philadelphia. NIH analysts estimate a current 30% deficit at the baccalaureate or higher level of preparation in the medical allied manpower field, and a 40% shortage where less than a baccalaureate degree is required. The projected increase in need for all allied health manpower in 1980 is 63%. Manpower shortages in the allied health field demand a re-evaluation of the motivational, recruitment, educational and training programs now available for meeting present and future manpower needs.

There are, in addition, various problems inherent in the rapidly expanding field of allied health manpower. Planning at local, regional, and national levels requires extensive data that are not presently at hand. Changing patterns of health service delivery are creating changing requirements in number and types of allied health personnel.

Many workers are being prepared in programs that do not allow for vertical and horizontal occupational mobility. They often cannot move to another related health occupation by building on their professional preparation and work experience. Rather, they must start from the beginning in another basic professional program. Furthermore, the absence of vertical mobility among the health disciplines and the restriction of occupational decisions to only one or at the most a couple of points of entry virtually closes the majority of health careers to the socially and culturally disadvantaged in our society.

Educational concepts and settings are just beginning to change from the traditional classroom situation to perspective that recognizes the value of knowledge and skill acquired from a variety of sources. The extent to which the knowledge and skills of those employed in the health professions and occupations are utilized is a primary factor in delivering quality health care to all who need it. Many services currently performed by highly trained professionals can be performed equally well by persons with considerably less training. An example of this in Philadelphia is the case of specially trained dental

assistants, under supervision in District Health Centers, successfully assuming tasks previously handled only by graduate dentists. Unfortunately, licensing requirements make expansion of programs of this nature difficult. Licensure can be a mechanism for helping to assure the quality of services that allied health personnel should deliver. We must attempt to ascertain, however, at what point licensure moves beyond protection for health care recipients, and becomes, instead, a restrictive means of excluding qualified and needed health workers.

A major area that both reflects and reinforces the problems already described is that of training and education. In Philadelphia, training and educational programs have inadequate enrollments. Uncoordinated programs duplicate one another; consequently, scarce teaching manpower is wasted and higher expenses for equipment, buildings and personnel are incurred. Lack of a common curriculum for trainees and students means that education and training are difficult to transfer from one occupation to another. Moreover, training and educational curricula do not always meet the demands of occupational requirements, nor are these requirements sufficiently uniform from agency to agency.

Low Entry Health Occupations

A high proportion of persons employed in the health field (especially in hospitals) occupy low status, poorly paid, dead-end positions which require little

or no formal education. In Philadelphia, slightly over 75 percent of these low-level jobs are held by blacks. (Table 26)

As a result of minimal training and educational qualifications needed for easy access occupations, persons employed in them find that the road upward, which requires increasing levels of both training and education, is largely blocked. Poor incomes normally preclude the possibility that these workers will obtain further education on their own time. The unwillingness of employers in most cases to invest in programs which have released time for training and education also militates against advancement beyond low level entry positions. The inability of persons already in health occupations to move upward eliminates a key reservoir of potential manpower for levels where real shortages exist.

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Table 26 - Hospital Employees by Occupation-
Fifty Hospitals by Ownership

	42 Voluntary			3 Government			5 Proprietary		
	Total	Negro	% Negro	Total	Negro	% Negro	Total	Negro	% Negro
Total	24,077	9,235	38.4%	1,429	788	55.1%	438	235	53.7%
Officials, managers and administrators	753	66	8.8	7	0	0	7	3	42.8
Professional (Total)	(6,141)	1/	(6.1)	(280)	(66)	(23.6)	(85)	(9)	(10.6)
Physician administrators	407	3	0.7	11	1	9.0	4	-	0
Nurses	4,504	230	5.1	177	47	26.6	65	4	6.0
Other Professional	1,027	138	13.4	92	18	19.6	16	5	31.4
Technicians	1,893	368	19.4	38	15	39.5	2	-	0
Secretarial and clerical	4,181	630	15.1	254	69	27.2	41	3	7.3
Craftsmen	819	170	20.8	179	70	39.1	3	2	66.6
Operatives	454	174	38.3	30	22	73.3	20	3	15.0
Laborers	271	183	67.5	25	21	84.0	-	-	-
Service Workers	9,565	7,271	76.0	616	525	85.2	280	215	76.8

1/ Total employees includes 203 and Negro includes 2 not listed by specific professional occupation. One hospital provided only a total in this category.

Hospital Employment Study

Commission on Human Relations, City of Philadelphia, June, 1966.

Who Trains Health Workers in Philadelphia?

--and who is in training? There are five medical schools and a college of osteopathic medicine in Philadelphia. Two university health sciences training programs include dental schools. There are thirteen nursing education programs of which two are degree programs, one is an associate degree program and the remainder are hospital based diploma schools, including that of the Philadelphia General Hospital. There were 1,597 students enrolled in nurses' training in the fall of 1969.

Allied health manpower education in Philadelphia is provided by 35 schools that offer programs in 75 disciplines. These include allied health sciences training programs of universities, hospital based or private technician training programs, community college occupational careers courses. The Philadelphia General Hospital is included by virtue of its training programs for x-ray and laboratory technicians. In 1968 3,166 students were enrolled in these various courses.

It is in the upper echelon professional sectors, requiring extensive education and training, that black citizens are acutely under-represented. Twenty-seven percent of the Philadelphia population is black. Yet, black physicians represent only three percent of the total number of physicians in Philadelphia. Black dentists represent seven percent of the dentists in Philadelphia. Black registered nurses employed in local hospitals make

up six percent of the total number of nurses employed by these same hospitals.

The enrollment of blacks in medical, dental and nursing schools reflects the same pattern of exclusion. Two percent of medical students are black. Two percent of students enrolled in collegiate nursing schools are black; five percent enrolled in diploma programs are black; and approximately ten percent enrolled in associate degree programs are black. It would also be desirable to know the proportion of black interns and residents in post-graduate training in Philadelphia institutions. This is available only for PGH. (See Table 27.)

There are only three types of health manpower educational programs in Philadelphia that seem to be preparing minority citizens in any proportions that approach their numbers in the population. (See Table 28) They each represent different levels of potential career development. Those being trained as institutional aides are 85% black, but this is the very career for which there is only an uncertain ladder up which to rise. Of the students in training for licensure in practical nursing, 23% were nonwhite. Particularly if some of the recommendations of this committee are followed, there is some opportunity for these students to go on into higher echelon careers.

The figures for black enrollment in health careers training at the Community College should be especially noted. Twenty-three percent of these students are nonwhite. They are in a variety of

training programs, all of them conferring some degree of college credit, and definite certification or licensure where this is required. Such advances deserve support.

Table 27 - Black Enrollment in Health Education and Training Programs at Philadelphia General Hospital - 1969

Type of Program	Total Enrollment	Black Students	% Black Students
Internships*	76	2	2
Residencies*	152	2	1
Medical lab technician	20	10	50
Nursing			
Diploma	172	18	10
Affiliate	19	0	0
Licensed Practical Nurse	20	18	90
X-ray Technician	26	5	19

*Does not include those in the dental post-graduate training programs at PGH.

Who pays? One of the problems evident in our analysis of these health manpower training programs lies in the fact that so much of the cost of training in Philadelphia must be borne by students themselves.

In the 48 schools of nursing or allied health training, enrolled students were responsible for 83.3% of the tuition costs. The city government contribution toward these educational costs accounted for 13.4%. This was mostly (70% of it) expended at PGH, but it certainly represents a greater public contribution toward education than the approximate 2% which came from state or federal sources. Voluntary hospitals also contributed 2% of the costs in aid stipends for some students. Despite these contributions, then, the burden of payment is left on the student.

Another of the most evident problems is that we do not know in our city whether we are emphasizing the manpower we need to train. Without definitive manpower planning, we will not know if the twelve different hospital-based radiologic technician programs, for example, make any sense. These range from free programs to programs which pay students to train, to courses which cost the student. Four of the programs have less than 10 students. Only four have more than 30 students. There are countless more examples of students in health careers training in many varieties of technicians and aide programs. The costs of these programs to trainer and trainee cannot be counted as worthwhile, until we know more of the actual need for various kinds of manpower, and also coordinate their placement opportunities.

Table 28 - Black Enrollment in Health Education and Training Programs in Philadelphia - 1969

<u>Type of Program</u>	<u>Estimated Total Enrollment</u>	<u>Estimated Black Students</u>	<u>Estimated % Black Students</u>
Allied Health (Temple, Univ. of Penna.)	368	21	6.0
Allied Health (Com. College)	315	75	23.0
Medical (6 medical schools)	2,989	51	2.0
Dental (includes Dental Schools, and allied dental training)	1,055	4	0.4
Nursing	1,597	86	5.4
Licensed Practical Nursing	693	158	23.0
Optometry	421	1	0.6
Pharmacy	1,054	33	3.0
Podiatry	160	1	0.6
Institutional Aides	170	145	85.0

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C. The Cost of the Personal Health Care System--Who Pays for What?

1. Introduction

This analysis of the expenditures for personal health care in the City of Philadelphia is a crude estimate of the local medical care market. It was prepared in order to give a general feel for total expenditures and the place of public money, particularly local tax dollars, therein.

A major problem of method has been an appropriate definition of the population base. The medical care system in Philadelphia is used by county residents--and by others. County residents use care facilities elsewhere. Since the population has this mobility and some freedom of choice, no really precise analysis can be done short of the nation.

Expenditures for personal health care in Philadelphia were analyzed by breaking them down into four general categories:

- . hospital care
- . physician care
- . drugs, appliances, nursing home care and miscellaneous expenditures
- . personal health care activities of local government such as the Department of Public Health, and the Board of Education.

The guide issue of the American Hospital Asso-

ciation was used to estimate the expenditures on personal health services for the hospital care category. The city mercantile license tax base was used for estimating expenditures for physician care, nursing home care, and drugs and appliance. The information from this source available to this study was based on 1967 gross business receipts. The City's activities were estimated from an analysis of Department of Public Health obligations for 1967, and Board of Education obligations for 1967-1968. Pertinent data was also extracted from reports of the Department of Public Welfare of the Commonwealth of Pennsylvania.

The nature of the data from which information must be gathered is such that these categories are not precisely independent. Some nursing home expenditures, for example, are included under hospital care. Furthermore, there are definite biases in the various data sources. However, useful generalizations may be made.

2. The Cost of Personal Health Care In Philadelphia

When all these sources of expenditure for personal health care are added up to give a total picture, the figure equals about \$487 million dollars. Since different years had to be mixed, and expenditures for health care have been rising each year, there may be an underestimation of the total local medical care market. It is, however, a lot of money and is characteristic of the increasingly large portion of the gross national product which is being poured into the "health industry".

National data show a per capita expenditure throughout the nation of \$233 per year per citizen for personal health care as defined by the categories above. The estimate for Philadelphia is \$238 per capita per year. National data indicate that such expenditures are usually substantially above the average in large urban centers. The close similarity of Philadelphia's figure to the nations, would lead to the belief that it is underestimated. But it is an average. From other sources we do know that private payers in Philadelphia probably spend \$300 per capita, but Pennsycare has provided only \$200 per eligible recipient.

3. What Part Does Government Money Bear?

Of the \$487 million or more spent for personal health care in 1967-68

- Federal government expenditures in Philadelphia amounted to \$70 million or 14.4%. Medicare, parts A and B, accounts for the major portion of federal contributions. (Part B co-payment by individuals is included as a federal contribution). Also included as a federal expenditure, are the costs of operating two federal hospital programs within the city limits. These federal expenditures for personal health care, benefitting only certain population groups such as the elderly, or veterans, amounted to \$34.27 per capita.

State government expenditures within Philadelphia in 1967-68 amounted to \$73 million or 15.4% of the total expended on personal health care. The major portion of this--\$59 million--represents reimbursement for care under Medicaid ("Pennsycare"). The federal contribution to Medicaid in the Commonwealth of Pennsylvania is about 54% of its total value. Most of the rest of state expenditures are represented by the direct provision of care through state hospitals within Philadelphia County. The state expenditures on personal health care services amounted to \$36.70 per capita.

City government spent approximately \$26 million toward total expenditures for personal health care in 1967-68. This represents 5.3% of the total funds spent for such services. The major portion of the city's expenditure, \$17.6 million, took place at the Philadelphia General Hospital. This figure includes the approximate \$3 million which was disbursed in that year by the hospital contract fund for the purchase of emergency and outpatient care. PGH served as the fiscal agent for this fund. The city's other major contributions were \$5,000,000 to the personal health care activities of the Department of Public Health (e.g., - the direct rendering of medical and dental care services to patients as distinguished from environ-

mental health activities and other programs); \$2,100,000 to operate the medical care programs for residents of Riverview; and \$957,000 as its contribution through the Health Department, to the federally assisted Maternity and Infant Care projects. The school health program of the Board of Education amounted to another .56% of the total sums spent within Philadelphia.

The city government's expenditures for personal health care thus amounted to about \$12.60 per capita. (See Chart 1)

4. What Comes From the Private Sector?

After subtracting public sources of funds from the total estimate, we find that private sources accounted for \$314 million or 64.4% of the total sums spent on the health care of individuals in Philadelphia in 1967-68. (Chart 1)

These funds came either out of individual pocket to pay doctor, hospital, dental and pharmacy bills, or were from an insuring source such as Blue Cross-Blue Shield. United Fund disbursements toward the operation of direct health services programs are also included.

The sum of \$313,949,000 represents these expenditures from private, rather than government sources. It is important to note that this includes the \$4,198,000 which the City government contributed to the purchase of health insurance for its employees.

5. Where do These Dollars for Health Care Go?

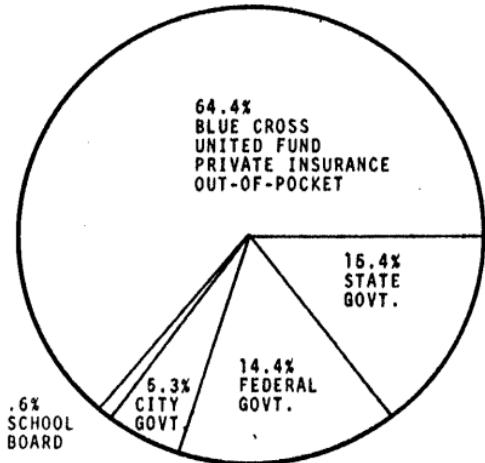
Total governmental expenditures amounted to \$173 million or 35.6% of the whole. Of this large sum, \$134 million or 77% of the total public disbursement--federal, state, and local, was spent on care rendered by hospitals. Hospital care is defined as both inpatient and outpatient care. However, the major proportion of these public dollar allocations were for inpatient care.

Another 12% paid private physicians, and 4% paid drug stores, nursing homes and miscellaneous services.

The private share totalled \$314 million. Almost 53% of this (nearly \$174 million) bought hospital care.

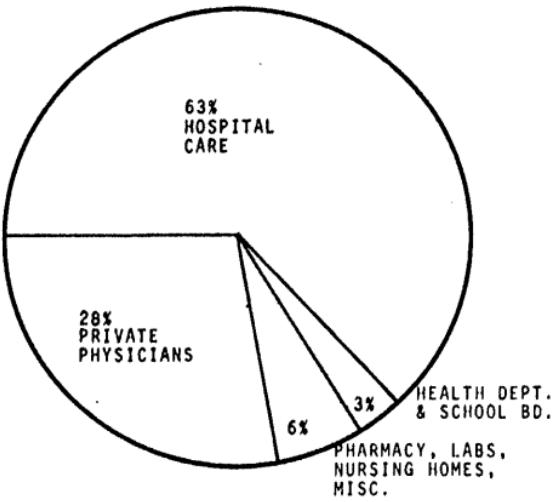
When all these funds are placed end to end to give us the grand total of \$487.4 million spent within the City of Philadelphia in 1967-68 on personal health care, we find that 63% went to hospitals, 28% for physician services, and only 3% to the direct medical and dental care activities of the City. (Chart 2)

SOURCE OF FUNDS



1

EXPENDITURE CATEGORY



2

6. Health Among the City's Priorities

What priority has the city government given to health in economic terms? There are two ways of approaching this question. The first is to treat the general fund in two parts: 1) operating funds, and 2) capital funds. The second way is to treat the general fund as the total resources available to the city to allocate to its different functions. Both approaches were investigated in detail and, either way, showed a similar picture. Consequently, only the first approach is discussed. That is, operating budget trends are analyzed. This is more useful for decision-making since operating resources might be regarded as indicative of current priority decisions. Capital allocations relate to decisions made in the past.

In 1968, City government spent approximately 13.7% of its total operating resources for health functions. In 1960, the allocation to health was 12.84% of the City's total operating funds. Table 29 shows that there has been a small but nearly steady increase. These are not major increases in local funds for human health preservation, or major marks of a sense of priority in the city for affecting health or the health care system.

One must dig a little deeper still to answer the initial question: What priority has health been within the operating budget resources that are actually local dollars? In the decade of the 1960's federal and state governments have greatly increased their contributions to local financing, especially in the area of health. So it is necessary to subtract out non-local sources of revenue to determine what portion of local dollars were still used.

In 1960 health activities received 10.66% of the operating dollars that were purely local. Since 1961 this trend has been slightly downward, so that it was 9.16% in 1968. The indication from this analysis is that the City of Philadelphia has been replacing local tax funds allocated to health with non-local revenue, to a modest degree.

Table 29 - Trends in the City of Philadelphia General Fund Activity with Emphasis on the Health Related Activity (in thousands)

	<u>1968</u>	<u>1966</u>	<u>1964</u>	<u>1962</u>	<u>1960</u>
Health Related Obligations	45,778	34,291	28,706	26,387	23,612
All City Functions Obligations	334,210	259,819	223,932	202,943	183,908
Health Function as a Percentage of All City Functions	13.70%	13.20%	12.82%	13.00%	12.84%
Health Related Net Revenues	17,801	11,719	9,307	7,523	4,569
Health Related Obligations Financed Locally	27,977	22,572	19,399	18,864	19,043
Health as a Percent of All City Functions	8.37%	8.69%	8.66%	9.30%	10.35%
Costs of All City Functions Minus Non-Local Sources of Revenues	305,490	243,718	211,922	194,364	178,631
Health as a Percent of Net Cost to City	9.16%	9.26%	9.15%	9.71%	10.66%

Source:

City of Philadelphia, Annual Financial Reports, and unpublished data

It can be argued that this is precisely what other sources of revenue were meant to do, namely lighten the burden on the city in the health area to free resources for other pressing problems. It is our belief, however, that the good intent of Medicare and Medicaid was to relieve the burden on governmental and citizen purchasers of health services alike of some of the costs of certain kinds of care. But the purpose of the relief should have been to free city dollars to use in creative ways to meet other health problems that are best handled on the local level.

Meanwhile, both the federal and the local applications of funds have continued to be spent in such a way as to push up the costs of care. There may be more dollars in the system, but their particular use has not resulted in effective care; and care of equal quality still remains to be distributed to all.

7. Resources for the Individual Health Care Institutions of the City

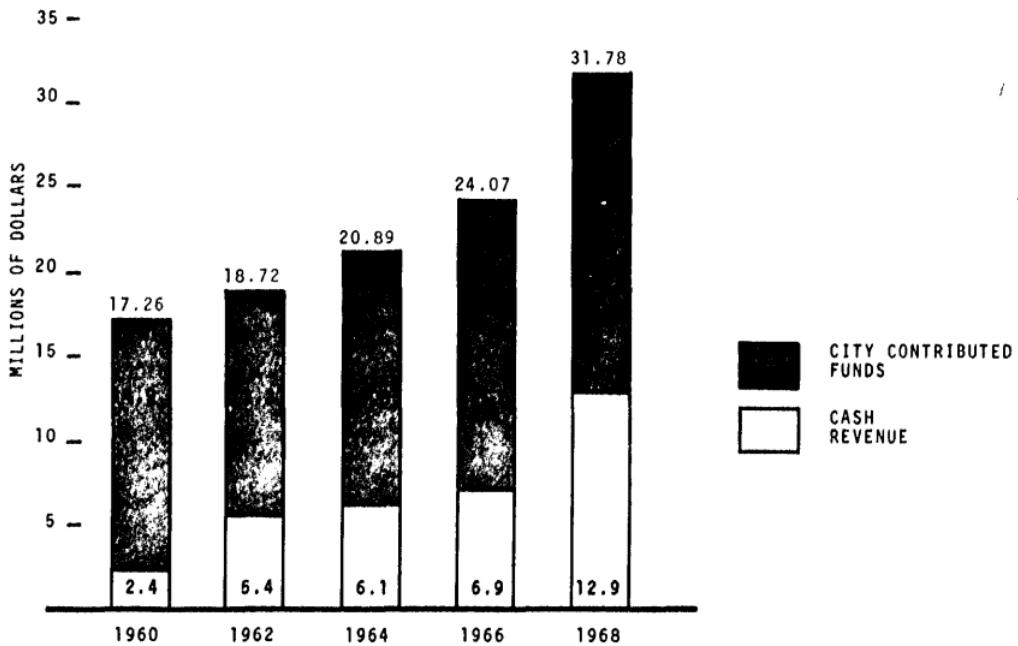
The Philadelphia General Hospital

PGH fulfills several roles in the City of Philadelphia. It provides inpatient care, outpatient care, emergency room care and home care. It serves both the low-income population and City employees. Some of its staff serve as fiscal agents for the City's program to purchase ambulatory care. The Hospital

also provides facilities in which education and research take place. The financial condition of the Hospital is a reflection of all these functions.

The city contribution to the operation of PGH has risen from \$14.9 million in 1960 to \$18.8 million in 1968. This represents an increase of 26%. However, it should be pointed out that this contribution has not had a smooth path upward since 1960. The city contribution was \$16.2 million in 1961 and only \$12.1 million in 1963. After 1963 the city contribution to PGH has shown a steady increase. (Chart 3) In order to get a better understanding of the city's contribution, it is necessary to look at both revenues and obligations over this time span.

Revenues from other sources have increased, and especially rapidly since 1966 when collections from Medicare began to be received. In 1960, total revenue at PGH was \$2,350,000. This was in the main reimbursement by the state for indigent inpatient care. In 1965, revenues to the Hospital had increased to \$6,381,700, still mainly state funds for inpatient care. In 1968 total revenue at PGH was up to nearly \$13,000,000. The major portion was still reimbursement for inpatient care, except the money was now coming from both the state and federal governments.



PHILADELPHIA GENERAL HOSPITAL
OPERATING COST: 1960 - 1968

Obligations - This requires definition since there is a difference between cost figures and city obligation figures. Cost figures, which are obtained from the accounting department of PGH reflect the purchase prices of items when they are used. Obligation figures equal expenditures plus encumbrances. They are derived from the Budget and Capital Budget Bureaus of the City's Department of Finance. Obligation figures reflect the purchase price of items when they are purchased. This distinction includes small items like drugs, and large items like equipment. The cost figure reflects the depreciated value of equipment in the current year. The obligation figure reflects the fact that all new equipment is expensed in one year.

A major problem in following trends would occur if cost figures were used. Over time definitions have changed. For example, it is only since 1966 that cost figures have included interest, depreciation, and city apportioned expense. Therefore, Chart 3 showing trends of increasing city contributions to PGH is based on obligation figures as here defined.

Some items are unaffected by this change in accounting. Two major items unaffected are the medical school affiliation contracts and the emergency and outpatient care purchase program. Since these two expenditures are the major

contributors to the overall increase in the costs attributed to PGH, these trends are important to illustrate.

	<u>1968</u>	<u>1966</u>	<u>1960</u>
Medical School Affiliation Contracts	\$1,762,100	\$ 450,000	\$400,000
Emergency Out- patient Care Con- tract Program	3,069,133	2,990,711	415,395

The next question is what does it cost to run PGH at present? In the terms of the PGH accounting department, it cost \$31,195,882 to run PGH in 1968. (The all inclusive obligation figure for 1968 was \$31,775,247. The difference has already been explained).

A gross breakdown of cost by function for 1968 is important. Of the total cost of \$31.2 million

- . \$19.6 million was spent on inpatient care
- . \$ 5.8 million was spent on outpatient care
- . \$ 5.3 million was spent on other patient care

All these costs include educational and training expenses. Where these are a part of the medical

school affiliation contracts, the contribution is most heavily to inpatient care. This is said because the confusing nature of the present arrangements with the three medical schools, leaves the city responsible for the staffing of the emergency room-receiving ward and some outpatient clinics.

A crude measure of output--or that is, what is purchased by these dollars, can be derived from the total number of patient days, or patient visits. In 1968, 395,362 general care inpatient days were provided by PGH. This averages at a cost of \$49.53 per patient day.

In a new public hospital built with efficiency and economy of operation in mind, there is every reason to believe that cost per patient day could remain in this favorable range relative to the cost per patient day in other hospitals. This is one of the many reasons for feeling that the city is obligated to show the way in building a new public hospital. The cost to the city of purchasing care in other hospitals, at present rates, would be about \$20 per day more than its own direct operations require.

The general outpatient departments at PGH provided 218,181 care visits in 1968. This means an average cost of about \$20.70 per visit. There are some accounting problems with regard to how certain cost centers are apportioned between

inpatient and outpatient care. Also the total outpatient cost is here disbursed among a great variety of functions from compensation clinic services, to short pediatric follow-up visits. Therefore, the average cost of outpatient visits is high. Nevertheless, it is a fair estimate.

After the non-city revenue of \$12.9 million received in 1968 is subtracted, the net cost to the city of operating PGH in 1968 was \$18,240,818.

- . \$7.9 million went for inpatient care
- . \$5.2 million went for outpatient care
- . \$4.95 million was spent on other patient care.

The rest of the disbursements even included the \$148,000 it cost to provide steam to heat the convention center across the boulevard.

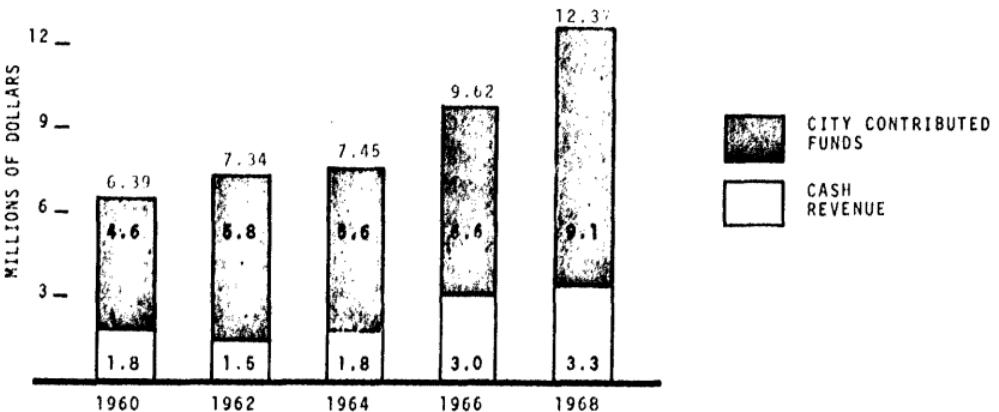
The Department of Public Health

The Department of Public Health carries traditional public health control functions and also performs personal health care functions. The public health functions are carried out through three divisions: a) Air Management, b) Environmental Hazards division, and c) Investigation of Deaths. The personal health care functions of the Department of Public Health are carried out directly through the Community Health Services component, and by purchase through the Mental Health and Mental Retardation component. The function of the general support division is to give executive direction to the entire department. This includes policy development and planning as well as administrative direction covering fiscal, organization and method analysis, personnel and building maintenance. So, the general support division contributes to both the public health function and the personal health care function.

The city contribution to the Department of Public Health has shown a steady increase since 1960 (Chart 4). Revenue has also increased even faster. It cost \$6,394,061 to operate the department in 1960 and this had increased to \$12,373,703 by 1968. The city contribution to the department has been steadily increasing even with increasing revenues.

Using 1967 obligation figures, it can be shown that it cost somewhat more than \$11 million to run the Department of Public Health, exclusive of the Philadelphia General Hospital. About 77% of this total calculates as having been spent on various activities that can be classified as personal health care services. It is estimated that it cost about \$6.6 million to operate the Community Health Services component of the department exclusive of the federally assisted Maternity and Infant Care projects. (Table 30) This component is the other major provider of personal health care services, through the District Health Centers.

15 -



PHILADELPHIA DEPARTMENT OF PUBLIC HEALTH
OPERATING COST: 1960 - 1968

4

**TABLE 30 - Department of Public Health
1967 Obligations and Other Estimated Expenses**

<u>Department of Public Health Components</u>	<u>1967 Obligations</u>
Air Management	\$ 410,891
Control of Environmental Hazards	993,700
Investigation of Deaths	575,494
Community Health Services	\$6,576,266
Mental Health and Mental Retardation	287,097
General Support	558,334
	<u>\$9,401,782</u>

Functional Breakdown of Obligations

<u>Public Health Function</u>	<u>\$2,130,835</u>
<u>Personal Health Function</u>	<u>7,270,947</u>

Additional Overhead Costs of the Department of Public Health

<u>Public Health Control Function</u>	
a) 299 level obligations	\$ 19,614
(contract services)	
b) 500 level obligations	176,599
(contributions to other health related agencies)	
c) Indirect obligations	37,800
d) 700 and 800 level obligations	247,189
(Capital items)	
Total Public Health Overhead	\$ 481,202

Personal Health Function

a) 200 level obligations	\$ 201,289
b) 500 level obligations	608,286
c) Indirect obligations	102,200
d) 700 and 800 level obligations	379,645

Total Personal Health Overhead \$1,291,420 160

Total Cost of the Department of Public Health by General Function:

<u>Public Health</u>	
Control Function	2,612,037 (23.4%)
<u>Personal Health</u>	
Function	8,562,367 (76.6%)
<u>TOTAL</u>	<u>\$11,174,404 In 1967</u>
Community Health Care	\$8,202,748
Mental Health and Mental Retardation (city portion)	359,619
Total Personal Health	\$8,562,367
Community Health Care	\$8,202,748
Less Maternity and Infant Care Cost (Approx)	1,620,000
Cost to run Community Health Services	\$6,582,748

Because of the current accounting methods, it is not possible to derive a cost per patient visit for the variety of personal health care services rendered in the District Health Centers. Such a figure would also be relatively meaningless if given as an average for services as diverse as a physical examination in a well child conference, or the comprehensive child dental care program, or the involved epidemiologic work related to VD control vs. the few minutes necessary for a walk-in immunization or a PAP smear for cervical cancer detection. However, as rapidly as the care becomes more comprehensive, it is essential that accounting methods permit the calculation of cost per patient visit, as is possible in a well-run hospital.

For the purposes of this study, the best derivation that could be made was an average cost per medical-dental activity. The costs of operating the health centers plus a portion of their administrative and educational overhead was related to the total number of visits (July 1967-June 1968) to all services that could be considered in the range of personal health care (for which the city paid) as above defined.

The average cost of medical-dental activity for all the health centers can then be figured in two ways. A low of \$9.63 is calculated if the costs of mass chest x-ray surveys and laboratory tests are included. Laboratory tests are known to cost an average of \$1.25, and the costs of mass chest x-ray service are calculated at \$1.00

per film taken. If these two activities are netted out, the more direct medical-dental activities average \$24.70.

One of the reasons the cost appears so high, under traditional and categorical service arrangements, is that the centers and their space, personnel and supplies are underutilized. More people could be seen at no additional cost.

Riverview

The City contribution to the operation of Riverview has risen from \$1,264,411 in 1960 to \$2,507,859 in 1968. This represents an increase of 98% from 1960 to 1968. However, similar to PGH, the City contribution to Riverview has not had a smooth path upward since 1960. The City contribution was \$1,509,123 in 1962 and only \$807,226 in 1965. From there, the City contribution has increased and in 1968 it was up to an all-time high. As was stated for PGH, the financial resources of Riverview are an interplay between revenues and obligations.

Revenue - In 1960, total revenue at Riverview was \$459,701. The major part of this revenue technically came from the residents themselves. Actually, the category titled "direct from patients and residents" represents revenue from federal and state income maintenance programs and private pensions and trusts. In 1960, revenue from the state was 14.9% of total revenues. By 1963, as the Medical Aid to Aged Program began, the percentage of total reve-

nue from the state increased to 31.3% and by 1968 the percentage was up to 64.0% of total revenues. It should be pointed out that State M.A.A. funds declined by \$370,000 from 1966 to 1967. This is a reflection of problems Riverview had with regard to the quality of care at the institution, and mandated improvements which are being made.

Obligations - The distinction between costs and City obligations has already been discussed. The same problem of definition is present with regard to the figures for Riverview. Riverview does not have a cost accounting department, for very practical reasons. The general accounting division of the Finance Department has prepared the annual cost report since 1963. Consequently, cost data are only available since that year. Further, the cost statement only breaks cost down into two functional categories, custodial care and nursing home care. In fact, there are three functions or types of care provided at Riverview: a) infirmary care, b) nursing home care, and c) custodial care.

In 1960 it cost \$1,724,112 to operate Riverview. This has increased every year since 1960 so that by 1968 the cost was \$4,064,565. The total number of patient care days provided at Riverview in 1968 was 292,242. This is equivalent to a 93.2% overall occupancy level and results in an average per diem cost of \$13.77 for all types of care.

8. City Economic Resources Devoted to Health Professions Education

Analysis has shown that health professions education in Philadelphia is subsidized by local public budget in only three ways ... through the training programs of the Philadelphia General Hospital, including the payment of salaries to physicians in training, and through the use of Board of Education budget One-third of the costs of training programs at the Community College also comes from city funds. The production of training at the Philadelphia General Hospital, in economic terms is a complicated process. It is a process that results in two products:

- a) training of students to become health professionals;
- b) health care services rendered by these students as a part of their training.

Obviously, the City is interested in both of these products, but its primary focus is on the health care services which must be provided.

In 1968, the total monetary cost of all training programs at the Philadelphia General Hospital was \$4,550,301. This consisted of \$3,147,693 direct cost and \$1,402,608 of overhead cost. The major portion of overhead

costs related to items quite easy to isolate, such as the operation and maintenance of the Nurses' residence.

An individual breakdown by program of the allocation of City funds to training is as follows:

Employee's In-service Training*	\$42,562
Practical Nurse - Cooperative Training Program	\$36,160
Registered Nurses Training	\$1,162,547
\$558,642 - Administration	
520,606 - General RN Students	
83,299 - Affiliated RN Students	
X-Ray Technology Training	\$52,959
Medical Laboratory Training	\$24,975
Physician Education	\$3,231,097
Cost factor in Affiliation contracts assignable to educational time	\$651,077
M. D. & Dental Residents	\$1,743,594
M. D. & Dental Interns	<u>\$508,087</u>
Total (1968)	\$4,550,301

* This figure does not include the probable cost of employee time away from service, to participate in In-service training.

In general, it can be assumed that about 55% of the costs of these training programs comes from City budget. This is said because the City has received some direct revenue related to these training programs, such as \$44,004 from the State in 1968 for the registered nurse training.

The City also recognized indirect revenue in the name of the patient care which trainees render. Both Medicare (Title 18 of the Social Security Act) and Pennsycare (Title 19) reimburse the City for patient care on the basis of actual cost. In 1968, the City received approximately 45% of the actual costs of the Philadelphia General Hospital from these sources which include training programs in the definition of actual cost.

Thus, it can be inferred that city taxpayers contributed about \$2.55 million in 1968 to health professions training conducted through the Philadelphia General Hospital. The largest portion of this local subsidization of health professions training was allocated, through the medical school affiliation contracts, to medical (physician and dentist) education, and the second largest portion to the registered nurse training program. The remaining sum of approximately \$2.1 million was paid by the various reimbursement programs of the federal and state governments, and thus is still the taxpayer's money, but not that left to the City to disburse.

Benefits From These Expenditures for Training

Some of the training programs at the Philadelphia General Hospital paid for with City funds do result in some direct health care services of value. The method for assigning such values is based on the concept of "shadow prices". That is, on the basis of numbers of hours of services rendered while in training and as a part of training, what would these same hours of service have cost if paid for directly?

- . The cooperative Practical Nursing program produced approximately \$40,000 worth of service.
- . The Registered Nurse Education program produced approximately \$538,800 worth of service.
- . The Medical Education program produced approximately \$2,718,000 worth of service.
- . The X-ray Technology training program produced \$47,400 worth of service.
- . The Medical Laboratory Technician training program produced \$26,200 worth of service.

Thus, \$3,370,450 worth of health care services accrued to the citizens of Philadelphia using the Philadelphia General Hospital from those in training programs financed by combinations of federal, state and local of taxpayer's money.

What additional benefits to Philadelphians derive from the taxpayer's investment in health professions training? The most obvious economic advantage is in the increase in income and productivity of the trainees. The in-service training program, if conducted so as to actually result in the professional advancement of employees, is a good example of a potential use of local dollars to increase both the capability for service, and the productivity and taxable income of Philadelphia's residents.

Another advantage is to help reduce any critical shortage of health manpower in a city or region. This is an appropriate economic benefit to a community if the health manpower trained remains generally available to that community. The premise behind this statement is that the local dollar must first apply to the benefit of the community which disburses it.

Certain information from the current training programs at PGH will give some useful insight into the use of taxpayer's money to train health manpower that remained in Philadelphia to benefit by both service and its own increased productivity.

. Cooperative Practical Nursing Program -

17 of 27 August 1969 graduates stayed to work at PGH; 7 stayed to work in the City; only 3 left the community.

. Registered Nurse Training Program -

of 53 August 1969 graduates, 43 stayed to work at PGH; 8 stayed to work in Philadelphia; 2 went outside the City.

. X-ray Technology Program -

of 11 graduates in 1969, 7 stayed to work at PGH; 3 stayed in the City; only 1 left Philadelphia.

. Medical Laboratory Program -

of 10 graduates in 1969, 6 stayed to work at PGH; 4 stayed to work in Philadelphia.

These five programs then appear to be effective with regard to training and retaining health manpower to serve in Philadelphia. Whether numbers of enrollees are sufficient to meet present and projected manpower needs, or conversely whether the same dollars would be better applied to training other kinds of health professionals, is a decision which must await the development of rational health manpower planning for Philadelphia.

No precise data are available on the graduates from the medical education programs at PGH. However, an analysis from national data underscores the well-known fact that physicians operate in a national market and their locational decisions are seldom dependent upon where they receive their training. Since no administrative leverage is used over these medical graduates in the form of some requirement for future service to Philadelphia in return for the City's subsidization of their post-graduate medical education, few graduates presently stay in the City, and even fewer in the service of the Philadelphia General Hospital.

It is an interesting note that certain other professional trainees whose salaries and tuition (M. P. H. degrees) are subsidized by the City, such as those doctors and dentists in public health residencies, are required to repay this community. They must spend a certain period of time after the completion of this post-graduate education, in the service of the City of Philadelphia.

It may be in this area of subsidization of health professions education that the City would wish to rethink the use of its money. The same sum of \$3,231,097 currently involved in the medical and dental post-graduate education programs, could purchase the direct services of as many as 100 full-time physicians

and dentists at the round figure of \$30,000 per professional and still leave sufficient money to salary nearly 20 medical and/or dental residents.

The committee is recommending that the city continue some investment in training physicians, but the growing trend for national and State-wide medical education assistance is more appropriate to workers in a national market. Since it is believed that medical schools in Philadelphia prepare about one-half the physicians who supply the state, it is important that the Commonwealth of Pennsylvania continue its support of these medical schools.

Table 31 - Costs of Training Programs at
Philadelphia General Hospital in 1968

<u>Programs</u>	<u>DIRECT COST</u>	<u>OVERHEAD COST</u>	<u>TOTAL MONETARY COST OF PRODUCTION PROCESS</u>
1) In-Service Training: Admin.	28,363	14,199	42,562
2) Practical Nursing Students (Cooperative Program)	19,576	16,584	36,160
3) Registered Nursing Education: Admin.	494,386	64,256	558,642
Registered Nursing Students	69,889	450,717	520,606
R.N. Affiliate Students	-	83,299	83,299
TOTAL R.N. PROGRAM	564,275	598,272	1,162,547
4) Medical Education: Admin.	101,246	127,384	228,630
Medical School Contracts: Medical Education Portion	651,077	-	651,077
Medical Residents	1,406,999	336,595	1,743,594
Medical Interns	310,100	197,987	508,087
Dental Interns	42,545	25,851	68,396
Dental Residents	23,512	7,801	31,313
TOTAL MEDICAL EDUCATION	2,535,479	695,618	3,231,097
5) X-ray Technology Students	-	52,959	52,959
6) Medical Laboratory Students	-	24,975	24,975
TOTALS	3,147,693	1,402,608	4,550,301

9. The Potential Leverage of The Public Dollar

Personal Health Services

The total public dollar is quite meaningful in the local medical care market since it represents about 35% of all expenditures for personal health care services. However, the leverage afforded the city by local tax dollar input does not now produce an effective economic voice. Under its current allocations for personal health care services, the city contributes 5-6% of the total. In terms of total economic leverage, this gives the city little control. If more control or surveillance over the uses of federal and state public dollars were expected of the city, its leverage would be increased.

However, in terms of marginal economic leverage, the city has a great deal of potential voice. Of all of the public agencies disbursing tax dollars into the health care system, the city now has the most flexibility. The city could exercise its potential economic ability to make the medical care system more rational by giving more budget priority to health care, or changing the emphasis of its health care programs, or both.

What can the city do to rationalize Philadelphia's health care system? Health care in the city, and in the nation as a whole, is one of crisis medicine. A major reason for the

existence of a crisis oriented delivery system is the present economic incentive. Some support is supplied to resources into which people can come, unknown as to their total health picture, and receive isolated episodes of care. Considerable support is supplied to inpatient care resources as a last resort effort to unravel problems that might have been prevented.

Reimbursement schemes used by the federal government, the state government and the health insurance industry supply strong incentive for the use of acute hospital care. The individual and his prime consultant--the physician--have relatively little incentive to use less expensive types of care, or to concentrate on the prevention of disease.

If the system for the delivery of personal health services could be redirected from crisis medical care, definite benefits would accrue to the citizens of Philadelphia. One would be medical in nature; namely, better health. A second would be economic in nature. If the change from episodic care to comprehensive care took place, after a short phasing period, the total cost for personal health care in Philadelphia would remain the same if inpatient hospital care declined by only 32%. The question is whether more than this decline can be expected. The national per capita inpatient days utilized per annum were 1,168 days in 1968. The figure for the city of Philadelphia was approximately 1,760 days in 1969. Well-run comprehensive

care organizations do better. The Group Health Association of Washington, D.C. has a figure of .56 days of inpatient care per capita per annum, and Kaiser has a figure of .4 days. Thus, there is a potential saving to the citizens of the city if their inpatient hospital utilization declines by more than 32%. The prospects are good for such savings.

The incentives, specifically the reimbursement mechanisms, must be changed in order to let the consumer and the physician make the system more rational. The incentive must be supplied to keep people well and out of hospitals. The city cannot change this economic incentive alone. It can use its political, moral and economic strength to lead the way.

Health Professions Education

The City of Philadelphia now spends a considerable sum on health manpower training, primarily through its subsidies to the post-graduate education of interns and residents at PGH. It also contributes about 13% of the total costs of allied health training and nursing education. Most of this also goes to its direct operation of training at PGH.

For this contribution it is probably not now getting a product that is of the greatest benefit. The present use of local money in education is not benefiting citizens who most need to become better trained and more productive, nor is it emphasizing the particular manpower supply the City may most need for the future.

However, the City's money, as with the provision of personal health care services may be redirected. In order to make policy decisions so that this redirection can bring the most direct benefit to the City, health manpower planning is imperative.

The present system by which the City subsidizes health profession education also raises some question as to whether these methods can conform to democratic principles of self-help and equal educational opportunity for all. The City does control the admission requirements (RN program, x-ray and lab technician programs), and the Board of Education administers admission to the practical nurse training program. Some of these programs are helping raise the sights and increase the incomes of Philadelphia's own residents.

Admission to the medical education programs is controlled by the affiliated medical schools. The City has no demonstrable influence over the development of physicians to serve its own people, or the kinds of physicians trained (community and family doctors vs. specialists), or the race or sex of those in training. This is a current fact--though the City pays the bill.

10. Summary -
(Is the City's Dollar Used Effectively?)

To answer this question an effort was made to assess, in economic terms, the City's input into personal health services divided into functional categories. These are:

- emergency care
- ambulatory care
- long-term chronic diseases care
- acute general inpatient care
- special care
 - related to City's role as an employer,
 - related to the care of social problems.

On the theoretical level, these categories do make sense. That is, each category relates to a distinct type of care. Each type of care is organized differently in order to deliver the appropriate medical services which the population requires. In a well organized medical care delivery system there should be linkages between the different functions. That is, each form of care should attempt to phase patients into the most appropriate type of care for the specific problem involved. If the health care of the population is considered both a fundamental right plus a fundamental need, then the relative costs of the different types of care can be analyzed in two ways.

The first analysis of relative costs relates to the internal efficiency of phasing within the

system. This focuses on whether patients are receiving the least costly type of care which is appropriate to their needs. The second analysis of relative costs relates to the internal efficiency of the structure of the current system. This focuses on whether one type of care can be a substitution for another type of care, and does this substitution result in a lower total cost for the system and/or a higher level of health to the population. A well organized medical care delivery system will of necessity be internally efficient both with regard to using the lowest cost type of care appropriate to the problem, and with regard to substituting that type of care which results in the lowest total cost.

But what is reality? The current system is not internally efficient. For example, the estimated resources devoted to emergency care, are definitely an overstatement of the actual resources devoted to emergency care. Under the current system, the population is using expensive emergency care because ambulatory care (less expensive) is not readily available to them. Chronic care patients are occupying expensive general acute care facilities rather than less expensive extended care facilities because these are in low supply.

In 1968 the City spent about \$2,600,000 on "emergency care" at PGH and nearly \$1,000,000 in purchasing emergency room care. However, neither the receiving ward at PGH nor the emergency rooms from which care was bought should be considered as offering solely

emergency care. There is a mixture of both emergency and ambulatory care.

In 1968 the City spent approximately \$15,300,000 on ambulatory care. However, this is a gross overstatement of the actual resources devoted to ambulatory care. In 1968 the personal health activities of the Department of Public Health, through its Community Health Services and Mental Health and Mental Retardation components, were far from comprehensive ambulatory care. So, the actual resources devoted to ambulatory care by the City was closer to \$7,000,000.

Resources devoted to chronic care by the City in 1968 amounted to \$11,306,624. Money allocated to acute inpatient care in 1968 amounted to \$14,254,786. The data in these two categories also present a severe problem. The facts are not independent on functional basis in the current system which keeps chronic care patients in acute care beds.

Special care is a category which requires attention. The City spent about \$1,000,000 in 1968 for personal health activities in its role as employer. Only another \$152,000 can be clearly separated out as expenditures for personal health services related to social problems. This figure is a major understatement of the actual resources devoted to such special problems. Many social problems which exist in Philadelphia go undiagnosed as such, and only

the secondary problem (sometimes medical) is treated. These are classified as chronic cases or acute care cases. Since the current ways of dealing with these problems do not solve them, the expenditures go on and on in time--in police costs, in educational system costs, in the untimely deaths of the victims of alcoholic drivers, in welfare costs.

In 1968 the total resources devoted to personal health services by the city was \$45 million. A true percentage distribution of this cost by functional activity would be interesting. But this is not possible to analyze accurately until both the phasing and structure of the system is made logical. The cost benefits, including in better health and functioning for citizens, could then also be understood.

A sample of these cost benefits can be summarized by trying an economic analysis of one of the major recommendations of this report. That is that the City itself put major emphasis on changing the local system for delivering medical care, that it stress comprehensive first-line family preventive services, rather than putting most emphasis on inpatient beds. Obviously, the main goal of the medical care system will remain the same: to have the population as healthy as possible. The change is proposed because it is felt that current stress on expensive in-hospital care is not achieving the goal.

Operationally, what this change would require is that ambulatory care facilities be made available to the population (the wider the population definition, the better). These facilities should be adequately staffed to provide the full line of medical care services which the population requires. This would include general medical care services like preventive medicine, screening, diagnostic analysis, and treatment of problems. It would also include special medical care services like treatment of alcoholism and drug addiction, and the care of psychiatric disorders. There should be emphasis on ambulatory care techniques in the management of these disorders. This will require a drastic change in the current methods of care. Certainly, the medical profession would agree that there are many such patients who could be cared for in a manner other than occupying a bed for an extended period of time. Innovation and experimentation in this area must be done.

Estimated cost of providing medical care services under the current delivery system to an assumed population of 60,000 people.

Let's assume a population (or subscriber) size of 60,000 people with characteristics similar to the general population (except lower income, which means that they are not now receiving the medical care services which they require).

This population in Philadelphia is currently using or receiving about 180,000 out-of-hospital visits per year (about 3 visits per person per year), for example, in the health centers. These visits are not of a comprehensive nature. This population is currently using about 76,560 inpatient hospital days per year.

- . at 3 visits per 60,000 per person per year
 - . (180,000 visits) at \$15 per visit
-
- | |
|---|
| \$2,700,000 |
| (estimated current cost of out-of-hospital care). |
- . at 1,276 inpatient days per 60,000 persons,
76,560 hospital days were used.

If the City were to purchase all this care, we would have to assume a price of \$100 per day. (The hospital bed cost plus the price of the physician). The total cost to purchase inpatient care would be \$7,656,000. If it were provided directly in a public hospital it might cost 80% to one-half of this price. Therefore, perpetuating the current system would cost for 60,000 people from \$6,578,000 to \$10,356,000.

Estimating the costs under the new system

It is expected that under the new system, the number of ambulatory visits per person per year will increase significantly. It is assumed here that this figure will be about 7 visits per person

per year. Then the 60,000 population would require about 420,000 ambulatory care visits per year.

It is assumed that it will cost about \$12 per visit to supply this ambulatory care. Why is this lower than the current system? The current system is very poorly organized institutionally, and the physician is very clearly receiving an economic rent for his services. Under the new system, the city might be able to integrate the organizational structure, and act as a purchaser of physician care from groups of physicians.

These factors should lead to a lower average cost. It is further thought that, as the program progresses, as additional segments of the population use the new system, the average cost per visit can well decline to a \$10 figure because the marginal cost to provide the services for the additional membership will be extremely low. This is proven from efficient group practice experience. However, for comparative purposes, the \$12 per visit figure will be used.

- . 420,000 ambulatory visit
at \$12 per visit
gives \$5,040,000 estimated cost of
ambulatory care visits.

If we were spending the \$10,356,000 envisioned before, by subtraction we would still have \$5,316,000, as a break even figure to purchase

inpatient care. This could buy at \$100 per day, 53,160 days of inpatient care at .886 days per person. It has already been pointed out that under successful comprehensive ambulatory care programs emphasizing prevention and health maintenance, much less hospital care is used.

If we were providing care in a hospital directly operated by the public auspice, we would still have, using the current estimate of lesser expenditure about \$1,538,000 toward that form of inpatient care. And even today more than 50% of acute care days at PGH are reimbursed by federal and state third party payment programs. The percentage of reimbursement would rise if unreimbursable patients now at PGH (such as long-term custodial cases, certain psychiatric problems) were cared for in other ways.

With regard to reimbursement for ambulatory care, the City would have to begin negotiations with the state as soon as possible to arrive at some innovative way to share the cost of services provided. Currently, the City does not receive any money from the state for care provided through its district health centers, but it does receive money from the state for outpatient care provided at PGH. Since some of the target population involved would be relatively low income, the state has a clear responsibility and the federal government should also share in the cost of the program. Further, the city might explore the possibility of charging some clients for some

of the services. It should be apparent that with only modest collections for services, the city could expend only what it is now spending, and obtain better care for more people.

D. The Organization and Role of the Public Sector

I. Introduction

In previous sections of this report it has been pointed out that the City of Philadelphia is more heavily involved in providing personal health care for its citizens than some urban governments. It does this both by the direct provision of services --

through the Philadelphia General Hospital,
the District Health Centers,
Riverview Home for the Aged,
and School Health Services

program of the Board of Education;

and by arrangements to purchase care. Both the Health Department, and the Department of Welfare negotiate and supervise purchase of care.

The mandates to be deeply involved in providing for the personal health care of Philadelphia's citizens are not at issue. The charge given to the Department of Health by the Home Rule Charter is sufficiently broad to have supported the development of a firm nucleus of health services ranging from preventive care to comprehensive family health care, hospital services and environmental health control.

The Charter is also regarded by most experts in public administration as providing an exceptionally well conceived structure for modern

and efficient government. There are minor flaws, but in general, the document outlines mechanisms of government that are rational and can function well in behalf of the people

Chart 5 shows a table of organization of the government of the City of Philadelphia and of the Department of Health within it. It is evident that from the Mayor, through the Managing Director, to the operating service departments there is a chain of command, and delegation of the implementation of public policy into operating programs. Budgeting, which is a key part of planning, has the same relatively smooth flow back up through the decision making chain.

There are minor inefficiencies in the translation of such centralized functions as personnel hiring and purchasing into the operations of a department as large as health and with specialized needs. But there is little in city structure that makes these insurmountable problems. Suggestions for improvement will be made in this section.

The final area which poses difficulties for the Department of Public Health is the present lack of a clear strategy for affecting the community's health care system. Since the Charter mandates the responsibility for the good health of all, this problem may result only from lack of support in previous times for an all encompassing interpretation of this responsibility.

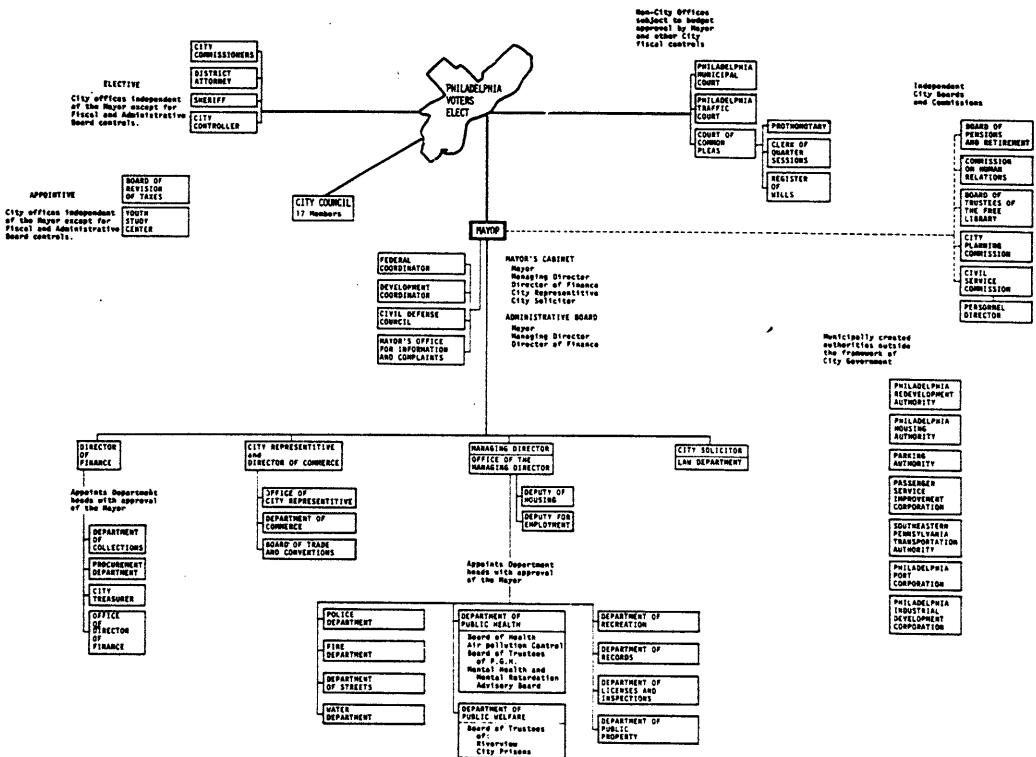


TABLE OF ORGANIZATION
PHILADELPHIA CITY GOVERNMENT

The assumption of many persons in the United States has been that government should only act to assume responsibility when the private sphere has shown itself incapable of dealing with a particular problem. This type of reasoning has led to the proliferation of government by crisis. The effects of this thinking have been felt especially in our urban areas. The prophecy that government operations will run with considerable internal and external troubles is therefore self-fulfilling, given the circumstances which generally precede government intervention.

Through a combination of historical circumstances, insights developed in other reports, and good fortune, the City of Philadelphia has developed a nucleus of services covering a broad spectrum of health. Decisions must be reached in the near future which will enable the City to effectively apply the impact provided by this nucleus in the interest of all residents of Philadelphia.

This is not to imply that larger operational and organizational difficulties do not exist within the Department of Public Health, or in the coordinative role of the Office of the Managing Director which should be able to mandate consistency between the health care operations of the Departments of Health and of Welfare for example. But we hope to show that these difficulties lie in the administrative

mechanisms chosen at the operating levels, rather than in fatal defects of overall governmental structure. Therefore, they could be remedied administratively. Occasionally, the Charter itself has left important areas of responsibility unclear, as in the case of the operation of the Philadelphia General Hospital within the context of public health policy. Yet legal interpretations of the past have never ruled out the right to these clarifications in the public interest.

Positive efforts, backed by recent recommendations of City Council after a typical health care crisis, are being made to enable the City to effect a smoother transition from one emphasis to another within the total health care field. A position called the director of health planning, has been created and filled within the Health Commissioner's Office. Staff, when developed, will provide long-range, on-going planning efforts for the department both internally, and in its relevant role toward the whole system. Hopefully this will enable potential problems and decisions to be anticipated and dealt with before they become crisis. This unit should be made fully operational at the earliest date and its role within the department made somewhat more explicit as a continuing step in the development of City health strategy.

Therefore, the City of Philadelphia through its Health Department now stands in an embryonic

but potentially commanding position insofar as leverage to affect the health care delivery system is concerned. Data contained in other sections of this report supports the belief that the economic leverage controlled by the City may, if used properly, be sufficient to assist change in the whole system. The organizational foundation of the Philadelphia Department of Public Health is potentially as valuable a resource as funds in the implementation of any strategy which might be formulated.

2. A Public Mission to Fulfill, and Administrative Problems Along the Way

The Philadelphia General Hospital

a) Its Mission

Philadelphia General Hospital is the oldest hospital in continuous service in the United States. Its mission is to provide good inpatient, outpatient and emergency care. Admission to PGH services is limited chiefly to Philadelphians who are unable to obtain such care elsewhere. For a time this was actually the stated admissions policy of the hospital, but in 1969 the Board of Health, responsible under the City Charter for determining such policy, broadened the definition of eligibility for admission to cover all manner of patients--resident and non-resident--indigent and affluent. In fact and custom the user of the hospital coincides with

the earlier policies for admission. This picture is repeated often in the data compiled for this report.

Perhaps the most significant internal management problems within the public health care sector are posed by the current methods for administering and staffing the Philadelphia General Hospital. They are designed to carry out this important mission of patient care. A description of these mechanisms should clarify whether or not they permit the mission's accomplishment.

b) Administration

The responsibility for "direction and control of the day to day operations" of the Philadelphia General Hospital is vested by the Charter in a Board of Trustees. Satisfactory hospital conditions, adequate facilities, proper care of patients, proper staffing of the hospital, and like matters are made the direct responsibility of this board. It is attached by further Charter enumeration, to the Department of Public Health which is responsible for determination of how many patients PGH may treat and the kinds and numbers of cases it shall treat. This area of responsibility is an off-shoot of the Department's responsibility to formulate overall City policy in the health field. The Board of PGH has no autonomous budgeting authority. The Board of Trustees of PGH consists of six members, each appointed for four years by the Mayor, plus the Commissioner of Public Health, who serves as an ex officio member.

The executive director of PGH is appointed by the Hospital Board of Trustees. He has a dual responsibility to the Board of Trustees and the Health Commissioner, an unwieldy arrangement which is somewhat offset by the fact that the Health Commissioner is himself a member of the Board of Trustees. The executive director is responsible for the administration of the hospital "in all its departments".

c) Staffing for Medical Services

Medical care services by physicians at PGH are provided in various ways. Emergency, compensation clinic and some outpatient clinic services are provided through contracts between the city and individual or groups of physicians. All ancillary services are staffed by civil service employees whether physicians or technicians. Direct patient care services are provided primarily by physicians contracted for through the Hahnemann, Jefferson and the University of Pennsylvania medical schools.

These contracts (re the agreement of June 5, 1968) provide that as an "integral part of the responsibility of providing high quality patient care", the medical schools also engage in and promote medical education and research at PGH. "Substantial autonomy in appointing and supervising the professional staff" is specifically agreed to by the City. Each medical school is permitted in specific language in its contract, a separate hospital division, independent of other divisions, for the delivery

of the particular services for which it has contracted.

The professional staff of each medical school division consists of a nucleus of full-time faculty members, whose salaries are disbursed by the affiliated schools. However, the conditions of the city's contracts of affiliation are such, that City funds provide a significant proportion of the money for these salaries.

In addition, there are faculty of the medical school who serve at PGH part-time. There is a staff of residents and interns for each of the three teaching services. The salaries of house officers are paid entirely by the City. "The composition and the staffing pattern (of the division) will be determined by the coordinator (of the medical school division) in consultation with the executive director of PGH and the dean of the medical school."

d) Coordination

The mechanism set up to achieve coordination between the three medical school divisions (each with separate Departments of Medicine, Surgery, Pediatrics, etc.) is a group of medical school coordinators who are supposed to function as the link between the hospital's executive director and the medical school personnel in the hospital. They report to their respective deans at appropriate times.

Still another body which functions as a co-ordinating agent is the Joint Conference Committee. It consists of two representatives of the Board of Trustees designated by the chairman of the board, the Health Commissioner, two representatives of the medical staff designated by the president of the medical staff, the coordinator of each medical school, the executive director of PGH and the Hospital's own medical director. (Because of the provisions of the affiliation contracts for three vertical care services, this individual is in reality responsible only for the city staffed medical operations such as Radiology, Clinical Pathology). The Joint Conference Committee makes its recommendations jointly to the Board of Trustees and the medical staff. It is concerned with inter-school and inter-divisional relationships, with review of patient care recommendations and proposed new and revised programs, and with all problems in policy and administration of the medical staff which are of mutual interest to the medical staff, the administration of the Hospital and the Board of Trustees.

In addition to these two bodies there exists in fact if no longer officially, a body formerly called the Ad Hoc Committee now called the Dean's Committee, composed of the respective deans, the Health Commissioner, the executive director, and the chairman of the Board of Trustees. This group concerns itself with

budgetary matters. In effect, this means that this has been the primary group which negotiates the affiliation contracts.

It should be stressed that the above list of formal and informal bodies is not the total extent of the communication channels open to the deans. They correspond directly with the Health Commissioner and have been known to go directly to the Mayor's office. They have also appeared directly before the City Council to plead their case for increased funding through the medical school affiliation contracts.

e) Effects of the Complex Structure for Administering Medical Care Services at PGH

A look at the table of organization of the Philadelphia General Hospital (Chart 6) discloses graphically the problems of coordination that the previous discussion has implied. Philadelphia's governmental structure permits a freedom to contract unheard of in many cities. But this useful tool, the contract, was not meant to deploy the mission of the government's institutions to other ends.

If coordination is the process which develops an orderly pattern of group effort among elements and secures unity of action in the pursuit of common purposes, then little coordination is possible at PGH under the present staffing pattern. Not only is PGH performing under the handicap of dealing with three completely independent

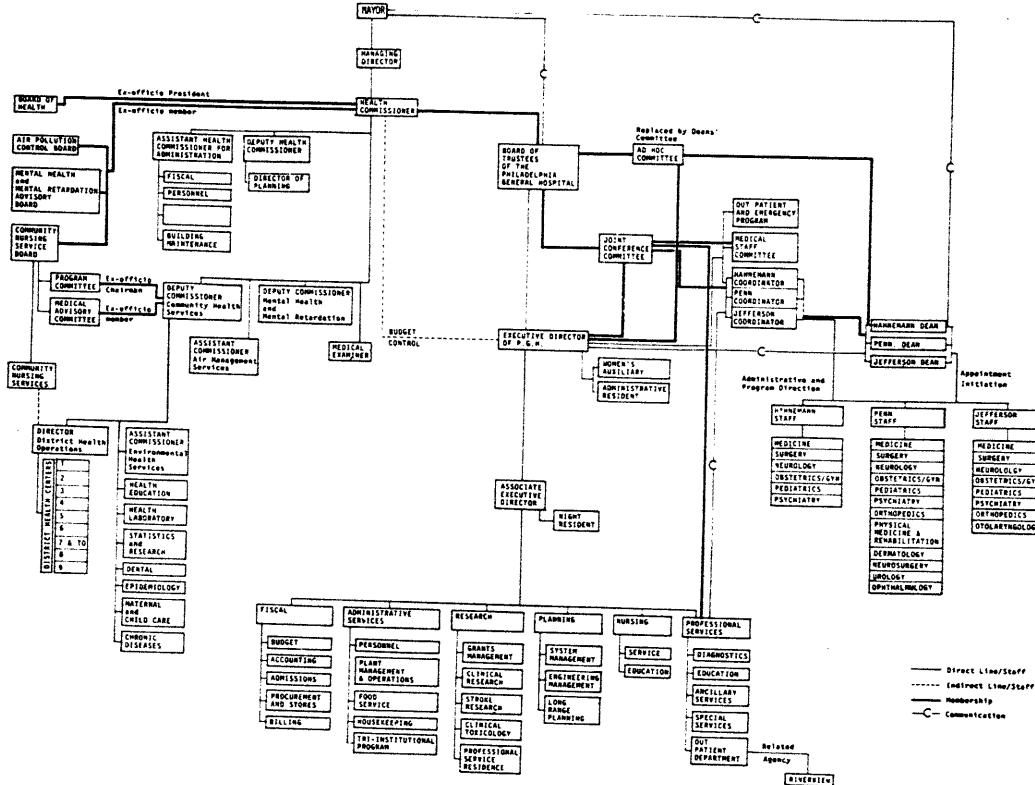


TABLE OF ORGANIZATION
PHILADELPHIA DEPARTMENT OF PUBLIC HEALTH
PHILADELPHIA GENERAL HOSPITAL

subsections in its own operations, but the primary goals of PGH may essentially differ from those of the medical schools.

Basically, neither the Hospital's board nor its administration can exercise direction over PGH as an entity. The Commissioner of Health can be only one of many conflicting inputs to the exercise of policy for publicly funded patient care. The triad of medical schools has autonomous personnel, and wide individual license under the affiliation contracts. There is no incentive to coordinate among themselves, much less with the rest of the health care system.

The tripartite organization of responsibility for clinical and educational programs is felt by all consultants to the committee to be the basis for much of the fragmented and episodic quality of the patient care activities in that institution. Educational goals and priorities often take precedence over program definition based on patient care needs. There is a manifest inability of the three teaching services to respond flexibly to the service demands and needs of the poorly defined and even more poorly represented community of users. This makes it impossible to describe, much less operate a uniform package of relevant patient care services.

Consultants feel that as a preferred solution to the above problems, the City of Philadelphia should attempt to clarify all processes of policy implementation with regard to the Hospital. It

should then make vigorous attempts to foster the development of a single, homogeneous medical staff component at PGH. This component might be made up of physicians directly hired by the City, a medical practice group, or a single medical school. If Civil Service has been an obstacle, a matter on which there is no complete agreement, then the freedom to contract is still widely available to the City. But the contract should not be with a multiplicity of conflicting providers, and it should much more clearly spell out the responsibilities of the contractor in relation to the production of excellent and full-time patient care.

Department of Public Health

a) Personal Health Care Mission

In the past, personal health services traditional to the public sector have been carried out by the Community Health Services component of the Department of Public Health. These services have included communicable disease prevention and control, health education, community nursing, chronic disease programs, child dental health care, and maternal and child care to meet high risk populations' obstetrical and pediatric needs.

The long neglected area of mental health has been brought up to its proper perspective, under state law, by the creation of a Mental Health and Mental Retardation component charged with the development, coordination and fiscal control of county-wide plans for activities in this area.

In more recent years the department has broadened the interpretation of its mission to protect the health of all citizens to include the provision, in its health centers, or by purchase, of primary ambulatory care.

This concept of mission requires the adaptation of administrative mechanisms which previously concentrated on categorical programs. These programs are under centralized direction, but were carried out in the decentralized health centers.

b) Current Administration

The final administrative control of district health operations, whether categorical program, or primary care, is the Health Commissioner's. In order to shift the emphasis of district health center programs to comprehensive care, certain administrative changes have been made in Community Health Services. However, because of the direct relationship between component heads and the Health Commissioner, simple administrative rulings back these changes. New components and deputy commissioners may be created by the Health Commissioner, and are formalized into city structure by approval of the Mayor's Administrative Board.

When the emphasis was on categorical programs for specific ailments, a practice abetted by state and federal grant mechanisms, personal health services operations

tended to centralize in program administrators within Community Health Services. In 1969, the operating emphasis was changed to the whole patient. A new director of district health operations, directly under the Deputy Commissioner for CHS, was appointed and the shift began away from "administrative verticalization."

Thus the Department of Public Health has taken steps to redirect the flow of authority within its Community Health Services component. In the proposed reorganization, operation of all programs, medical, environmental, and community relations, will be the responsibility of district health operations. Programs will be planned to meet the needs of a particular community and then carried out on this local basis. Categorical program chiefs will work as a consultant group. Under this reorganization, which is under way, all persons working to implement a specific care plan through a district health center, report to their district health director, he to the director of district health operations, and so on up to the commissioner. This is in considerable contrast to the previous critique of the operation of patient care service at PGH.

The Department is also moving away from medical district health directors. Highly qualified lay administrators are replacing doctors who previously served as district directors. The physicians are becoming medical advisors to several districts in the development of the integrated patient care programs. The next logical

step, as in the evolution of hospital administration, may for medical direction of the physicians giving care in tandem with lay administration of all other care program functions.

The administration of PGH finds its main complaints in incoherent management and decision making structures, and the effect of these on staffing patient care services. Health center administration finds the main obstacle within current public structure to be that of rapid procurement of supplies. But the department can work out more efficient procurement procedures, accurate inventory methods and a system of follow-up of items requisitioned. The development in the department of methods of centralized requisitions, follow-up and distribution more efficient than that which is now in use must be worked out. Another useful step would be the development of more extensive liaison between the Department of Public Health and the City procurement division which has actual jurisdiction over the acquisition of supplies.

When the Health Department does actually plan and coordinate its entire spectrum of patient care services, it should know much more about the size and the needs of each target population. The development of a departmental procurement procedure against more specific projections of need should help both the health centers and PGH. The final

mechanisms for perfecting procurement might be in the provision of full time specialized procurement staff housed in the Health Department to administer purchasing for the health centers and the Hospital together.

c) Staffing for Medical Services

At the present time, the nine health centers are staffed by full and part-time civil service physicians and dentists. The authority of the Health Commissioner and his deputies is such that medical staffing can also be arranged by contract. This committee recommends the effort to contract with practice groups, rather than institutions.

d) Coordination

If the administration of the district health programs is accomplished along the pathways just given, coordination within Community Health Services, and between this operating component and the Health Commissioner's office, should be smooth and matter of fact.

This is said with one exception, which an examination of the organization chart will illustrate. Community Nursing Services is the development of a famed merger between the City's division of public health nursing and the voluntary Visiting Nurse Society. It has a separate board of equal numbers of private and public appointees,

including the Health Commissioner. Its budget melds both public and private funds. Its executive director is appointed by this board, and paid from the private portion of funds.

Provision for program coordination is provided by a program committee, appointed by the board, and chaired by the Deputy Commissioner for Community Health Services. He also is expected to provide the medical supervision for the implementation of medical policies and procedures for the public health nursing program. He serves only in an advisory role to the CNS Medical Advisory Committee with regard to therapeutic nursing. This situation has already resulted in fiscal and program confusion. With the Health Department's expansion into comprehensive primary health care, both public health and clinical nursing functions become even more indispensable. How are nursing roles to be resolved in this complex policy making structure?

The rest of the problems of coordination which remain lie outside of CHS. One is between separate agencies of City government. Riverview is providing medical care and doing much of the public chronic diseases and geriatric care programming. The Health Department has contributed in an advisory capacity, but its own internal management problems in this area of patient care services, have prevented

more functional assistance. For example, though Riverview often depends on PGH for some of the diagnoses and care of its patients, the medical director of Riverview who plans care of these patients, has never been able to achieve a staff appointment at PGH. The City abrogated its access to such appointments when it turned their control over to the medical schools.

Finally, if the City itself is to achieve an outstanding system for ambulatory care, there are problems of coordination between components of the Health Department to solve. But these are due to a lack of arrangements for linkages that have been identifiable as relevant only as the department moved toward comprehensive care. Previous to this commitment, there was no real need for liaison mechanisms except through the Commissioner.

For example, any comprehensive health plan must include provisions for meeting the mental health needs of its clients. The link which must eventually develop between the Mental Health and Mental Retardation component and the programs in the District Health Centers has not been dealt with as yet by the organizations concerned. For the immediate future the input into comprehensive care programs by the mental health component may be indirect, but a mechanism for liaison and coordination must be found on a level below that of the Health Commissioner.

The problem of the gross lack of linkage between the health centers and PGH has been infinitely repeated in this report. As one step toward meeting this, the Health Commissioner recently appointed a physician who will serve in dual roles. He is both a Deputy Commissioner for Medical Care (on the Commissioner's staff) and an associate executive director of PGH (on the executive director's staff). His duties will include relating the outpatient services at PGH to the city-wide program for ambulatory services. His actual authority is not now fully defined. It cannot be defined until some of the important administrative solutions suggested in this report are put into operation.

Many of the recommendations of this committee address themselves to the grave issue of bringing the public hospital into a humane and efficient health care system. If the City's increased emphasis on comprehensive ambulatory care is supported, then the medical staffing of the health centers becomes paramount, and the Hospital becomes a major back-up resources available to these doctors for their patients. The next round of contract negotiations will require a high degree of skill, compromise and foresight. The preferred recipients of contract funds should be sources of medical practitioners that are most in concert with the City's goals and concepts for patient care.

Riverview

a) Mission

Riverview, formerly called Home for the Indigent for many years served the Philadelphia community

as an old folk's home for the needy. However the advent of federal old age insurance and other forms of public assistance, combined with the general affluence of the nation, has produced a situation where most older persons even though physically or mentally ill, no longer seek to enter purely residential homes. Riverview patients tend to be needy and have serious health problems of various natures. This has produced a redefinition of the role of Riverview. In a report prepared by the Health Department in 1966 entitled, "Proposal for Riverview, The Philadelphia General Hospital and the City's Medical Services for the Aged and Chronically Ill," this redefinition is stated clearly:

"Although Riverview should continue to accept the range of persons the Charter describes as 'mentally defective, aged, infirm and destitute adults', its functional mission should have maximum relevance to today's community needs. This means it must be a principal source of care for elderly, low-income Philadelphians who are in need of skilled nursing, intermittent physician care, medical rehabilitation, counselling, health education, and crucial personal care."

Enormous shifts have taken place within Riverview in the past few years in an attempt to meet the increased health needs of its population. Persons with acute medical problems are no longer admitted to Riverview until these are corrected and both the quantity and quality of personnel and operations of the in-house medical

division have been improved. In addition, an informal set of working relationships with local medical specialists who serve as consultants has been developed utilizing Medicare and Medicaid assistance monies. Night and weekend coverage has been improved by arrangements with Jeanes and American Oncologic Hospitals to supply casual professionals to provide this coverage.

b) Administration

Riverview is set up in a manner similar to that of the Philadelphia General Hospital insofar as the Charter is concerned. The responsibility for the direction and management of the institution is vested in a Board of Trustees which, in turn, selects a Superintendent to administer the institution in all its departments. But the Commissioner of Public Welfare has general supervision over Riverview and can determine and designate all aspects of eligibility for those who receive care at the institution. The Department itself is also charged with bringing to the attention of the Board of Trustees of Riverview "standards and methods helpful in the government and administration of such institutions and for the betterment of the condition of their inhabitants."

c) Coordination

Despite these commendable techniques and efforts to rise to and meet extreme needs, there seems to be no evidence in the relationships between Riverview and other municipal facilities of an integrated provision of health care. This is partly attributable to its position as a component of the Department of Public Welfare and its own redefinition of its role in relation to its clients. Representatives of the institution express increasing disillusionment about using PGH as the primary source for medical care backup. There is also apparent failure of the other city agencies, notably the Department of Public Health, to implement plans to develop extensive links with Riverview with an eye toward drawing it into its proper place in the health care chain.

3. The Public Purchase of Ambulatory Care

One expression of public responsibility for medical care in Philadelphia has been through partial reimbursement to the private sector for the costs of emergency room and outpatient clinic services to the needy.

Generally, public funds were made available and formulated when the private agencies complained that they could not continue to absorb the burden of care for the needy alone. The inevitable result of this approach has been a succession of crises concerning the care of the medically indigent. Ad hoc approaches have failed to deal effectively with the problems.

There are several reasons:

- a) The public sphere in fulfilling its responsibilities to its poorer citizens, has only PGH as an alternative for dealing with the medical care needs of the indigent. This has left a "charity hospital" not coordinated or planned into the rest of the system on one end of the care spectrum; an amorphous, uncoordinated and closed private system--on the other end.
- b) At the same time, some hospitals are straining under a deluge of patient visits for which they are fundamentally unequipped. This will always be true in a system which is unplanned. Tremendous diseconomies of operation result.

The cooperative planning role for the Health Department recommended in this report can do much to correct these two problems. The care of real emergencies and the meeting of family practice needs must be planned for Philadelphia--in parallel. Public contract funds can then be distributed in a less haphazard fashion.

- c) The public sphere, in accepting the role of subsidizer of privately provided care, has not heretofore concerned itself sufficiently with the logic, organization, effectiveness or quality of the care for which it has been paying. The report of this committee has in effect stated that the local health care system can no longer be supported as a status quo. It can no longer be assumed that helping existing institutions, including those publicly operated, to continue to deliver care in traditional ways, is the best answer to the health needs of Philadelphia. Current contracts between the city and the numerous hospital outpatient departments and emergency rooms do make this assumption; e.g.

"(The) City recognizes the necessity of maintaining adequate hospital emergency and outpatient care...."

Further, in the present contracts the only requirements upon the hospitals on which performance review might have been based--are the following:

"Hospitals shall keep adequate records as required by the City relating to all collections for services rendered outpatient cases reported as eligible for City reimbursement and submit such records to the Philadelphia General Hospital at monthly intervals as a basis for reimbursement..."

and

"Records pertaining to outpatient service shall be subject to examination by authorized personnel of Philadelphia General Hospital

and

"The executive director of Philadelphia General Hospital shall have the responsibility to see to it that proper standards are maintained in accordance with the reimbursement program...for emergency medical services and outpatient clinic visits...He or his authorized representatives, shall have the right at all times to observe the operation of the outpatient services."

The same requirements for records, standard setting and observation of emergency rooms, are spelled out in the contract. In addition, with regard to emergency rooms, the contracting hospitals to be eligible for reimbursement, are required -

"to maintain an emergency facility and keep it open 24 hours a day, seven days a week, to staff this facility with competent personnel and to equip it adequately..."

The burden of operating within the contracts is clearly up to the City. It is charged with setting standards, and it has not. In the present contracts, a hospital's eligibility is based only on JCAH or its osteopathic counterparts accreditation, or the satisfaction of the Delaware Valley Hospital Council Board that the hospital is qualified for such accreditation "except for the passage of time." (But there is no limit placed on time to meet standards).

Emergency rooms are merely required to be professionally staffed. OPD's are required to have a minimum of medical, surgical, combined or separate obstetric-gynecologic, and pediatric clinics. But elsewhere it states that "general clinics are eligible."

It would seem that the city should undertake, within the planning process, to set the standards against which contracts might be negotiated more specifically. This is especially so for emergency services. These standards should be ratified by the Board of Health, if necessary. Care resources may then be invited to participate in the reimbursement program on the basis of their standardized competence, or their specific plan to meet standards within a defined period of time.

The Department of Health needs budget and staffing support to set standards, carry on sophisticated contract negotiations in cognizance of such standards, and to redesign the record-keeping process so that major emphasis can be on "outcome of care", and distinct diagnostic criteria, rather than book-keeping methods. It is also desirable to provide the Health Department with competency to carry on contract surveillance and performance audits in an organized and professional fashion.

The same expertise, if provided the Health Department, can cover its other expensive contracts, notably those with any auspice providing medical staff to the Philadelphia General Hospital.

These processes require medical competence and participation. The

Health Department therefore, must review whether surveillance should remain solely with the lay administration of PGH.

Mechanisms should also be defined within City government whereby the Health Department may offer comment, review and guidance to the other existing powers of the City that can be used to help encourage the health facilities and programs that are needed. These are such powers as zoning, tax rebates, and disbursement of redevelopment funds.

4. Alternative Management Systems for
Publicly Funded Health Care Programs

a) A health services authority

Public law permits the designation of authorities, such as in the control of operations of regional transportation systems, and in the public housing and redevelopment fields. Public accountability is supposed to be maintained, in part, through a specified number of appointees to the authority board by the governments involved.

Advantages in health services operations

1. Increased flexibility in staffing outside the civil service system.
2. Increased flexibility in purchasing.
3. Power to contract.
4. Could receive grants, and keep income.
5. Would it remove medical care from "politics?"
6. Public accountability could be superficially provided through funding and audits.
7. Would facilitate regionalization.

Disadvantages

1. The authority's jurisdiction would have to be specified and if it were solely over the operation of a new Philadelphia General Hospital and/or the Health Centers, the publicly supported health care resources would be even further removed from the rest of the system.

2. Access to local public funds is even less direct than in the present system. (The Charter provides that the Director of Finance shall "make inquiries and investigations as to the financial needs, expenditures, estimates on revenue of any officer, department, board, or commission of the City, or other agency requesting appropriations from the City." Thus the budgetary process would remain substantially the same as presently exists).

3. There is no assurance of less "political influence" either in the operation of medical care, or its staffing.
4. Since the Charter specifies that the operation of the public Hospital be by the Board of Trustees, and the operation of health centers be by the Board of Health, the Charter would require amendment.
5. Quality controls will fall outside public jurisdiction.
6. Under the laws of Pennsylvania, authorities do not have separate revenue raising powers; e.g., cannot request bonded indebtedness by referendum.
7. Income to tax supported institutions is generally federal or tax fund revenue. Should such funds, which are virtually all public, be retained by a semi-private auspice, or should they be retained for further disbursement in the public interest,

out of the general fund, which is the public's money?

8. Is specific state legislation required to create such an authority?

b) A publicly created non-profit health services corporation

The city has set precedent for the use of public bond funds as revolving monies used by non-profit corporations for both economic and housing development. Both are envisioned, however, as profit-making, or at least return on investment enterprises. Therefore the public funds can serve as seed money, but are not necessarily dissipated.

Advantages

- 1) Under this system, the city can use its bonding power to direct capital to both public and private auspices for building. This is an undeniable advantage in systems wide planning, and should be the subject of further study, even if this were the only role of the corporation.
- 2) The city could also contract with a corporation to manage its own facilities. Where it presently contracts for staffing, it might be contracting instead for management services, or both.

- 3) If sufficiently funded, a corporation could also be responsible, under the conditions of its contract, for its own staffing.
- 4) Standard setting authority could be retained by the Department of Health, and in fact this may be an implied requirement of the Charter.
- 5) Other funds, such as those now behind emergency care contracts could be paid into the corporation and disbursed against these standards.
- 6) Since the Health Department would require funds in order to contract with the new corporation, the budget process would still be direct.

Disadvantages and Questions

- 1) Who would monitor the operations of the corporation?
- 2) Except for the freedom to use capital budget in different ways, and against the best plan for a community-wide system, are there any other advantages to corporate management or operation of health care resources, that are not now present in the city's direct freedom to contract?
- 3) If the city cannot promptly perfect its own present contract system in the health care field, what advantage is to be found in "total contract" to a new agency for present responsibilities?

4. The non-profit corporation would require an increase in funds to the city agency which would contract with it, but the city would retain all collected third party payments. This combination is not necessarily undesirable, as previously stated, but might inhibit initiative on the part of the corporation to collect reimbursements for which it is eligible.

5. If the corporation were actually to operate the hospital and the health centers, the Charter might need to be amended. This requires further study.

PART V - PUBLIC PRIORITIES

A. Introduction

In order to establish a series of public priorities, a definition of the goals to be achieved by a series of actions is necessary. Before goals can be established, thorough knowledge of the existing state of affairs must be obtained as a means of establishing the base from which future activities must begin. This process of defining the nature of an existing system also identifies the parts which no longer function efficiently, and provides measures of the system's output. When these steps have been taken, a series of goals to be achieved by effecting changes in the existing system or by replacing it with a new system, can be established. A plan for action can be designed and priorities for carrying out the various parts of the plan established.

These are the reasons why this committee has tried to place its emphasis on defining the present health care system in Philadelphia, and the role of public mission, dollars, and organization within it. Only in this context could we answer the Mayor's charge, make recommendations, and order public priorities for the future.

Our study of the medical care delivery system in Philadelphia has identified it as antiquated, disorganized, and expensive. It was able to function in the past because the practice of medicine was comparatively simple and the traditional

fee for service system of financing plus public absorption of indigent care, limited the use of the medical market.

Today the practice of medicine is vastly more complex than in the past due in part to a technological explosion. The elimination of the fee barrier for a large part of the population has overloaded some of the available care resources, while other parts of the system are misused for ill-defined care of those for whom the money barrier has not been removed. This is beginning to render the entire system inoperable. We now find Philadelphia at the point where critical shortages of some medical manpower and most high quality facilities have resulted in dangerously rising costs and the possibility of breakdown of a medical care delivery system.

The source of the problem with respect to the Philadelphia medical care delivery system can thus be traced to increased demands for service resulting from the removal of the cost barrier and the impact of the new demand upon the traditional entry point into the system--the doctor visit. And while some are now enabled to make these greater demands, there are many who still have no coherent entry point.

The people seeking care are not all sick, but include well and worried people in increasing numbers. To continue to operate a system that denies entry on one end, and requires, on the other, that a single physician--or any physician--be the first point of contact for a person, partic-

ularly a well person, is inefficient and expensive. It interferes with the care of the sick by utilizing available doctor time to care for people who in fact require another form of help. It mixes almost well and gravely injured in emergency rooms, thus pushing up costs, and inhibiting good standards.

What is needed is a model of a medical care delivery system that provides appropriate forms of care for all without depending upon sick care resources for the provision of all services. Such a model requires that a new regulator at the point of entry be devised to replace the traditional doctor visit, or to assist the previously unassisted to find their way into the system. The new regulator must be more sensitive to medical needs than to the ability to pay. It must separate the well from the sick at the point of entry and establish priorities for treating and sick and injured.

If the City of Philadelphia is willing to accept the responsibility for leading the way, this could mean the beginning of a new and better system of delivering medical care. It can do this both by setting an example in its own direct provision of services and by leading, inducing and supporting other providers of care to work toward a true medical care system. If it does all this, in the future the City may no longer find it necessary to provide medical services directly. At this point governmental responsibility could shift to the role of monitoring the system as a means of insuring that standards of

quality were maintained and the system continued to be accessible to and meet the needs of all people.

Thus, the City's first priority is to plan--properly. This means accepting responsibilities in the whole system. It means the political and budgetary support to do so. It means clarifying its internal operations in relation to the goals expressed. Its plans should not evolve a life of their own. They should be viewed as dynamic instruments to assist rational systems development and to be modified by feed back available in the form of measured results of the previous decisions.

This section will give some order to public priorities, and will enumerate some of the first steps which must be taken to implement these. It will also suggest the probable costs, and a time frame for some of these steps which the City should take to bring its own operations into concert with this committee's recommendations.

B. The Health Department's Role in Planning

The report of the special committee of Philadelphia City Council appointed on July 31, 1969 "to conduct an inquiry and investigation concerning a threatened suspension of hospital services in the City of Philadelphia, included the following among its recommendations:

"....in light of the inaction of private organizations in developing any overall health plan

for the City of Philadelphia, this responsibility should be assumed by the Health Department of the City. . . It is reasonable to assume that the City will continue to make financial contributions to private institutions in the health field in Philadelphia. Public policy requires that such contributions be made not in a haphazard manner based on an outmoded system, but in accordance with a well delineated and well balanced overall health services plan."

Recommendation #2 of this committee says essentially the same thing both with regard to the community's personal health care system as a whole, and with regard to a "strategy for the City's own operations" as contributory to this system.

In order to establish the steps the City must take to ready its planning function for such a far ranging role, forecasting on a national level was desirable. What directions is it most advantageous for a local government to take in preparation for predictable national policy?

This committee was fortunate to have as one of its staff consultants, an individual who is also consultant to both official and unofficial task forces operating to design the national dimensions and policy. The insights she could furnish are some of the substantiation for Recommendation #1 of this report. Therefore, the political activity of this City to help bring about the most desirable national system is a

first priority activity along with the operating priority to ready the planning functions. The political leadership is as necessary as ensuring the planning capacity in order to create the national framework without which one can do little logical planning.

I) Alternative Roles for Local Government under National Health Insurance

Until national health insurance is actually enacted into law, the probable system can only be described in very general terms; the actual legislation may contain a variety of detailed provisions spelling out exactly who is covered, what the benefits are, how the program is to be financed and how it is to be administered. Most students of the subject, nevertheless, expect that, when enacted in the United States, national health insurance will have the following characteristics:

Universal coverage; e.g., all U.S. residents.

Identical benefits including prevention, diagnosis and treatment in and out of the hospital for every one, regardless of the state of residence or locality.

Three-way financing by employers, employees and general revenues.

Federal administration with circumscribed roles for states and localities.

The important things for a local government to

know in order to place itself in a situation of early advantage are both the positives of special programs incentives that may be in the plan, and the negatives of what necessary services or groups may have to be left out initially.

a) Federal Incentives to Redirect Health Care Systems

A system of national health insurance applicable to all residents would bring with it the end of determining who could personally pay for medical care and who must be a ward of government in this respect. With the end of means tests as a prerequisite to receiving medical care when unable to afford it, individuals would be free to obtain care where and when they chose. The burden of providing convenient, acceptable, high grade care in pleasant surroundings would shift to the providers of care including public providers. The poor would be able to compete for attention on an equal footing with the more affluent. There would no longer be parts of the country without medical care programs for low-income people.

The program would probably initially provide for care in a general hospital and for the attending physicians' services while there; ambulatory care, including prevention, diagnosis, treatment; and after-care including rehabilitation and home health services. It is anticipated that the program will initially emphasize ambulatory care and be so designed

as to foster improvement in its delivery through incentives and similar devices promoting orderly organization and delivery of services and rewarding continuity of care.

Under such a national system of health insurance, providers of care may be private or public facilities; non-profit or for profit enterprises would be embraced. The City of Philadelphia Health Department is already filling a provider role in relation to Medicare and Medicaid, and for presently uncovered persons and problems. Under a program of national insurance which stabilized health care resources, the City could continue to be a provider, or it could reduce its operations or expand or alter them.

If a City has used its own resources and leadership to alter a system so as to place the emphasis on ambulatory and preventive care, and if it were assisting in using tax-payers' dollars for hospital bed care in the most economical and effective way, it would be ready to stay in the business of demonstrating good delivery systems. But it would now receive the same income, or incentive rewards from the national system as any other outstanding provider.

Staffing Problems

In looking ahead to the time when a program of universal medical insurance will be part of the fabric of American life, one has only to think about the current impact of insurance on hospitals. Hardly anyone enters the hos-

pital now without a third party standing in the wings ready to pay the bill. Hospitals then must, perforce, deal with insurance as their nearly total income resource. When all the population is insured for their physician care, physicians will not have any other sources of patients, and hence of income, and will of necessity accept insured patients on terms consumers find acceptable. When this fortunate situation occurs, physicians' incomes need no longer be governed by location of practice (Park Avenue vs. the ghetto). It should be far easier to staff health centers serving depressed areas than in the past. Furthermore, the proposed incentives to be built into the national health insurance program should add another hope for the organized pattern of group practice and its income potential in centers of population.

Outlook for Construction of Health Center Facilities

A major deterrent to the spread of group practice has been the obstacle presented in securing capital to provide the physical facility in which the group can serve its patients. A program of national health insurance provides the assurance that loans (or bonds) for construction can be paid off out of income. This is done by having the charge made for the service, or the capitation or premium payment include a built-in facility cost figure for capital similar to rent or overhead in other businesses. In

the tooling-up period before the program becomes operative, funds may become quite freely available for the construction of facilities in which to provide organized ambulatory care.

A City government looking ahead might be well advised to anticipate this need and step up its program of establishing health centers even if the centers operate below capacity during the tooling-up period.

Help with the Costs of Training

Belatedly, recognition has come that the health industry has not kept pace with other industries in having built into its operations funds for research and development. The Social Security Administration has supported out of its trust fund a modest level of research, largely operational but sometimes designed to explore new territories. Congress authorized some specific experimental funds from Medicare to be spent on cost controlling efforts.

A recommendation that has gone forward from the McNerney Task Force on Medicaid and Related Programs calls for devoting at least 2% of Medicaid expenditures to development, and to training of health personnel. The rationale now being put forward is that any program using health manpower and facilities should contribute to their upgrading and advancement.

The Technical Advisory Committee to the Committee of 100 considering the myriad details of a program of national health insurance, very early came to the conclusion that a percentage of the funds that would be available from the payroll tax and from general revenues to finance the program should be earmarked to be used specifically by the program to promote the availability and supply of health personnel. It was also agreed that these activities were not to replace existing manpower, construction, or demonstration programs, but were to give the program flexibility in meeting difficult situations. Such funds could be a resource to a local government faced with a special problem of providing care in the inner city.

b) Continuing Public Responsibilities Under National Health Insurance

A national system of health insurance applicable to all age and income groups could be launched in several ways: all at once for everyone, or its benefits can be phased in. Alternatively, the population groups to be covered might be phased in. Both techniques might be used. Any of these alternatives except the rather unlikely one of providing all kinds of services and goods to the entire population from the start of the program will obviously leave some medical services outside the system and possibly some people temporarily outside the

system. Since most, if not all types of services, are currently reaching at least some of the population, many will necessarily be continued in tandem with the new national program for an indefinite period. They will be financed by other resources, some public, and some private.

Services which may be phased in, or remain outside the system indefinitely are likely to include prescribed drugs, dental care, mental hospital care, ambulatory psychiatric care, care of the drug addict and the alcoholic. Long-term chronic care other than mental illness, nursing home care, and care of the mental retardate is likely to be among the last to be covered.

Financial considerations or utilization control efforts may dictate placing limits on the benefits that would be provided (e.g., limits on days of care, visits by the doctor, etc.) so that part of these services could fall outside the program for some insured persons. So the public agency on the local level will necessarily have to be active in the provision of these items of service outside the national system.

Without elaborate documentation, we can also agree that there are desirable goals in a Health Department's providing certain aids to good health that individual providers cannot necessarily do as

broadly or as well. Children and others should continue to be immunized against a variety of diseases. From the citizens' standpoint it is both cost-effective and worthwhile in greater enjoyment of life not to have smallpox, diphtheria, poliomyelitis, measles, influenza. Similarly, it has been demonstrated that adequate pre-natal care and post partum follow-up as well as well-baby care produce a healthier citizenry. Population control is a related activity which meshes public and private objectives. Furthermore, these preventive measures are types of medical care not very challenging to the private provider; yet their universal application via a public program will continue to be essential to forestall serious and costly sequelae.

Mass screening (sometimes called multi-phasic screening or automated multiple testing) is another activity that cannot be undertaken by a physician practicing alone and requires access to sizeable populations to be effective, economical and worthwhile. Such programs use skills whose employment the average physician finds less challenging than diagnosing and treating an acutely ill person. A high degree of organization is required for the necessary follow-up whenever any abnormal findings show up. Mass screening programs therefore appear to be an activity peculiarly fitted to a public medical care program since it can reach large groups and can provide for early detection of diseases that have long been the province of public health. It can also identify the major killers--heart disease and

cancer, and pinpoint such problems as hearing and eye defects which are reasons for public concern. (Car operators must be able to see; school children need to hear).

However, the basic tenet of the proposed system of national health insurance is that it shall serve as a primary tool for restructuring the health care delivery system, and not merely add new administrative layers to an uncoordinated series of subsystems. Such coordination will be possible only through integration of the major components of health care into a unitary delivery system. For the City, therefore, to decide that it will furnish only certain pieces of the full array of health services without undertaking the whole package appears to abrogate a responsibility or to make it a party to the continued fractionation of services.

This furnishes an additional argument for the City to continue to furnish as broad a package of services as at present, or perhaps an even broader one. If the City is to supplement the benefits of national health insurance, these should be received as part of one package, not splintered off. There is also the moral responsibility for the continuity of care for many of those now served by PGH and the health centers. But it is not for the City to attempt to induce the restructuring of the rest of the health care services within its boundaries, without having the same goals for itself.

2) Steps in Developing Planning Capacity

- a) There must be Administration support and budgetary commitment.
 - b) There must be community support. Therefore the mechanisms for launching public input into planning and policy making as envisioned in our Recommendation #7, must be designed and followed up. There should be some community discourse on the design of these mechanisms.
 - c) The Planning Office should be staffed so that it can develop the kind of continuing information system that is necessary for logical planning and standard setting as well as feedback and evaluation. This committee believes that it has used information about the existing system in sophisticated ways, but it was for an isolated project. These kinds of data must become available and retrievable with predictable periodicity. Data gaps must be filled. Data analysis capacity must be present so that the data can be used for what they point out.
 - d) The information system, and planning staff of the Department of Health should also be such that realistic health manpower planning can take place in Philadelphia. For example the following must be known:
 - All health occupations in Philadelphia
 - Current distribution figures (both geographic and organizational)
 - . Vacancies in all health job categories
 - . Projected needs and the bases of projection
 - . All career motivation programs
 - . All training programs for health careers
 - . All loans, scholarships and other funds, public and private, available for training in health occupation categories
 - . All public and private programs which provide funds applicable to health manpower.
- e) There must be staff to carry out on a continuing basis the kind of economic analysis, and facilities modelling, and some of the management analysis, that was available to this committee.
- f) Specific administrative mechanisms must be developed so that the planning staff of the Health Commissioner's office is brought into a clear relationship with program planning and relevant operating staff in the various components. One need not dominate the other; neither can ignore the other. But the department must develop the same internal logic with relationship to its parts, it expects of the rest of the system.
- g) When these steps are underway, the Department's Planning Office should also develop a mutually useful relationship with other health planning operations in the area.

h) The priorities for planning activities within the recommendations of this report are:

- . Community-wide ambulatory care planning (including the ambulatory management of certain special disorders).
- . Community-wide emergency care planning.

(Neither of these pieces of planning can occur logically without the other).

- . Planning for alternative uses of public capital budget.
- . The new public hospital planning.
- . Long-term and chronic care planning.
- . Health manpower planning.

C. Ambulatory Care and Emergency Medical Services

1. Introduction

In the process of conducting this study the committee examined the role the City of Philadelphia District Health Centers presently perform in the spectrum of available ambulatory care services. Our findings are presented in Part IV of this report. We also examined the function of the outpatient and emergency services being provided at the Philadelphia General Hospital as integral parts of the total ambulatory and emergency care system in the City. In all three instances, it was not possible to identify a situation in which the City was using its influence or money to work toward or encourage others toward the development of a rationalized system of delivering services.

The scope of this study did not allow more than a generalized description of a future system for delivering health care in the City. However, we were able to conclude that a better system would require more extensive use of comprehensive ambulatory care services than at

present. We also determined that most emergency room use was inappropriate at this time, and that perhaps as a consequence, few emergency rooms could adequately handle the truly serious problems.

A plan for providing emergency services is now being developed by an Emergency Medical Services Task Force of the Philadelphia Department of Public Health. More efficient and appropriate use of emergency services will depend a good deal upon the availability of other forms of ambulatory care including the development of a more efficient regulator of the disposition of system input.

There are existing problems in the distribution and accessibility of medical services for sizeable portions of the population that cannot be easily solved. These necessitate the continued and expanded provision of personal medical services by the City.

Programs for providing first line comprehensive medical care have helped to alleviate some immediate problems with respect to the availability of care but have not, for the most part, attempted to deal directly with deficiencies in the medical care delivery system itself. With this in mind the committee postulated that in addition to providing certain personal medical services, the ambulatory care center of the future will include arrangements for a patient's entry into any appropriate aspect of the health care system as well as educational and preventive

maintenance services not generally available today.

The existing and planned district health centers operated by the City present a unique opportunity to begin the process of changing the nature of the medical care delivery system in Philadelphia. The specifics of such a program must be left to the next phase of planning. However, models were prepared for the committee to illustrate the feasibility of converting two existing health centers for use as comprehensive ambulatory care centers.

2. Conversion of Health Centers

Drawing 8 shows a possible conversion of Health Center #2.

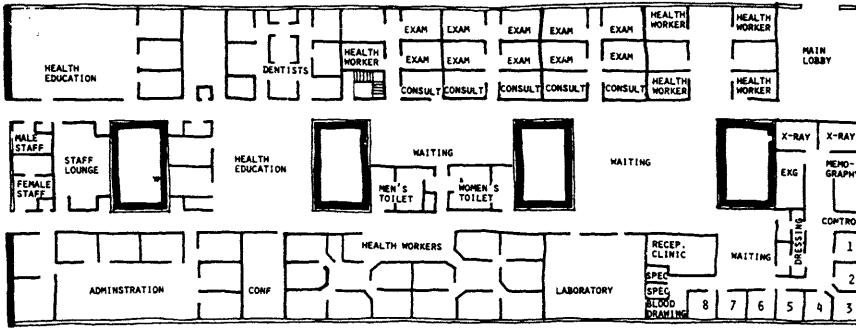
Drawing 9 shows a possible conversion of Health Center #5.

These examples should not be looked upon as recommendations for program development or as architectural designs as insufficient data is available to permit an accurate estimate of the demand for service that exists in the health districts served by these facilities. Building requirements must finally be determined by program requirements. However, these models do estimate the capacity of the buildings to house new programs and what volume of service might be expected. They are also useful for establishing the probable costs for remodeling and equipping the buildings for new functions.

In both instances we were able to project large increases in the volume of service that these buildings could house using annual visits as the unit of measurement. In making these projections we have assumed that specialty clinics would be centralized, probably at a back-up hospital, that on-site laboratory work would be confined to those procedures that could be handled by an on-line automated chemical analyzer, and that data handling and storage would be accomplished through a link to a centralized computer center thus permitting immediate access for information regarding a particular patient from all parts of the health care system.

The projections for these two health centers are as follows:

1482



DISTRICT HEALTH CENTER #2
POSSIBLE RENOVATION FOR COMPREHENSIVE HEALTH CARE

8

Health Center #2

Assume 2 sessions per day, 5 hours per session, 5 days per week, 50 weeks per year = 500 sessions per year.

General Clinics staffed by 10 physicians and health workers.

10 physicians and health workers @ 5 visits per hour = 150 visits per session.

Assume 100 visits per session to allow for scheduling 50,000 visits per year.

Dental Clinics

4 chairs @ 45 minutes per visit = 16 visits per session.

Assume 10 visits per session to allow for scheduling 5,000 visits per year.

Health Education and Preventive Maintenance

8 staff at 3 visits per hour each = 72 visits per session.

Assume 50 visits per session to allow for scheduling 25,000 visits per year.

Multiphasic Health Testing

Assume 7 1/2 hour operating day with a 5 hour intake period and 2-1/2 minute intake intervals = 120 patients per day.

Assume 100 patients per day to allow for scheduling, breakdowns, equipment maintenance, etc. 25,000 visits per year

Total visits per year 105,000

This volume could be increased to 160,000 visits per year if operating hours were extended to three sessions per day and two Saturday sessions were added to the schedule. In 1967-68 this health center provided for about 22,000 annual visits.

The cost of converting and equipping this building from its present function to an operation of the type described above would be approximately \$225,000 estimated as follows:

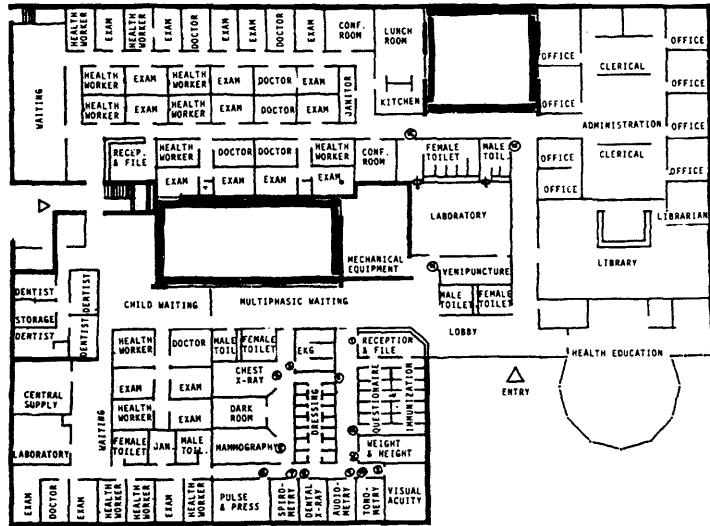
Remodel 5000 sq. ft. of existing space:

5000 sq. ft. @ \$20 sq. ft.	\$100,000
Add 25% for fees, furnishings and equipment	25,000
Add for special equipment - autochemist, x-ray equipment, data processing terminal	100,000
Total 1970 cost for conversion	\$225,000

Building Utilization Factors

Gross building area = 20,000 sq. ft.

At 500 sessions per year: approximately 5 visits per sq. ft. per year, at 850 sessions per year: approximately 8 visits per sq. ft. per year.



DISTRICT HEALTH CENTER #5
POSSIBLE RENOVATION FOR COMPREHENSIVE HEALTH CARE

Health Center #5

Assume 2 sessions per day, 5 hours per session, 5 days per week, 50 weeks per year = 500 sessions per year.

General Care - staffed by 14 physicians and health workers.
14 physicians and health workers @ 5 visits per hour = 210 visits per session.
Assume 150 visits per session to allow for scheduling = 75,000 visits per year.

Dental Clinics

3 chairs @ 45 minutes per visit 12 visits per session. Assume 8 visits per session to allow for scheduling. 4,000 visits per year

Health Education and Preventive Maintenance
7 staff at 3 visits per hour each = 63 visits per session.

Assume 40 visits per session to allow for scheduling. 20,000 visits per year

Multiphasic Health Testing

Assume 7-1/2 hour operating day with a 5 hour intake period and 2-1/2 minute intake intervals 120 patients per day. Assume 100 patients per day to allow for scheduling, breakdowns, equipment maintenance, etc.

25,000 visits per year
Total visits per year 124,000

This volume could be increased to 193,000 annual visits if operating hours were extended to 3 sessions per day and two Saturday sessions were added to the schedule. Again the volume of health testing would not increase because time must be reserved for equipment maintenance. In 1967-68 this health center provided for about 40,000 annual visits.

The cost of converting this building from its present configuration to an operation of the type described above would be approximately \$250,000 estimated as follows:

Remodel 7000 sq. ft. of existing space:	
7000 sq. ft. @ \$20 per sq. ft.	\$140,000
Add 25% for fees, furnishing and equipment	35,000
Add for special equipment	75,000
Total 1970 cost for conversion	\$250,000

Building Utilization Factors

Gross building areas 23,000 sq. ft.
At 500 sessions per year: approximately 5 visits per sq. ft. per year.
At 850 sessions per year: approximately 8 visits per sq. ft. per year

The preceding discussion shows that a wide range of possibilities exists for varying both the type and amount of service that can be provided in a public health center. Preliminary analysis of existing operational data has indicated that different parts

of the city will require a different mix of services. Skillful planning can identify these different requirements if all those involved in planning the future of Philadelphia's medical care delivery system will cooperate in exchanging information. If this can be achieved, a major step toward rationalizing the delivery of care will have been made.

3. First Steps

After developing the planning capacity necessary to undertake all other activities projected by this Committee, the first priority for the City is "to place its primary emphasis on the provision of ambulatory health services." To implement this important recommendation the City should -

- a) Develop a master planning process for ambulatory care centers to include the conversion of its own district health centers, but also to encompass operating neighborhood health centers under other auspices which meet standards for quality of program which the City may wish to adopt.
- b) City budgets for purchase of ambulatory care, as well as capital funds should be studied in order that they can be allocated in an orderly and useful fashion to bring about the recommended city-wide program of a more effective system for delivering health care.
- c) The planning activities of the Emergency Medical Services Task Force should be accelerated,

and carefully coordinated with these other aspects of planning and providing for centers for non-emergency health care.

d) The City's Preventi-Test multiphasic screening program should also be carefully integrated with total ambulatory care planning. Automated profiles resulting from physiologic and history-taking screening processes, should be available through all centers. In some centers the information which will enable the care team to develop the best health maintenance plan for the patient, will be used in that same center since it will be the primary source of the patient's care.

In other areas of the city where more definitive data collection will prove that adequate ambulatory services already exist either in other neighborhood health centers, or in the supply of private physicians, the screening and educational activities should be the predominant activity of the center with careful plans for distributing the results to the patient's primary caretaker.

e) Master planning for the new PGH must also be closely integrated with the ambulatory care planning. This is said both for physical planning and for experimenting with new uses of contract and other funds for staffing patient care. .

The provision of ambulatory personal health services in neighborhoods which are not convenient to PGH, but from which PGH clinic users still come, should result in more

effective and continuous care. The success of this conversion will predict the size and staffing needs of ambulatory services in any future PGH and help provide the knowledge for redistributing the City's funds for this form of care.

Future clinics are programmed to provide specialized diagnostic and therapeutic ambulatory services that cannot be economically or efficiently done in health centers. Therefore service experience in the health centers will help determine these back-up needs.

The predicted reduction in the need for hospital beds can be verified after about two years of utilization of comprehensive ambulatory programs in certain neighborhoods. This will assist in predicting the necessary size for the new public hospital.

The recommendation of this committee is that the future public hospital be placed in this back-up relationship to ambulatory care programs. Conversion of arrangements for staffing the hospital could begin experimentally with the present PGH. Contract funds should be studied for the purchasing power they represent for placing medical and dental staffs in ambulatory centers, and with clear cut privileges and responsibilities also at the hospital.

f) First steps in the Health Department should also include providing staff direction to the stimulation of medical groups which will engage in full-time care of patients in the health centers, and will

follow their patients into the hospital. These groups might be formed by medical school faculties or practicing physicians or both.

g) Master planning for both the ambulatory care centers and their related new PGH should also include liaison with the Department's mental health planning. As this report has stated, it is most important to prepare and implement models for the ambulatory care of such special problems as the addictive diseases.

D. The Philadelphia General Hospital and Long-Term Care

1. Introduction

The future of PGH as part of the Philadelphia health care system must be considered in terms of its present function as an individual institution and as part of the total city hospital universe. The possibilities considered during the course of this study ranged from discontinuing operation of the hospital, to rebuilding it at approximately its present size.

Closing the hospital was considered to be impossible even though there appears to be sufficient bed capacity in the rest of the City's system to provide care for the present PGH patient load. However, questions of quality and accessibility combined with the new role postulated for the City in the ambulatory care area led the committee to conclude that continued operation of a public hospital was necessary.

On the other hand, rebuilding the hospital at its present size is not necessary. A modern facility of smaller bed capacity can, if efficiently organized and appropriately used, handle the expected patient volume.

2. Models for a New PGH

Specifically, four models or schemes for rebuilding PGH were investigated. Three of these models presumed that the hospital would remain on its present site and the fourth is a more generalized concept that could either be located on the existing site or could readily be built elsewhere in the City. As was the case with respect to possible alternative uses for the health centers, these models are not to be considered as recommendations for either master plan development or for programs. They were developed as a means of describing a range of programmatic possibilities and estimating good facilities for these programs. A tremendous amount of planning work must still be done before any definitive description of the future Philadelphia General Hospital can be developed.

The four models studied were defined as follows:

Scheme A

600 bed Special Services Hospital

Psychiatry:200 bed inpatient service.
Transitional, ambulatory and
emergency care.Estimated gross area including
shared services. 220,000 sq.ft.Extended Care:P. M. & R. and extended care
200 beds.Day care and outpatient services.
Estimated area including shared
services. 200,000 sq.ft.Addictive Disease Program:200 bed inpatient service
Transitional, ambulatory and
emergency care.
Estimated area including shared
services 165,000 sq.ft.

Total area: 585,000 sq.ft.

Phase I300 beds and related services in
new construction (300 beds and
related services in Mills Building)*

1970 estimated cost:

300,000 sq. ft. @ \$60	\$ 18,000,000
Demolition and site work	1,000,000
Replacement of warehouse functions in existing buildings	1,000,000
	\$ 20,000,000
Fees equipment and contingency @ 25%	5,000,000
	\$ 25,000,000

Phase II

300 beds and services in new construction 285,000 sq. ft. @\$60	\$ 17,000,000
Demolition and site work	1,000,000
	\$ 18,000,000
Fees, equipment and contingency @25%	4,500,000
	\$ 22,500,000

Total: Phases I and II \$ 47,500,000

(These are 1970 costs; if
escalated at 10% per year,
completion of both phases by
about 1978, would cost approx-
imately \$86,000,000)*Cost not included; total reno-
vation would be approximately
\$750,000

Scheme B

600 bed Special Services Hospital
(same as Scheme A)
300 bed General Hospital

Estimated Areas:

Special Care Hospital	585,000 sq.ft.
General Hospital	<u>360,000 sq.ft.</u>
Total	945,000 sq.ft.

Phase I

300 beds Special Services in
new construction
300 beds Special Services in
Mills Building*
150 bed General Hospital

1970 estimated cost:

300,000 sq.ft. Special Ser- vices components and shared services @ \$60	\$ 18,000,000
200,000 sq.ft. General Hos- pital components and shared services @ \$70	14,000,000
Temporary relocation of Radiology and Clinics	3,000,000
Demolition and Site work	1,000,000
Fees, equipment and contingency @ 30%	<u>10,800,000</u>
	\$ 46,800,000

*Cost not included

Phase II

300 beds Special Services
150 beds General Hospital

1970 estimated cost	
285,000 sq.ft. Special Ser- vices components and shared services @ \$60	\$ 17,000,000
160,000 sq.ft. General Hos- pital components and shared services @ \$70	11,200,000
Demolition and site work	<u>1,000,000</u>
	\$ 29,200,000
Fees, equipment and contingency @ 30%	<u>8,800,000</u>
	\$ 38,000,000

Total Phases I and II (These are 1970 costs; if escalated by 10% per year and both phases were com- pleted by 1978, approximate costs would be \$155,000,000)	\$ 84,800,000
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Scheme C

600 bed special Services Hospital
 (same as Scheme A)
 600 bed General Hospital

Estimated areas:

Special Care Hospital	585,000 sq. ft.
General Hospital	<u>720,000 sq. ft.</u>
Total	1,305,000 sq. ft.

Phase I

300 beds Special Services in
 new construction
 300 beds Special Services in
 Mills Building*
 300 beds General Hospital

1970 estimated cost:

300,000 sq. ft. Special Ser- vices components and shared services @ \$60	\$ 18,000,000
400,000 sq. ft. General Hos- pital components and shared services @ \$70	28,000,000
Temporary relocation of Radiology and Clinics	3,000,000
Replacement of warehouse functions in existing buildings	1,000,000
Demolition and site work	<u>1,000,000</u>
	\$ 51,000,000
Fees, equipment and contingency @ 30%	15,300,000
	\$ 66,300,000

* Cost not included

Phase II

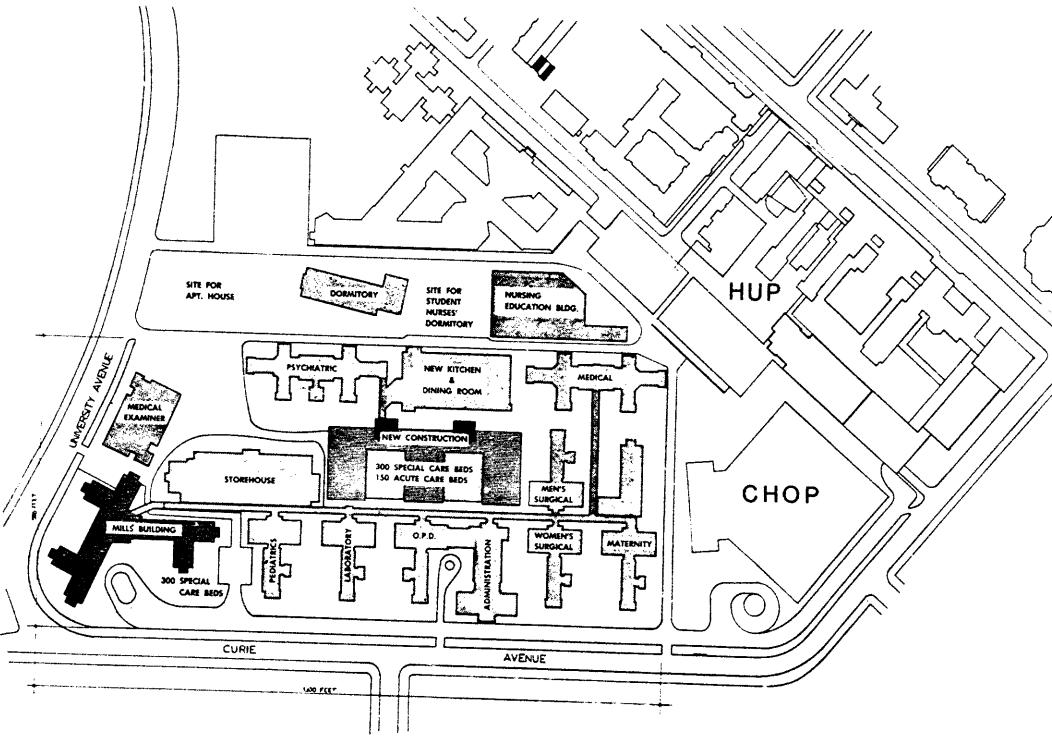
300 beds Special Services
 300 beds General Hospital

1970 estimated cost:

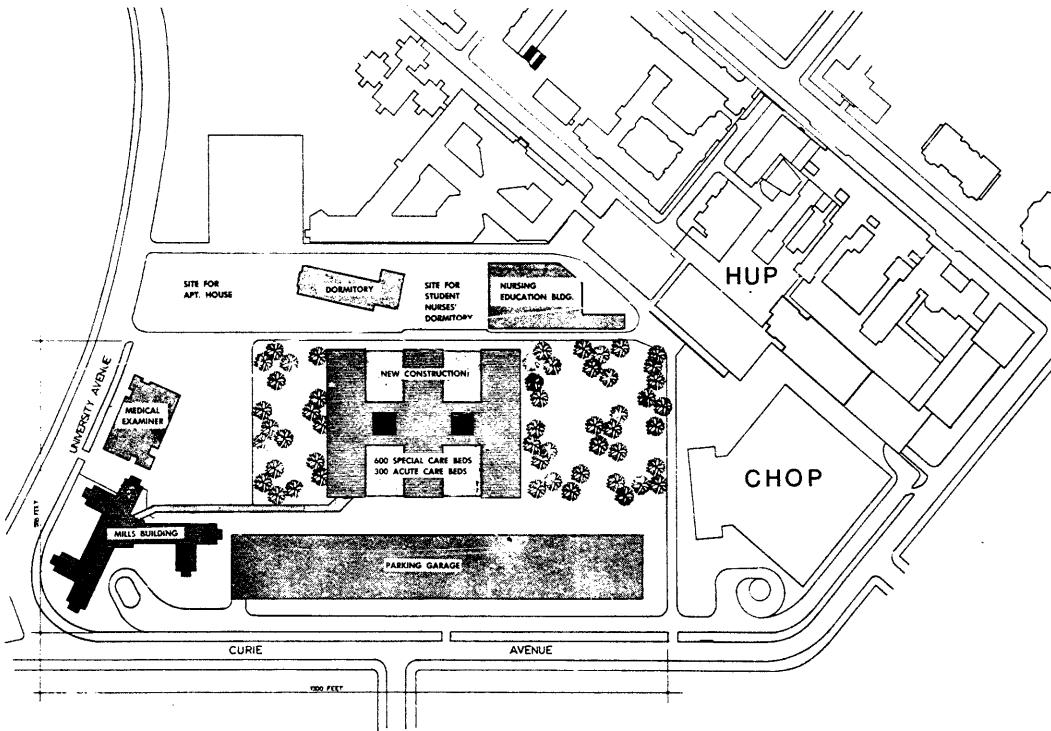
285,000 sq. ft. Special Services components and shared services @ \$60	\$ 17,000,000
320,000 sq. ft. General Hospital components and shared services @ \$70	22,400,000
Demolition and site work	<u>1,000,000</u>
	\$ 40,400,000
Fees, equipment and contingency @ 30%	12,400,000
	\$ 52,800,000

Total Phase I and II
 (\$With escalation at 10% a year
 and completion by about 1978,
 approximate cost would be
 \$219,000,000)

Drawings #10 and #11 are included as a demon-
 stration of how Scheme B would relate to the
 existing PGH site.



PGH MODEL MASTER PLAN
SCHEME "B" - PHASE I



PGH MODEL MASTER PLAN
SCHEME "B" - PHASE II

After review of these schemes and submission of additional data, a model of closer fit with requirements emerging from the study was postulated. It presumes that the future PGH will function primarily as a back-up hospital for health centers where the emphasis is on keeping patients out of the hospital.

Scheme D

A hospital of this description would require a gross square footage as follows:

400 short-term acute beds at 900 sq. ft. per bed	360,000 sq.ft.
200 extended and chronic care beds at 500 sq. ft. per bed	100,000 sq.ft.
outpatient, physical medicine and rehabilitant facilities (assumes 250,000 visits per year)	50,000 sq.ft.
Total	510,000 sq.ft.
acute care beds at 360,000 sq. ft. @ \$100 per sq.ft.	\$ 36,000,000
extended and chronic care beds, at 100,000 sq. ft. at \$70 per sq.ft.	7,000,000
outpatient, PM & R, chronic disease evaluation and referral, etc. - 50,000 sq.ft. at \$60 per sq.ft.	3,000,000
fees, equipment and contingency at 25%	11,500,000
Total all Phases	\$ 57,500,000
(1970 costs; if 10% per year allowed for escalation, and completion by about 1978, approximate cost would be \$103,500,000)	

Final Note:

In all cases the escalation rate has been determined by recent experience. However, there is reason to believe that economic policy has resulted in a slowing of the inflation of the past few years. Therefore, a 10% escalation rate may be excessive.

3. Steps for the City

- a) The master planning of the new Philadelphia General Hospital is dependent on and closely related to the master planning of ambulatory care centers. This has already been explained, but the process for making this a fact is a priority.
- b) Analyses for staffing, facilities maintenance and such, might occur related to the actual needs of present patients of PGH, so that the hospital can be supported to function at a high level during transition.
- c) Joint planning should be initiated with the Department of Welfare toward current and long-range solutions to the problem of the use of PGH and other hospital's acute beds for long-term care patients.

One simple and inexpensive step would be for the Health Department to design and put into operation a chronic diseases evaluation and referral service. Patients' medical, social and nursing needs could be defined by the

team, and organized referral to an appropriate program could occur. This presumes the additional function of a continuous roster of available resources for such patients, computerized if possible.

E. Supporting Health Professions Education

There are a number of immediate steps which could be taken by the City of Philadelphia to benefit its citizens through training for the health professions. The need to add manpower planning to its other planning functions has already been described. In addition--the City could

1. Carry out the analyses of its current expenditures on health manpower education to a finer point. If this is done in concert with more detailed planning for the staffing of the old PGH in transition, and the new PGH, it should become evident what funds could be shifted from the intern and resident education costs, and what additional funds might be needed for such uses as -

- . loans, administered jointly with professional schools, to medical and dental students which might not need to be repaid if the recipients agree to and actually practice, for a specified period of time, in the family care centers and other areas where they are needed.
- . scholarships to assist promising black and other low-income college graduate

residents of Philadelphia in acquiring medical and dental degrees.

development of a demonstration program at PGH and with its school of nursing so that qualified persons can move from a nurse's aide position through that of licensed practical nurse to the level of registered nurse, and can earn while learning.

(Two models successfully utilized in New York City have been studied for this committee. The New York City Health Services Administration--equivalent to the Department of Public Health in Philadelphia--has committed its training funds to areas of proven need. Jointly with the Hospital Employees Union of AFSCME (AFL-CIO) it sponsors a program wherein nurse's aides remain employed at city expense and with the retention of all fringe benefits while training for higher levels in the nursing profession. Promotional qualifications are carefully tied to the training.

Hunter College of the City University of New York has established a program, with some federal assistance, which accepts the city employed LPN's into an abbreviated educational program. This training qualifies LPN's to receive a R.N. license. The city releases trainees half time and pays a full-time salary.)

- . expansion of the aide training programs of Community Health Services with provisions for continuing education in order to qualify for upper level positions, and with new civil service classifications where necessary.
 - . stipends to students or aid directly to such institutions as the Community College, including for pre-entry crash programs to help needy Philadelphia high school graduates prepare and qualify for health professions training.
 - . assistance to the Board of Education so it can expand, implement and consistently fund programs such as the Simon Gratz High School bio-medical project which motivates, educates and supports black students in the pursuit of health careers.
2. Create within the Health Department a central position of Deputy Commissioner or Director for Health Manpower to carry out the operating responsibilities implied from the manpower planning, to administer the use of the City's health training funds, and to assist in bringing the City's own training programs, including at PGH, into the context of public policy.
3. Create a systems model in the health manpower field based on specific job analyses. This model requires consideration of the relationships between occupations at various levels in terms of knowledge to be mastered, skills to be acquired and the opportunities for career mobility. The Department of Public Health should lend both planning staff and personnel technicians to this enterprise, but the project may be carried out together with the regional comprehensive health planning agency and all health careers training institutions.

F. Management Mechanisms

The recommendations of this study for the improvement of the administrative structures for personal health services operations supported by public budget, have been made in the spirit of preserving public accountability and of adhering to the current constraints of public law--namely the Home Rule Charter. Therefore, the first steps to be taken to implement the recommendations are conceived as activities of Boards, or between Departments, as they now exist. For example:

1. There is precedent for joint, or special meetings together, of the Boards of Health and of the Philadelphia General Hospital. It is therefore within the structural bounds of the Charter for these boards to meet together to work out the implementation of portions of this committee's Recommendation #5. If they find that such a simple mechanism will make the operation of the spectrum of publicly funded health care services more rational, there is nothing to prevent such joint meetings in perpetuity.

2. Some similar device must be found with the Board of the Community Nursing Service to work out program and administrative aspects of the nursing role in the envisioned ambulatory care programs, and the relationships to the Hospital's nursing program.

3. The Commissioners of the Departments of Health and of Welfare, or their delegates, with appropriate consultation from the Departments of Law, and Finance, and the Managing Director's office, should be enabled to work out the management of the medical care functions of Riverview, and related arrangements for long-term care planning and programming.

4. This committee has carried out its analyses within the present Charter, considers all recommendations feasible within present structure, and has reviewed same with the Law Department. However, it is the intention of the City to appoint a commission to consider revision of the Charter. Therefore, appropriate individuals within City government to whom the implementation of this committee's recommendations will be assigned, might also be requested to consider and to recommend whether Charter amendments might be desirable.

G. A Summary: The Costs - and the Benefits

1. More Cost Projections

Capital costs for revising certain District Health Centers to encompass ambulatory care have been given. These figures are relevant for seven of the nine existing public health centers. Alternatives for rebuilding PGH have been analyzed as to probable construction costs.

In the 1970-'71 and 1972-'73 capital budgets of the city, funds are projected for the planning and construction of a new health center in District #10. We estimate that approximately \$3,000,000, at present cost levels, would be required to plan and build two more centers to serve District #8 and #7 in which there are now only inadequate renovated buildings.

But what of operating costs? Consultants to this committee have made certain estimates with regard to operating budget needs both with regard to carrying out first steps in implementing our recommendations, and long-range.

- a) Coordinated planning for the Philadelphia health care system would require the addition of about \$200,000 per year to the operating budget of the Department of Public Health. Master planning costs and professional consultants' fees have been included in the capital cost

- estimates for the health centers, and the new hospital.
- b) Some additional funds - perhaps \$250,000 should be budgeted for group practice organization, the development of a coordinated medical records system, the establishment of the chronic diseases evaluation and referral services, and eventual monitoring operations with regard to planned emergency services.
- c) Ambulatory Care - Operating Cost Projections
 Data provided this committee has estimated the operating capacity of the re-ordered health centers at 30,000 persons, 5 or more visits per year. Five visits per year, under full utilization would mean 150,000 annual visits. At our estimated average cost per visit of \$12, gross estimated annual operating costs per center would be \$1,800,000.
- d) Inpatient care - Operating Cost Projections
 We estimate the annual operating cost of a new Philadelphia General Hospital and the necessary purchase of inpatient services not available

at the hospital as follows:

Assume 400 acute care beds and an average daily operating cost of \$80	\$11,680,000
Assume 200 extended care beds and an average daily operating cost of \$50	\$ 3,650,000
Assume 250,000 specialty outpatient visits per year at an average cost of \$15 per visit	\$ 3,750,000
Gross annual operating cost	\$19,080,000
To allow for contingencies say	\$20,000,000

. Pediatric inpatient care

Some costs to the City should be projected for the purchase of inpatient pediatric care when required by children of the families receiving medical care from the health centers. This may need to cover seasonally, as many as 100 children per day, but at relatively short stays.

$$\begin{array}{r} \text{100 patients per day} \\ \text{365 days per year} \\ \hline \text{36,500 annual patient days} \\ \text{at \$100 per day equals \$3,650,000} \end{array}$$

However, it is known that 75% of present pediatric inpatient care in Phila-

delphia is reimbursable. Therefore the net annual cost to the City could be \$912,500.

Obstetrical care

The Maternity and Infant Care projects should be re-examined, and the residence and high risk status of the mothers who still deliver at the present Philadelphia General Hospital related thereto. It is probable that the majority of the fairly small number of patients still delivering at PGH, is eligible for this financing of care. Therefore the City has the mechanisms at hand for covering these costs. There may still be a public responsibility for motivation, education and other aids to guiding patients to this method of receiving and paying for their prenatal and obstetrical care.

2. Benefits - to the City and its Citizens

a) If the necessary reorganization of staffing patterns and of billing procedures in the ambulatory care centers takes place, an average reimbursement of \$8 per visit could be recognized under existing legislation. Therefore, the net annual operating cost to the City per center, and at full utilization, could figure at only \$600,000.

Thus, a more effective production of personal health care services could also operate at a net cost to the City of less per patient, and per center than is now invested in the categorical operations. All this is predicted without calculating the possibility of further input from charges to some patients, or of the transfer of some funds now used to operate clinics at PGH. To the support of comprehensive care in these patients' own neighborhoods.

b) If the new hospital becomes truly related to the ambulatory care centers as a back-up resource, the ultimate saving to the tax-payer has already been explained. Fewer expensive beds will be needed. The beds which do exist will be more effectively and economically used. It has also been made clear that extended care beds are less expensive to build and operate than acute care beds. If the City carefully planned a certain number of such beds related to the new PGH, this would help fill a vast need. It would also represent an economy over the present use of as many as 300 of PGH's acute beds for extended and custodial care patients.

The operation of a well built hospital such as that detailed by Scheme D, could net the City an 80% recovery of operating costs per patient day. Therefore, the net operating costs to the City would be as low as \$4,000,000 per year.

It may seem without heart, to summarize the reasons for the public priorities we have set forth--in monetary terms. However, this committee is firmly convinced of the benefits to the health of citizens in stressing out-of-hospital and preventive care, and feels the philosophy needs no further argument.

There is, however, an additional value to the taxpayer to explain. That is the value to be found in allocating his resources in a different way. This is why we stress that the operation of more effective health centers related to a hospital, or hospitals, placed differently in the system, could eventually result in programs servicing more people, and at less expense than current operations within an obsolete system.

APPENDIXA. Processes of the Committee

Members of a steering committee began to meet with Dr. Dixon and research staff in October 1969. Several such meetings served to prepare technical materials for review by the full committee, to discuss the possible shape of recommendations these data suggested, and to point up further areas for staff research.

Meetings were held with the full committee in November and December, 1969. At one of these, a motion was carried to submit the information collected to a wider public, before the Committee determined and voted upon final recommendations to be made to the Mayor.

Therefore, in December, 1969 and January, 1970 two public seminars were held by the committee with more than 100 individuals in attendance. These individuals represented a wide range of provider and consumer interests. All had been furnished with the same technical materials provided to members of the committee.

In addition, as preparation for the first public discussion, several small informational sessions were held with various interest groups. These ranged from representatives of health care consumer organizations to the medical staff of the Philadelphia General Hospital, deans of medical schools, and the like.

In general, members of the Mayor's Committee took the responsibility for organizing these small discussion groups. This process enabled a number of groups most particularly concerned with the future of the Philadelphia General Hospital to prepare position statements, some of which were later formally presented to the Mayor's Committee.

By unanimous vote of the Committee, such statements are herewith included as a part of this report to the Mayor.

On January 23, 1970, with due consideration for this important public input and review, the Mayor's Committee on Municipal Hospital Services voted to adopt the recommendations which appear in this report. Observers from the medical staff of the Philadelphia General Hospital, and from the Citizens' Health Conference, a new coalition produced by a caucus of over 30 consumer organizations, were present.

B. Statements of Position on the Recommendations of the Mayor's Committee on Municipal Hospital Services1) From The Citizens Health Conference -
A. A. Bey, Chairman

The time has come when the first priority for the use of local health dollars and health manpower should be shifted to modest income neighborhood health centers. The elderly find it difficult and

often hazardous to travel long distances required in order to reach the Philadelphia General Hospital. We feel that neighborhood clinics employing neighborhood staff people combined with the visiting nurses and home-maker services is a modern answer to public responsibility for personal health care in Philadelphia. We will hope you will give this matter serious study since many of our members are 65 and over and have been faithful taxpayers for a long time.

Recommendations

- a) Recognizing the inseparable function of research in medicine, we, the citizens recommend that the medical profession redirect its primary emphasis from research to the quality of care and delivery of services and the most humane consideration of the patient; do not use the helpless poor for experimentation.
- b) Persons indigenous to the community and who have been responsible to the needs of the citizens must be proportionately included on the board of directors of all hospitals and health institutions so that they will be able to protect the voiceless citizens.
- c) A city-wide independent review board should be established to investigate the delivery of care in the City of Philadelphia with the view to developing a system of total delivery of health care. All future financial support should be

dependent upon the implementation of their report.

- d) A community review board should be established in consultation with a group of representatives of hospitals to

- 1) Set fees and determine and explain services.
- 2) Be responsible for handling complaints.
- 3) Be responsible for all patients and receive a complete account of bills regardless of source of payment.

- e) The Health Department of Philadelphia and the hospitals concerned should give the community an inventory of the existing medical research activity in Philadelphia hospitals.

- f) Clinics should be handled on an appointment basis with repeated visits being made to the same doctor to insure continuity of care.

- g) Private physicians within each area should be afforded care and greater rapport and increased hospital privileges in order to insure adequate care for their patients.

- h) All persons should be guaranteed full and complete medical care from any hospital regardless of ability to pay.

- i) No hospital is to curtail in any way its emergency, accident or outpatient services at this time.

j) There should be effort to bring about an increase in fully accredited nursing homes, and a broadening of home care and rehabilitation services to shorten time spent in nursing homes or hospitals.

2) For the Citizens Health Conference -
by Mr. B. Russell

This statement represents an evaluation of the technical data submitted before the December 15, 1969 public seminar.

a) There is no objective evaluation of the quality of service administered by area hospitals and health facilities in the data. We are interested in a qualitative change in the level of service offered and are opposed to a mere quantitative change in the number of facilities offering the same inadequate quality of services.

b) We question the ability of a group, dominated by hospitals, medical schools, and health professionals to operate in our best interests. Medicine, the fourth largest business in this country, is a tremendously lucrative enterprise. Health consumers fear manipulation by the profit motives of special interest groups. Profit motives manifest themselves to us in the form of large buildings, tremendous research grants, and supposedly better educated doctors.

c) As we view the perspective of the hospital of the future, whether teaching or community, we feel it will have to be designed to care for

a new type of patient, no longer the traditional ward patient available for teaching material. We do not want to be viewed as cadavers, as species, but as patients.

d) We question the logic that those who have created the problem, can by some miraculous change of mind and reference points, solve the problem. Hospitals and doctors are given "economic incentives" to deliver services to people, and that there is, therefore, vested self interest to allow those persons in need of these services to become ill.

e) We question your preoccupation with buildings. Your data make the erroneous implication that expensive new buildings at Philadelphia General Hospital (PGH) and new health center buildings will improve the quality of services offered. Buildings may be desirable, but substantial improvements in municipal health can be made without enormous capital expenditures. (Particular issue was taken with a model, later rejected by the committee, for a new 1200 bed PGH, that would have cost about \$110,000,000 to construct.)

Conclusions

- . We object to material considerations superceding humane considerations.
- . We object to the exclusion, at any and all levels, of persons who will be the recipients of any municipal health services offered.

Information on long-range and short-range plans, data, legislation, and design making mechanisms should be shared with us.

- We object to the inference that persons of technical background know our problems better than we do.
- We object to the negation of the fact that we are considered only health consumers; we are also providers through our tax dollars.
- We object to establishing any priorities that will perpetuate crisis medicine as opposed to comprehensive medical care.

3) In behalf of the Medical Staff of PGH.
Edward S. Cooper, M.D., President

We need a new Philadelphia General Hospital with expanded services to the community.

a) Philadelphia General Hospital offers primary and secondary care for thousands of Philadelphians who are not reached or admitted by other Philadelphia hospitals. This would be true even if a comprehensive national medical insurance scheme were adopted. Witness the situation in Philadelphia last summer when it appeared that the receiving ward at PGH might be the only large hospital emergency room to remain open. What other institutions would be able to care for our many special groups of patients? Those with stroke, tuberculosis,

chronic debilitating neurological and medical diseases, policemen and firemen, referrals from social agencies, city compensation patients, alcoholics, drug addicts, - not to mention the majority of our patients who are ordinary citizens whose families have depended upon PGH for generations for health care. PGH, with new modern facilities, would be an ideal back-up general hospital for referrals from the community health centers which will offer primary care. In other words, a new PGH would be the hub of a new comprehensive system of health care for many citizens of Philadelphia.

It is universally accepted that the present PGH buildings are old and obsolete. A new hospital could function much more efficiently and at less cost. We must have a new modern facility in order to provide medical care equal to that found in other hospitals in the community, and to provide an attraction for the proper socio-economic mixture of patients to dispel the image of second class medicine for "poor folk" and special problem cases only. Second class medicine is no longer acceptable.

b) As universal health insurance becomes a reality, Philadelphia will need more and better health facilities, not less. PGH welcomes, both philosophically and in fact, all patients, regardless of socio-economic status, age, race and type of disease. Our type patients are frequently "first come, last admitted" at other hospitals. Many patients consider PGH "their hospital", and great inconvenience and emotion-

al turmoil will result if an attempt is made to phase them out of our institution. With proper financial support, this spirit can continue.

c) Philadelphia and our nation simply cannot afford to lose one of its oldest, best-known and effective facilities for the training of health personnel. This is especially true when cries are heard daily for more doctors, nurses and other paramedical personnel, including a greater representation from minority groups. PGH serves as a major teaching facility for hundreds of medical students each year, hundreds of interns, residents and fellows, nursing students, medical technicians, x-ray technicians, practical nurses, and approximately 1000 nursing students from other smaller affiliated hospitals in the region. In addition, programs are in the formative stage for physician, nurse and paramedical personnel training in: special areas such as pulmonary diseases and rehabilitation, stroke care, liver diseases and medical diseases associated with alcoholism, renal dialysis, drug and alcohol addiction, and coronary care unit duty. Each large city must have one complete public hospital for training personnel.

d) PGH is a major facility for medical research, with a yearly research budget of approximately \$2,000,000 obtained mainly from federal government sources. It has taken decades to build these programs. They probably could never be replaced during any period of constriction of sources for research support. In addition to

its inclusion of large grants for research in the ordinary basic and clinical sciences, PGH has extraordinary strength in research in special problem areas such as stroke and other neurological diseases, collagen metabolism and diseases, hypertension, gastro-intestinal, and infectious diseases, alcohol and drug abuse, and mental illness. The federal government has recently given highest priority to a special head trauma unit at PGH to be funded beginning January 1, 1970, and has under favorable consideration now a stroke intensive care unit and a massive research program in collagen metabolism. There has also been recent investigative research in new and better methods of delivery of health care (stroke, home care services, mental diseases, etc.) and health personnel training (e.g., remedial training for prospective nursing school applicants).

e) PGH needs an optimal "critical mass" of acute beds and accompanying diagnostic studies and treatment sections with appropriate personnel in order to support required special care units and teaching and research programs. At least 600 acute beds and the maintenance of an obstetrics unit are necessary for PGH to carry out this mission.

It is generally recognized that 1000-1200 beds is the optimal size for any modern hospital. Therefore, it is unlikely that the other major teaching hospitals of the City, which offer complete medical services, will be willing to build

and expand further in order to accommodate the hundreds of thousands of inpatients and outpatients seen yearly at PGH.

It is inconceivable that the City and citizens of Philadelphia would withhold support from PGH and thus destroy one of its most famous and distinguished institutions while using its energy and funds to build up other institutions over which it has no accountability.

f) If the mammoth, highly-trained and expert PGH staff is permitted to disband, it will take severa' generations to rebuild--a tragedy of the greatest order. Such a development will have a devastating effect upon the reputation of Philadelphia as a major medical city, and will mean the loss of a major attraction for our prospective bicentennial celebration. Remember, PGH was founded in 1729, almost 50 years before our union was formed!

In summary, a new and revitalized Philadelphia General Hospital, with a new physical structure, is essential to serve as the hub of a new comprehensive system of health care for many citizens of Philadelphia of various socio-economic backgrounds. A particularly attractive feature of PGH is the easy and reliable accessibility of entry by any sick person regardless of socio-economic status, race or type of disease. In addition, PGH lends itself to greater public accountability than other institutions, though it needs an increased flexibility and

autonomy for optimum operation. A strong PGH is a necessity because of its extensive general and specialized facilities for patient care, teaching and training of health personnel, and research in many areas including new methods of delivery of health care. PGH needs at least 600 acute beds and an obstetrical unit. In addition there must be at least 300 specialized and extended care inpatient units. Such a plan for the new physical structure of PGH is essential for it to survive and carry out its mission. Medical school affiliation is essential.

4) From the Citizen's Health Conference
Rev. D. Weeks, Jr.

A statement of consumer interests in health:

a) Hospital Costs are Too High

Hospitals will not consider a patient unless he has Blue Cross, Blue Shield and other policies and these are insufficient to meet the cost of medical care. It is now time to make the talk of national health insurance a reality if we are to assure all citizens equal quality health care. Philadelphia should support a national health policy because of its obligation to the citizens of this City. The City should revamp and reshape its policy in health to assure Philadelphians of equal quality health care.

b) The Need for Emergency Care

The poor at present are directly dependent upon

emergency room services. Certain hospitals apparently do not wish to treat the disadvantaged poor. Hospitals that have contracts with the City should be made to accept all patients in their geographic areas. No patient should be refused treatment because of inability to pay. An emergency ward must be kept open unless and until other systems that are better are developed.

c) Mental Health

Programs as set up do not meet the needs of the community because they are not community oriented. How can a sick society attempt to create a mental health program without first dealing with its own sickness? It is a known fact that treatment of the mentally ill has been lagging for years and there still exists a tremendous gap between the needs of the patients and concepts of how to treat patients.

d) Doctors Are Not in Areas Where Most Needed

Doctors do not remain in the needy areas. There is a related problem. If one is lucky enough to find a doctor, he will have difficulty finding a pharmacy to fill the prescription. If doctors will only specialize, or go to paying areas, this is the same as a shortage of doctors. They can also charge exorbitant prices. This country is importing thousands of foreign doctors to make up the shortage within hospitals. The disadvantaged poor who have the knowledge and ability cannot afford the high cost of medical

school and very little is being done to change this unbalanced situation.

Train more disadvantaged poor to be doctors but require them to spend five years in community practice. This is a small price for them to pay for medical education financed by others. Set up community pharmacy co-ops, or have groups of pharmacists coordinate hours to provide drugs in a given area.

e) Inadequate Planning for Elderly Persons

This country is obligated to its senior citizens but in most cases they live out their lives in some little room caring for themselves. They are placed in mental institutions and nursing homes in the guise of being crazy or permanently ill. At best, programs for the elderly are similar in nature to those of horse trainers -- for race horses that have outlived their potential and can only graze in the pasture until death. Programs must be developed whereby the elderly will know they are useful and appreciated by society.

f) Lack of Walk-In Care Facilities

Some care for which patients lie in hospital beds running up huge hospital bills, taking up bed space while waiting for an x-ray, blood test, pap test, skin test, etc., can best be provided by special neighborhood health clinics. Philadelphia should help create and encourage neighborhood health clinics, and hospitals should

establish relationships with such.

g) Hospital Beds

Before we can decide if there are too many or too few, we need to know -

how many beds are for training purposes?

how many beds are only for wealthy patients
or remain unoccupied until the "right"
patient is admitted?

h) Childrens' Protection

A health program should be initiated for youth under 21 to assure the country of healthy citizens for the future. This program should seek to protect against childhood diseases, environmental defects such as air and water pollution, poor houses, lead poisoning, malnutrition, etc. This program should seek ways to protect against social ills--dope addiction, alcoholism, and racism.

Positive Policy Directions

- The health industry should redirect itself toward a health policy of preventive medical care. Crisis care and hospital care only treat an individual after he or she is sick--which leaves doubt as to whether those who make their living off of the sick are really concerned about keeping individuals healthy and wholesome.

Federal health planning law concepts should be implemented. These call for consumer representation in policy planning. This law does not state 51% but actually says: "a majority of the membership of such a council shall consist of representatives of consumers of health services". Seventy percent of persons most affected by health plans is a better figure.

The present laws of Pennsylvania decree that corporate boards dealing with health insurance be comprised mostly of doctors. This should be changed.

Hospitals should not be permitted to exist on tax dollars without public accountability. They should reveal all their sources of funds.

A consumer citizen board should be established to set policy and evaluate health related programs. This should include the Health Department which at best is fragmented like all other agencies.

This body should evaluate policy, help form standards, set salaries, hire and fire, set conditions for promotion, and hear grievances. It should also supply grass roots persons with accurate health information.

Local boards (at least 70% consumers) for all health related programs such as hospitals, health centers, community mental health centers, rodent control, should also be established. Each local board would name a representative to form a regional health corporation which could receive grants and funds and in turn contract with public and private institutions for health services.

1509

Senator KENNEDY. Mayor Gibson was unable to be here and join with the mayors this morning. But Dr. Clark is here with Mayor Gibson's testimony. Dr. Clark, would you be kind enough to come up?

Dr. Clark, we want to thank you for coming. I understand that the mayor wanted to be here, had planned to be here, and at the last moment had to change his plans. We appreciate your presence here.

**STATEMENT OF HON. KENNETH A. GIBSON, MAYOR OF NEWARK,
N.J., PRESENTED BY DR. ALAN B. CLARK, DIRECTOR OF HEALTH
AND WELFARE FOR THE CITY OF NEWARK**

Dr. CLARK. Thank you, Senator Kennedy; and to other members of this committee I would like to make it clear Mayor Gibson has asked me to deliver this testimony because he considers it a very high priority issue within the whole thrust of his administration.

The crisis in health care is nowhere more serious than in Newark. Physicians leave Newark in increasing numbers, leaving behind a small number of older physicians; facilities for primary care are inadequate in numbers, and consist of disease-oriented hospital clinics, where care is fragmented and impersonal; medicaid, although it covers nearly a third of Newark's citizens, has failed to improve the quality or distribution of health care; and almost one quarter of our citizens have no health insurance of any kind. The results of all this are health indices which rightfully belong in the history of medicine, yet which are sad realities today in Newark.

Today in Newark we have the highest rate of infant mortality in the Nation, which has not changed significantly since the 1930's. Doctors do not fully understand the causes of infant mortality, but certainly nutrition and prenatal care are important. Only one third of those eligible receive food stamps. And the rest of those of welfare have a food budget which permits the expenditure of 32 cents a meal. One-third of all the women who give birth at the Martland Hospital, where most of the city's indigent receive their health care, have had no prenatal care of any kind. And it is here where the rates of prematurity and neonatal death are highest.

Tuberculosis, a disease which is a memory in the minds of people living in suburbs a scant 10 miles from the heart of Newark, still is a living reality for our citizens. Our rate of TB is triple our surrounding communities. We have a few TB clinics, but the need far outstrips their capability, and TB is a disease which requires attention to the patient's family, for followup of contacts and counseling.

Syphilis and gonorrhea are endemic. Yet, the city dispensary is the only place in Newark where these diseases are treated now. It is a squalid, undignified place. This group of diseases requires a sensitive physician to whom young people can turn with trust and confidence, not an anonymous clinic doctor.

Lead poisoning is perhaps the most insidious of the urban diseases. A recent screening by pediatricians at the College of Medicine and Dentistry in Newark showed that 40 percent of the children in

Newark are at risk to be poisoned by lead. The results of lead poisoning, a preventable disease, are mental retardation and death. The city council, at our urging—passed ordinances to require the abatement of lead paint in apartments, and to prohibit its further use. The College of Medicine runs a small lead poisoning screening clinic with city support, but these are halfway measures at best. To prevent this disease, we need to rebuild the substandard houses in Newark. And to treat those affected, we need centers where all children can be screened, followed and treated in a hospital if that is required.

And while these problems mount, physicians continue to leave Newark. Now we have just over 400 physicians living and practicing in Newark, or about 115 per 100,000 population. At the same time, the number of physicians in our neighboring suburbs has almost doubled, so that there are 220 physicians per 100,000 population in the suburban area. There is scarcity amidst abundance. And even in Newark, there are many areas of the city which have no physicians at all. Of those doctors in Newark, one-third are over 65, while the suburbs attract the younger, better trained men. So our need for doctors will grow considerably in the next few years, unless the Congress helps the cities provide real incentives and attractions for doctors to return to the cities, and more importantly, supports those medical schools which promise to turn out more physicians.

We have five major voluntary hospitals in Newark, and the Martland hospital, formerly city run, but now operated by the College of Medicine and Dentistry of New Jersey.

The college planned to build a small "referral" hospital of 275 beds while it renovated the existing Martland structure with what is, in our view, an inadequate amount of money. This would have perpetuated a dual system of health care, with a small hospital for those outside the city with private insurance, and a community hospital for the poor within the city. We publicly opposed this plan, and instead, called for the phasing out of Martland, and the construction of a 600 bed modern facility to function both as a community and a referral hospital, so that the medical school exemplifies a one class system of health care. The faculty of the College has supported us in this, and we are hopeful that as the permanent facilities of the college are built that this new hospital will become a reality.

The voluntary hospitals recently expended over \$15 million for improvements and renovations, but there is still a shameful lack of primary care facilities. The outpatient departments of the voluntary hospitals and of Martland are still disease-oriented, and care is fragmented and impersonal. These clinics are undergoing the start of reorganization now, but we still require double or triple the space to provide comprehensive family oriented care for all those in Newark. And as we do this, I have no doubt that the number of hospital beds in Newark, now about 2,000, might turn out to be inadequate as we begin to detect and treat long neglected disease.

And even within the hospitals there are contrasts. One hospital runs a heart surgery suite and an artificial kidney unit, but the

surrounding community complains about the lack of service to its health needs. The hospitals and their medical staffs are beginning to question the appropriateness of what they are now doing.

Recognizing the enormity of these problems, we have assigned health a major priority in this administration. We have created in Newark a partnership for health council, to bring together the providers and consumers of health service to identify goals and objectives in health care, and to begin to create access to health care for those who have not enjoyed it, and to redirect the purposes of the health institutions in Newark. During the last several months, in cooperation with community groups and the major providers, we have been planning a network of neighborhood health centers throughout Newark. These centers will provide comprehensive, family oriented health care. Some will be located in hospital outpatient departments; some in the neighborhoods. One of these centers is operating already, another just opened on a small scale, a third is about to be built, and two hospitals are developing such centers within their outpatient departments. We are helping a strong pediatric group practice expand into a comprehensive center; and a group of 20 specialists is building a referral center on an urban renewal site in the heart of Newark. We hope to link all of these components into a unified system.

But these are small efforts, and the Federal grants are limited and will not last forever. To maintain this system on a sound financial basis, we need a universal system of health insurance, which guarantees access to this system for all Newark citizens. This system of health insurance should not passively pour money into the existing framework, but rather it should be used creatively to encourage and direct the kinds of changes which we in Newark have set as our goals. This means money to build new facilities for primary care, and the formation of prepayment, capitation systems.

The present pluralistic system of health insurance has failed to create the kind of changes in Newark we all seek. Instead of guaranteeing a single, high quality system of health care, we have two systems: One for the middle class, financed by Blue Cross, Blue Shield, and the private insurance companies, and one for the poor, financed by medicaid, or subsidized directly by State and local government.

I do not believe that even the middle class in Newark is satisfied with the quality of care their insurance premiums purchase. And the cost of premiums continues to mount. Recently, the State insurance commissioner approved a 9 percent rate increase in Blue Cross, but those who must pay can see no improvement in the quality of care.

And only 155,000 people in Newark are covered by Blue Cross-Blue Shield and private insurance.

Of the remainder of the population, 110,000, almost one-third of the city, are on categorical welfare, and are eligible for medicaid. Medicare covers another 25,000. But almost 100,000 are not covered by insurance of any kind.

Medicaid has perpetuated the two class system of health care. It is, in truth, welfare medicine. Thousands of citizens who are not

receiving assistance, but who would be eligible for medicaid, do not apply because they refuse to go through the demeaning process of eligibility at the local welfare board.

The best that medicaid has done has been to afford limited access to the better voluntary hospitals in Newark. Before that, all welfare patients went to the Martland. But even in the voluntaries, these patients stay on the oldest, unrenovated wards, while the new recently built wings are reserved for the so-called private patients. These patients still do not have their own doctors, but are as always "service cases" to be cared for by interns and residents.

A look at the 1970 experience with medicaid in Newark is instructive. For 115,000 eligibles, a total of about $6\frac{1}{2}$ million medicaid dollars were spent. Of this, \$4.4 million went for hospitalization, and \$1.4 million for ambulatory care.

A disproportionate amount was spent, therefore, for hospitalization. This reveals that medicaid eligibles do not have access to primary care, and hence their diseases frequently go untreated until they become sick enough to require hospitalization. Conversely, many patients are hospitalized unnecessarily because of a lack of alternative facilities. The medicaid dollars have not encouraged a reorganization of the delivery system. These dollars have not even controlled costs. Some hospitals are being reimbursed at \$35 for a clinic visit.

And sadly, while State legislators are complaining about soaring costs, the total spent in Newark, $6\frac{1}{2}$ million, amounts to about \$56 for each eligible.

This compares poorly with what some prepayment plans, like the Kaiser group on the west coast or HIP in New York spend per person, about \$200. Clearly, the costs of health insurance cannot be borne by State government.

And finally, we must provide insurance for those who exist just above the poverty line, who are not eligible for medicaid, but who cannot afford other health insurance. I might add that the sharp cutoff of medicaid benefits as the welfare line is passed is a strong incentive for those, especially with chronic illness, to remain on welfare to continue receiving medicaid benefits. At the same time, to create a sliding scale, with deductibles and coinsurance, is not, in my view, the way to control utilization. Nor are maximum benefits. We need, rather, to more fully develop more sophisticated screening techniques, to sort out the well, the incipient ill, and the frankly ill.

Therefore, we strongly recommend to you that the Congress enact health insurance legislation with the following features:

1. Universal in scope, with comprehensive benefits, without deductibles or coinsurance.

2. Financing by the most progressive form of taxation which we have at our disposal. In practical terms, this means employee-employer contributions according to income, and a generous contribution out of Federal tax revenues. And complete Federal support for those who cannot afford it. We must emphasize, however, that a single system of insurance is a prerequisite for a single system of health care delivery.

3. Setting aside special resources to improve the delivery system in facilities, organizations, and manpower. More specifically, where local government has demonstrated leadership and initiatives along these lines, that these resources come to us to effect the kinds of changes we all desire.

With your support we in Newark can create a model health care delivery system for the Nation.

Thank you, sir.

Senator KENNEDY. Thank you very much, Dr. Clark. This is excellent testimony, and the graphs which you brought show visually what the real problems are in terms of the availability of doctors, the distribution of physicians, the age of various physicians, what is happening to growth in many suburbs, as well as the diseases that are present. The charts reflect very well what the nature of the health crisis is that we are seeing in many of these areas. I think this testimony is superb, and we will indicate to the mayor our great appreciation for it; it reflects a good deal of study and is really first rate.

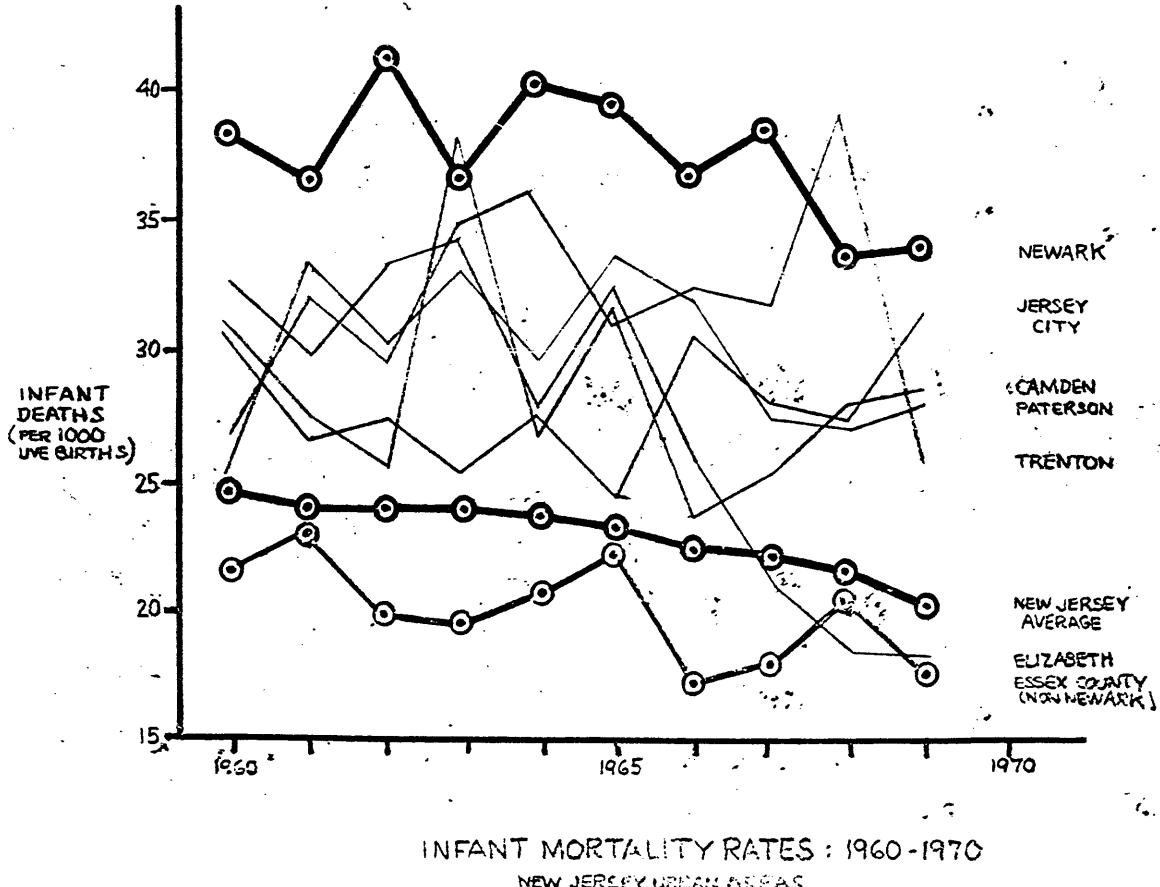
So I want to commend you for coming down here and taking the time to be with us and to express these views for the mayor. I wish you would wish him well for me. I know the mayor, am an admirer of his, and think he is trying to provide dynamic leadership in an area where it is sorely needed. We can understand his pressing problems there making it impossible for him to be here. So I want to thank you for coming.

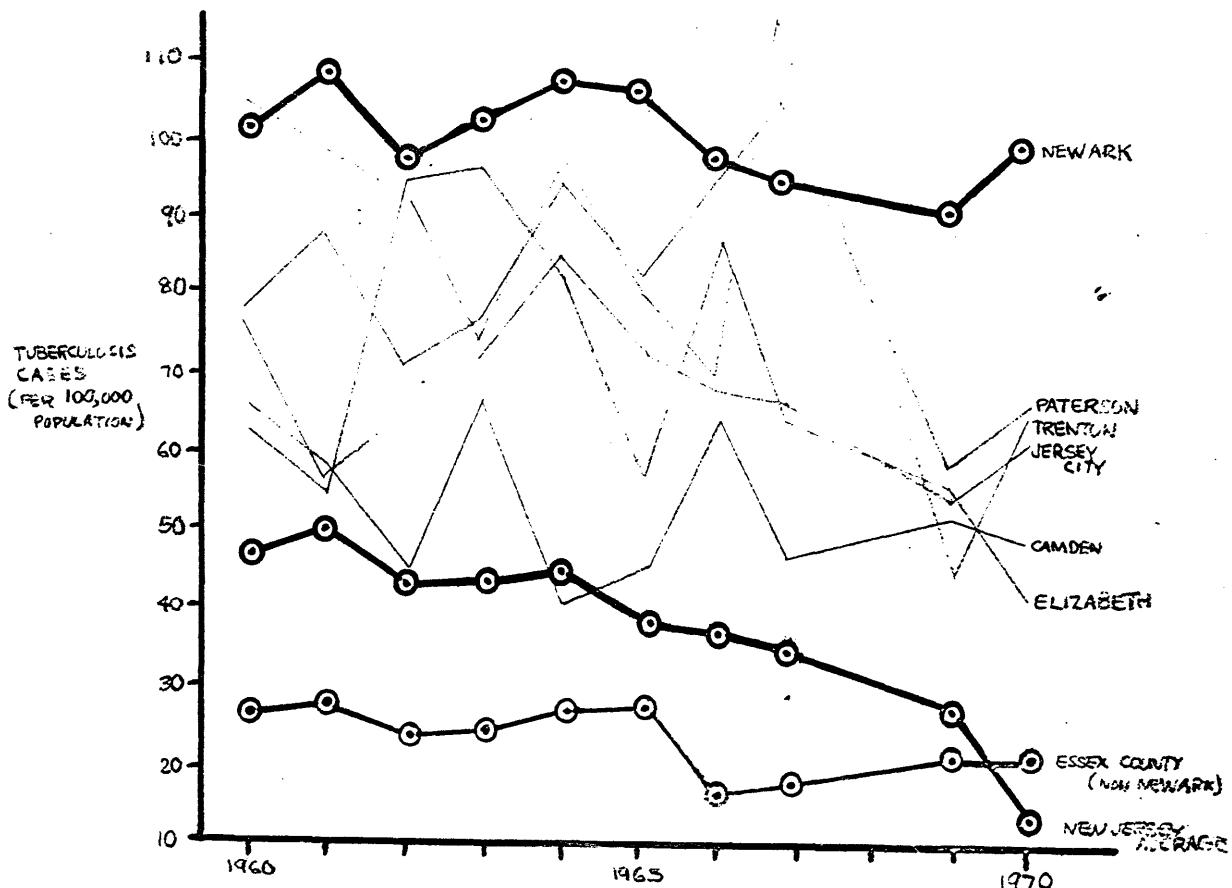
We will include those charts in the record.

Dr. CLARK. The same ones, sir.

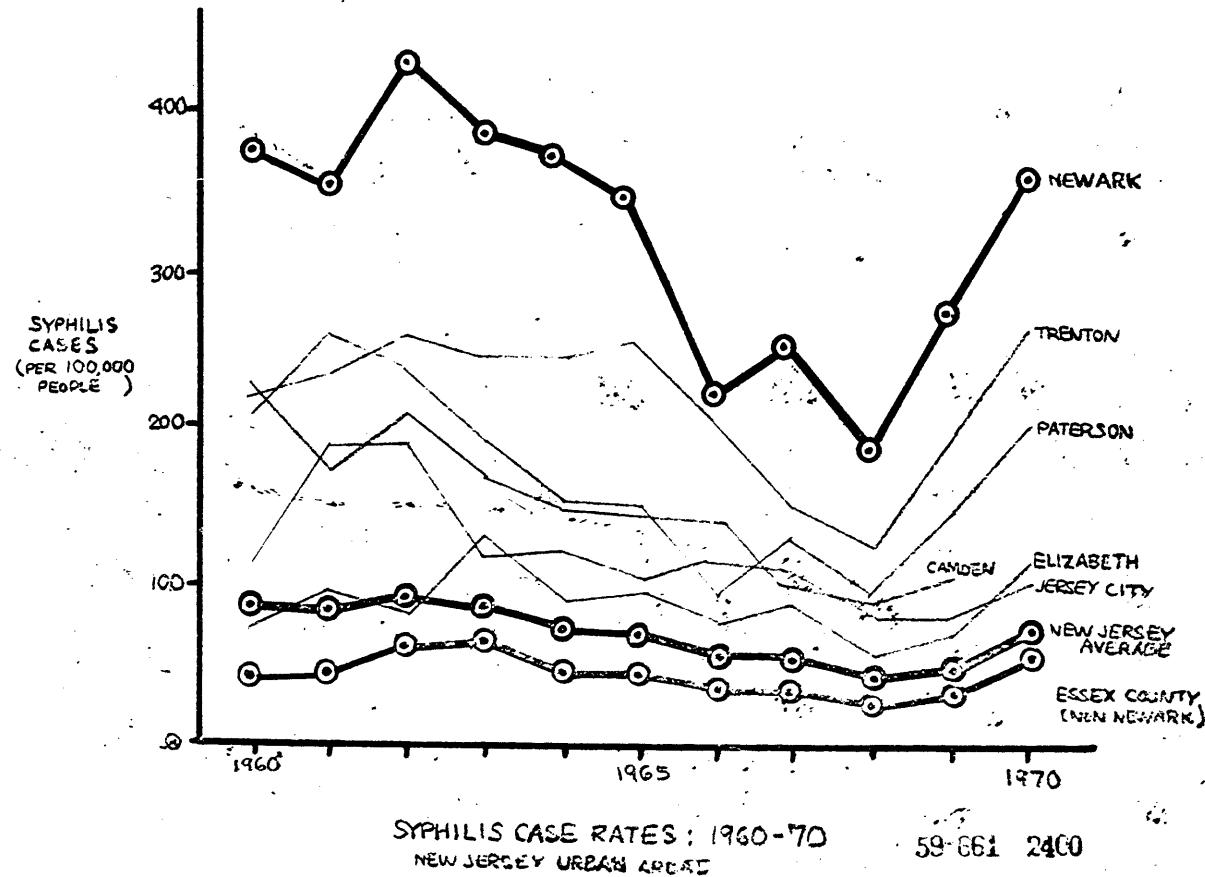
Senator KENNEDY. I want to thank you very much. I would like to feel that our staff could be in touch with you as we develop this legislation.

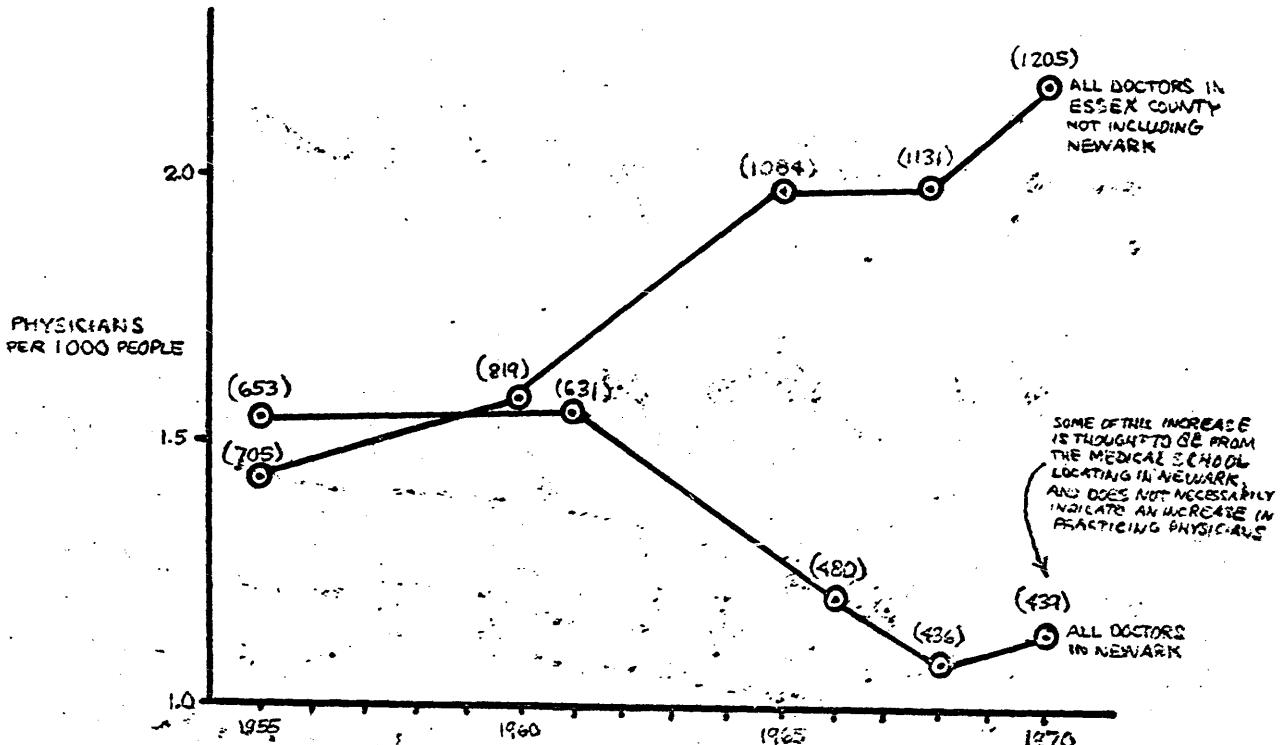
(The graphs referred to follow:)





TUBERCULOSIS CASE RATES : 1960-1970
NEW JERSEY URBAN AREAS



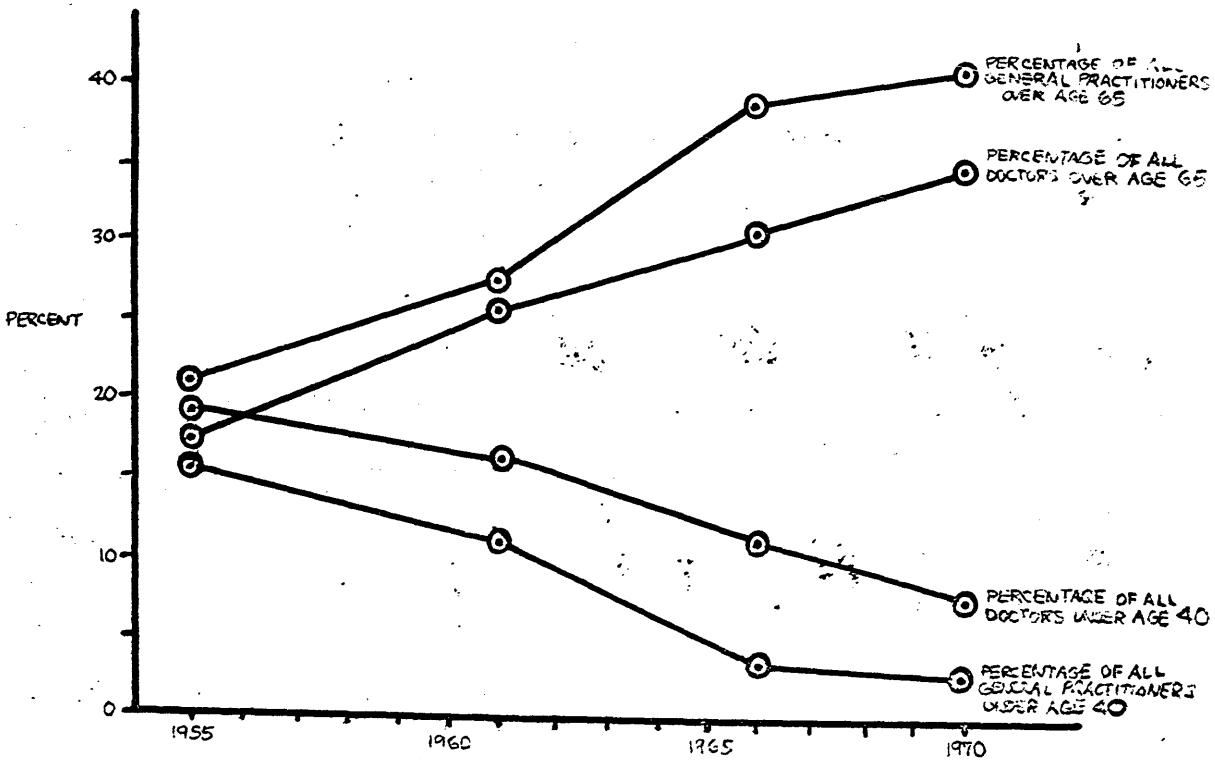


59-861 2401

PHYSICIANS IN NEWARK AND ESSEX COUNTY (NO TCLUDING NEWARK

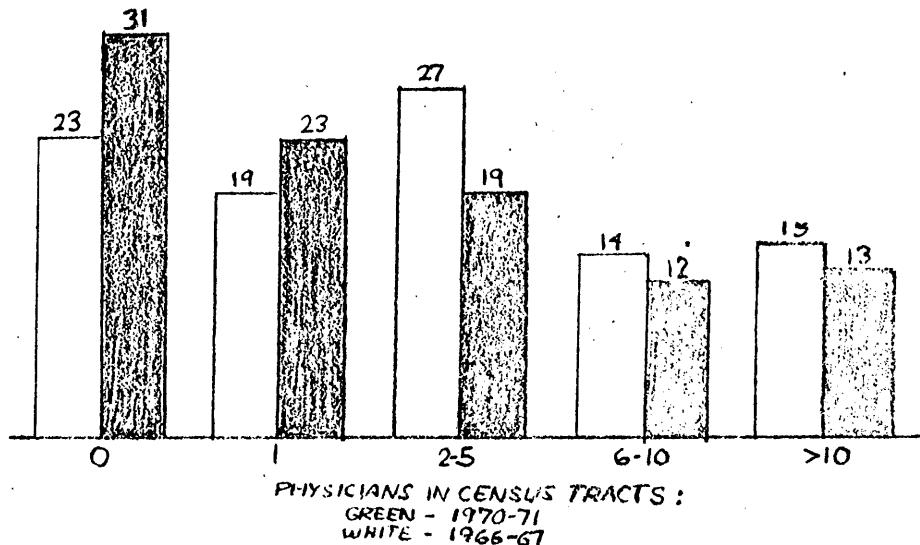
TTENDEN IN PHYSICIANS/POPULATION RATIO

(NUMBERS IN PARENTHESISS ARE NUMBERS OF DOCTORS
IN THE RECIPEG AREAS)



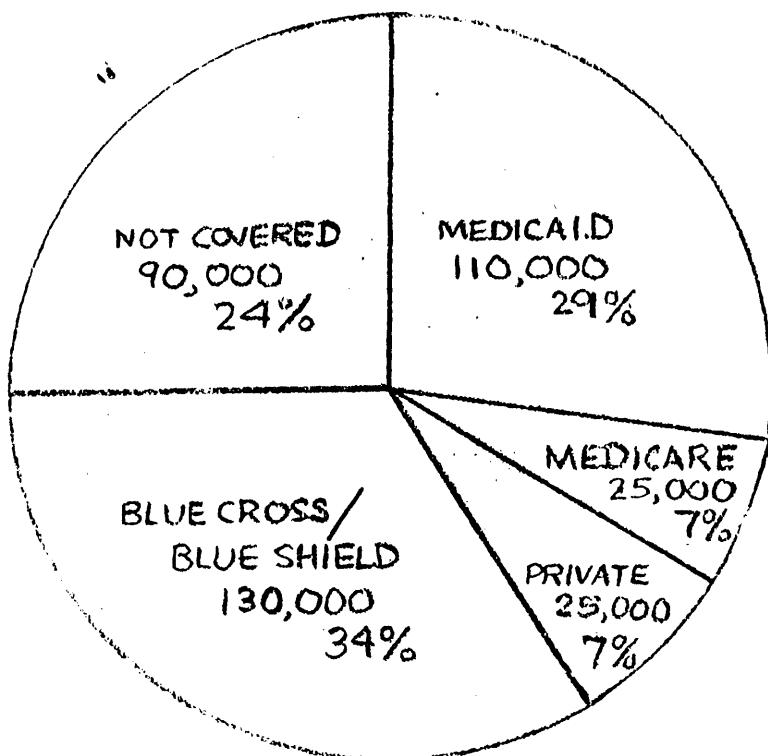
DOCTORS IN THE CITY OF NEWARK:
AGE DISTRIBUTION TRENDS, 1955-70

DISTRIBUTION OF PHYSICIANS
IN NEWARK (BY CENSUS TRACTS)



SOME INDICATION OF THE DISTRIBUTION OF DOCTORS IN NEWARK IS SHOWN BY THE ABOVE FIGURES:

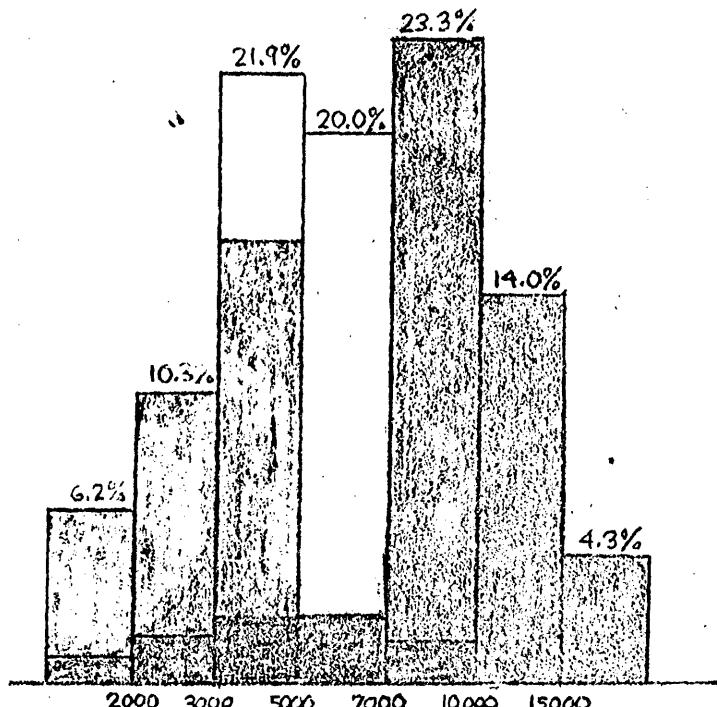
- OVER HALF (55%) OF NEWARK CENSUS TRACTS HAVE ONLY ONE OR NO PHYSICIANS. ALTHOUGH 1970 CENSUS DATA BY MALT IS NOT YET AVAILABLE, THESE TRACTS ARE KNOWN TO CONTAIN A SIZEABLE PROPORTION OF THE CITY'S POPULATION.
- THIRTEEN OF THE TRACTS (13%) HAVE A TOTAL OF 281 OR 64% OF THE CITY'S PRESENT 434 PHYSICIANS. TWO OF THE TRACTS OR 2% HAVE 98 PHYSICIANS, OR 22% OF THE CITY'S DOCTORS.
- AS THE CITY'S PHYSICIANS DECREASED FROM 534 TO 434 IN THE 1966-70 PERIOD, THE TRACTS WITH OVER 6 PHYSICIANS DECREASED ONLY SLIGHTLY, THE NUMBER OF TRACTS WITH 2-5 DECREASED GREATLY AND THE NUMBER OF TRACTS WITH ONE OR NO DOCTORS INCREASED GREATLY. THERE IS NO REASON NOT TO EXPECT THIS TREND TO CONTINUE.
- THIS DATA WILL BE CORRELATED WITH POPULATION FIGURES AND MAPS AS SOON AS POSSIBLE TO PRODUCE EXACT LOCATIONS AND POPULATION ESTIMATES FOR THOSE AREAS WITH NO DOCTORS.



ESTIMATED 1970 INSURANCE COVERAGE OF NEWARK RESIDENTS

FROM THE ABOVE ESTIMATES WERE CALCULATED EXACT COVERAGE FIGURES WHERE AVAILABLE, ESTIMATES FROM SOME OF THE CARRIERS AND HOSPITALS, AND AN ANALYSIS OF HOSPITAL UTILIZATION IN THE NEWARK AREA. ESTIMATED OVERLAPS BETWEEN THE VARIOUS COVERAGES WERE TAKEN INTO ACCOUNT (FOR EXAMPLE, THE 10% ESTIMATED BLUE CROSS SUBSCRIBERS WITH DUPLICATE PRIVATE COVERAGE ARE INCLUDED IN THE BLUE CROSS SEGMENT).

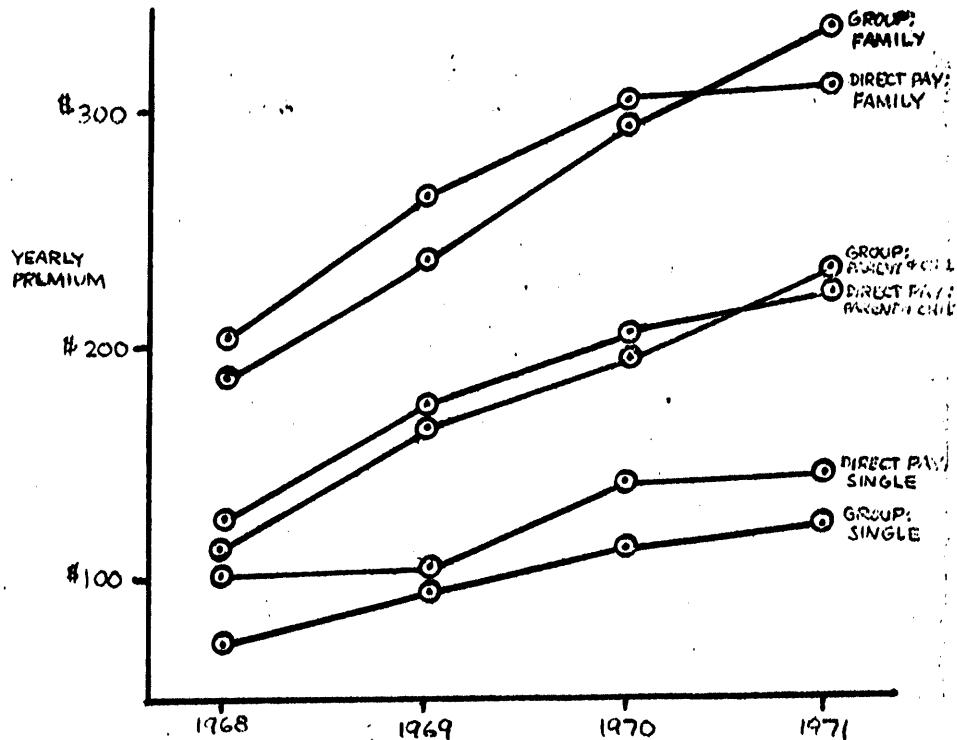
THE ACCURACY OF THE METHOD OF ANALYSIS IS SUCH THAT THE NON-COVERED GROUP IS CERTAINLY NOT LESS THAN 75,000 AND PROBABLY NOT MORE THAN 120,000.



MEDICARE	3000	5000	7000	7000	3000	0	0	$\Sigma 25,000$
MEDICAID	21000	34000	55000	0	0	0	0	$\Sigma 110,000$
B.C./PRIV.	0	0	0	0	86000	53000	16000	$\Sigma 155,000$
NOT COVERED	0	0	22000	68000	0	0	0	$\Sigma 90,000$
	$24,000$	$39,000$	$84,000$	$75,000$	$89,000$	$53,000$	$16,000$	$\Sigma 380,000$

INCOME DISTRIBUTION IN NEWARK, SHOWING
A THEORETICAL INSURANCE COVERAGE BY
INCOME GROUP ESTIMATION.

THIS IS A ROUGH ESTIMATE SHOWING THAT PEOPLE IN THE
\$9,000-\$7,000 INCOME RANGE ARE THOSE MOST LIKELY TO NOT BE
COVERED BY ANY REASONABLY COMPREHENSIVE HEALTH INSURANCE.
INCOMES ARE FROM THE 1967 RUTGERS STUDY (1970 CENSUS DATA
NOT YET AVAILABLE). OVER 65 INCOMES TAKEN FROM ROUGH NATIONAL
CHARACTERISTICS. ALL PERSONS WITH INCOMES OVER \$7000 ASSUMED
TO HAVE OR BE ABLE TO AFFORD BLUE CROSS/BLUE SHIELD OR PRIVATE
INSURANCE COVERAGE.

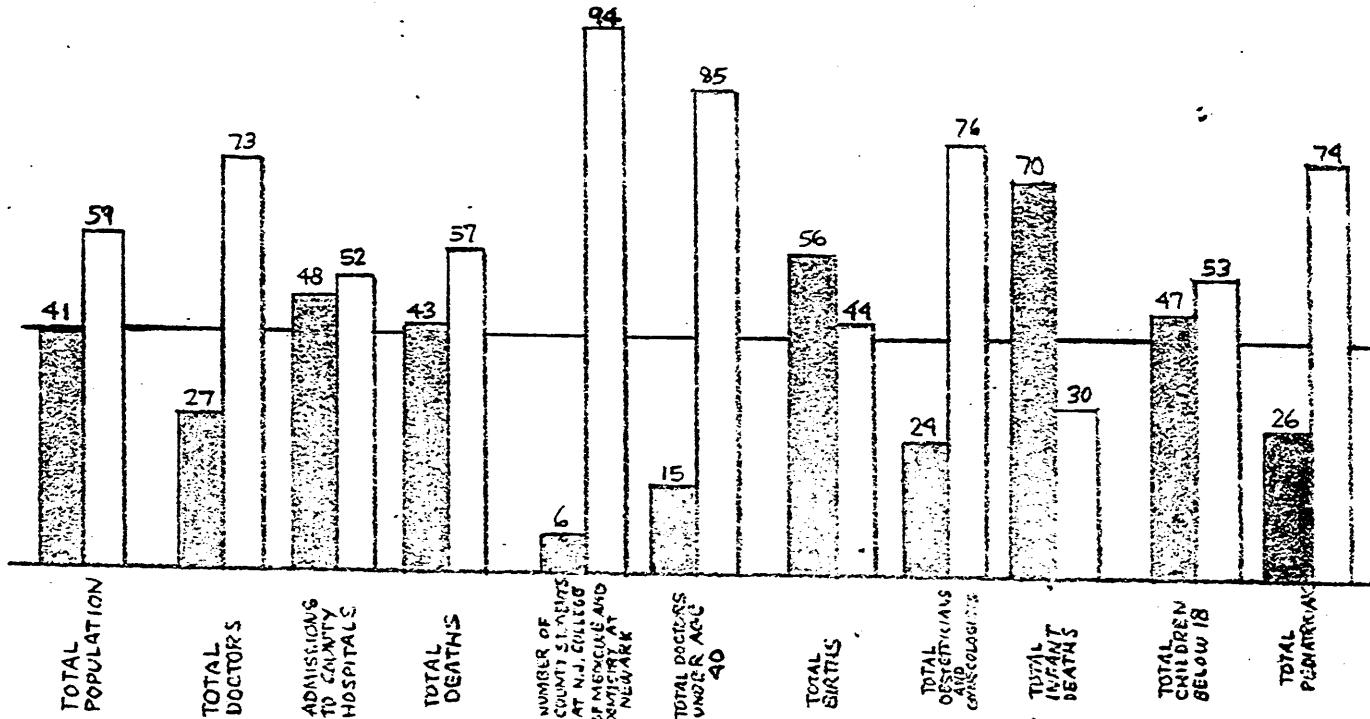


N.J. BLUE CROSS RATES: ESTIMATED YEARLY PREMIUM
NEEDED FOR COMPREHENSIVE COVERAGE (RIDER J INCLUDED).
BLUE SHIELD COSTS NOT INCLUDED.

HOSPITALIZATION INSURANCE IS RAPIDLY OUT-PRICING LOWER AND MIDDLE INCOME GROUPS. THE ABOVE NEW JERSEY RATE INCREASES WERE APPROVED DESPITE A GENERALLY ACKNOWLEDGED SUCCESSFUL HOSPITAL BUDGET REVIEW COMMITTEE IN THE STATE. BLUE CROSS REIMBURSEMENT POLICIES HAVE ENCOURAGED UNNECESSARY HOSPITAL UTILIZATION BY FAILURE TO PROVIDE OUTPATIENT BENEFITS, EXCEPT FOR DIAGNOSTIC TESTS UNDER RIDER J. NEW BENEFITS FOR OUTPATIENT AND HOME OR NON-HOSPITAL CARE ARE SCHEDULED TO BEGIN JANUARY 1, 1972. THE FUNCTIONING OF THESE NEW BENEFITS IS UNCERTAIN, BUT IT IS UNLIKELY THEY WILL CURB THE STEADILY RISING PREMIUM COSTS IN THE NEAR FUTURE BY THEMSELVES.

COUNTY RESOURCE AND HEALTH EXPERIENCE DISTRIBUTIONS
FOR EACH CATEGORY:

GREEN IS % NEWARK
 WHITE IS % NON-NEWARK ESSEX COUNTY
 THE GREEN MIDLING REPRESENTS WHAT ONE WOULD
 EXPECT NEWARK TO HAVE OF EACH CATEGORY BASED
 ON ITS PERCENTAGE OF THE COUNTY POPULATION.



Senator KENNEDY. At this point we will enter the prepared statement of Mayor Roman S. Gribbs of Detroit, Mich.
(The prepared statement of Mr. Gribbs follows:)

Statement by

ROMAN S. GRIBBS

Mayor of Detroit, Michigan

on behalf of

Legislative Action Committee

The U. S. Conference of Mayors

Senate Health Subcommittee

on

Health Crisis in America

April 7, 1971

Mr. Chairman and Gentlemen:

My name is Roman S. Gribbs. I am the Mayor of the City of Detroit, Michigan and am grateful to have the opportunity to discuss with you the serious nature of the health-care crisis in my City and my State.

Congress and the press recently have done much to stimulate national discussion of America's health-care system and possible remedies.

Unfortunately, however, many Americans, including many Detroiters, need not be reminded of the inadequate and inequitable health system. Poor and moderate-income Americans' experiences with "dollar care" medicine has been too real and too harrowing.

By this point in the hearings, this committee must have been told repeatedly that Americans are dying younger and leading less healthy lives than the citizens of most other industrialized nations. The United States ranks 14th in infant mortality rates, and among industrialized countries, seventh in maternal deaths, 18th in life expectancy of males, and 11th for females.

Although I am not a health expert, I do have a major responsibility for providing health care in the City of Detroit. It is for this reason that I am particularly appalled by the chaotic situation in the health-care field. The "system" hardly deserves to be called a system.

Let me discuss with you three particularly troublesome areas: prenatal and maternal care, the shortage of trained medical personnel, and medical economics and insurance.

Prenatal and maternal care is perhaps the single most distressing aspect of Detroit's health-care crisis. In 1969, 1300 Detroit women were delivered of babies without prior medical care; 95 of those babies died at birth or shortly thereafter, a substantially higher rate than the City-wide average.

More insidious and perhaps more extensive in effect is malnutrition. Adolescent girls, pregnant women, nursing mothers, infants, and children are particularly vulnerable to poor diets even when they are receiving adequate health care. Without such care, premature deaths and diseases with long-range ramifications increase sharply.

Because of an antiquated health-care system, caused to some extent and compounded by the City's current financial crisis, we cannot educate mothers, provide adequate prenatal education, or satisfactorily combat malnutrition. Infant and maternal death rates

are increasing in the inner-city.

The first line of defense in this battle are our clinics to which most pregnant, ghetto women go--if they go at all--for obstetrical and prenatal care. Yet at clinics these women often encounter hospital personnel who are hostile to the poor, especially if the poor are also black.

The clinics are crowded, impersonal, and often run down and dirty. The young, poor mother--particularly if it is her first visit to the clinic--is often overwhelmed by the foreign environment and the inattention of harried medical personnel who do not have time for kindness and explanations. The important process of educating new mothers on the health and welfare of their newborn children is totally ignored.

Contributing to and compounding the disastrous maternal-health-care situation is the severe lack of trained medical manpower. Michigan, I am told, currently has 10,907 physicians of whom only 8,759 are in active practice. There are, in addition, 1,876 osteopaths and 266 chiropodists.

The majority of these are in private practice; only one Michigan physician in twelve engages in any form of prepaid group practice, a rate 10 per cent lower than the national average and lower than any other state in the east north central area.

The number of doctors available is simply not enough. Michigan's seven southeastern counties have a combined population of nearly 5 million. Within this area there is only one doctor for every 792 people and one nurse for every 134. And it is money which determines who has access to medical care. Some areas of Detroit's inner city have only one doctor for every 10,000 people.

Michigan has 4.3 per cent of the Nation's population and a level of personal income nearly 10 per cent higher than the national average, yet it has only 4.14 per cent of the Nation's physicians. There are more than 200 Michigan towns of 1,000 or more people who do not have even one doctor. One town (Deckerville) has four veterinarians but no doctor to look after the health needs of its people.

Right now Michigan needs 2,000 more doctors and 4,000 more registered nurses. By 1980 there will be a need for 7,600 additional doctors.

On top of this physicians' incomes have skyrocketed. In Detroit we used to pay a doctor \$12.80 an hour, the equivalent of \$25,000 a year. Today we pay almost \$30 an hour, the equivalent of nearly \$70,000 a year. It appears that doctors have priced themselves out of the small-town and inner-city markets and have flocked to the suburbs to care for the affluent, the only people who can afford their services.

Given our straightened financial circumstances, we in Detroit and Michigan cannot possibly pay to train the new doctors, nurses, and dentists that we need.

Health professionals currently available must be used more effectively and paramedical personnel must be trained and utilized. We would like to see an immediate implementation of the Health Emergency Manpower Act, which would send commissioned Public Health Service doctors into communities desperately in need. And this should be expanded into a program of required community service for all health personnel as an alternative or complement to military service.

But the sharp increase in costs is not limited to physicians' services. Since 1965, while the consumer price index has been rising an annual rate of 3.9 per cent, the medical-care price index has been rising at an annual rate of 6 per cent--paced by an even steeper rate of increase for doctors.

In Michigan we spent \$2.26 billion for poor health care in 1969. Michigan workers have spent a larger share of their incomes on private health insurance, yet the private insurance industry is incapable of controlling costs, assuring quality care, or protecting the forgotten health-care consumer.

Last year the City of Detroit, as an employer, paid \$8,475,000 to provide its employees basic-ward-coverage hospital insurance. This

is a significant factor in the City's current financial crisis.

I have been to Washington several times already this year, testifying on the gravity of the cities' financial plight. Although we have cut back every essential City service, next year we will face a revenue-expenditure gap of \$43 million. The cost to the City of its employees' hospital insurance equals nearly 20 per cent of that gap.

I believe that the Federal Government must assume the financing of the Nation's health care because only the Federal Government has both the necessary resources and--more importantly--the ability to effect a reorganization of the health-care delivery system.

The health-care situation I have described as existing in Detroit and Michigan is duplicated, my fellow mayors tell me, in other cities and states throughout the Country. Clearly the American people are not receiving the adequate health care that they need. But what is to be done?

If the Congress is to alleviate the health-care crisis, it will have to develop a financing procedure which provides incentives for reorganizing the limited supply of health services and making more efficient the delivery of health care. It may do more harm than good to finance a private health-care system without simultaneously

increasing the availability and quality of services, and improving preventive health-care education.

I believe that we cannot wait to develop a program to reorganize the health care systems in terms of both supply and demand. Nor can we expect improved performance from those in the health-care field without financial assistance and incentives. We must use every means possible to urge those in the health system to act now before an increasing crisis endangers a private health-care delivery system in this Country. A government health insurance program must contain incentives for efficiency, improved use of health manpower, and other improvements in the health delivery system. It is my hope that passage of some type of national health insurance can elicit further action.

It is not surprising that I am one of many persons from every field and of every political persuasion who now endorse the idea of national health insurance. Undoubtedly the major factor in this increased support of a health insurance scheme is the economic one. But I do not believe we should settle, in desperation, for a health insurance scheme that does not direct itself to reorganization of the delivery of health services.

I believe that any national health insurance program should have the following elements:

First, the concept of a Resources Development Account as outlined in the Kennedy-Griffiths bill. A portion of any health insurance fund must be directed towards strengthening the Nation's resources of health personnel and facilities and its system of delivery of health service. Under the Kennedy bill as much as \$800 million would be so earmarked and would be a catalyst to create needed changes within the system.

Second, that some mechanism for fee control be included in any insurance plan. Medical costs have continued to rise in Detroit since the passage of Medicare and Medicaid. Accountability must be demanded of the health professionals or the Federal Government will just be issuing a blank check and supporting continued inefficiency.

Third, that private insurance coverage for individuals be retained. It is my belief that the private insurance industry can serve a useful function in a national health insurance scheme.

I have attempted to outline for you the health situation in my City. Clearly the health of the people of the City of Detroit and of the people of this Nation is a priority item. The City cannot pay for it. I urge you to direct yourself to the health-care crisis in the manner I have suggested and to make a healthful, harmonious, and rewarding life for all Americans a goal of national policy.

Senator KENNEDY. At this point I order printed all statements of those who could not attend and other pertinent material submitted for the record.

(The material referred to follows:)

PHONE: VINEWOOD 2-8380

FORD LOCAL 600 UAW



WALTER DOROSH
President
JAMES L. O'ROURKE
First Vice-President
ROBERT BATTLE III
Second Vice-President
WILLIAM BROWN, JR.
Recording Secretary
JAMES RODNEY
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Sergeant-at-Arms
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Officer
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Trustee
CARL FRIOT
Trustee
WADDELL JOHNSON
Trustee

10880 DIX AVENUE — DEARBORN, MICHIGAN

February 19, 1971

Honorable Ted Kennedy
United States Senate
Washington, D. C. 20510

Dear Senator Kennedy

The Executive Board, in session on February 9, 1971, discussed your very intensive efforts, in conjunction with Representative Martha Griffiths and others, to secure the enactment of a comprehensive, compulsory national Health Security Program.

The Executive Board members were highly laudatory of your efforts in introducing legislation in the U. S. Congress and your diligence in pursuing the enactment of this vital program. As you know, this type of legislation has long been a cherished goal of our Union. We have long sought a national health program to cover all American citizens, regardless of ability to pay, station in life, or employment status. We feel that all citizens are entitled to this as a matter of right.

Local 600 General Council, in session on February 14, also adopted a resolution endorsing the "Health Security Program" introduced in the 92nd Congress as Senate Bill No. 3 and House Bills Nos. 22 and 23. (Resolution is herewith enclosed).

Again, in behalf of our entire membership, comprising approximately 33,000 in-plant workers and 15,000 active retired members, I want to express our utmost gratitude for your work in this field. We are most confident that, with your continued efforts, that of Representative Martha Griffiths, and other dedicated members of Congress, the Year 1971 will finally see the enactment of a national Health Security Program.

Very truly yours,

James L. O'Rourke
James L. O'Rourke, 1st Vice-President

JLO'R:moc/opeiu42af1-cio . . . FORD LOCAL #600, UAW
enc.

RESOLUTION ON HEALTH SECURITY PROGRAM

WHEREAS: The continuing escalation in the costs and deterioration in the quality of health care in the United States is of continuing concern to all Americans, and

WHEREAS: UAW members and their families have seen direct and adverse effects on their collective bargaining efforts resulting from the uncontrolled cost inflation, and

WHEREAS: Some thirty million disadvantaged Americans continue to be confined to the grinding cycle of poverty and ill health, so that cause and effect are increasingly indistinguishable, and

WHEREAS: Almost all proposals to change the present unfortunate state of affairs fail to deal with the basic problem of reorganization of the health delivery system, and

WHEREAS: The Committee for National Health Insurance, with substantial support from the UAW, has developed the most comprehensive, practical and promising program for health security for all Americans, and

WHEREAS: This program has been introduced in the 92nd Congress as Senate Bill No. 3 and House Bills Nos. 22 and 23, with broad Congressional support, and

WHEREAS: All major segments of the labor movement are now united in their support of these legislative proposals,

THEREFORE BE IT RESOLVED: That the UAW International Executive Board reaffirms its support of the Health Security Program and of legislative Bills S.3 and H. 22 and 23, and

BE IT FURTHER RESOLVED: That the UAW calls upon all segments of the Union to join in giving high priority to the development of support for this comprehensive Health Security Program, and

BE IT FURTHER RESOLVED: That UAW CAP Councils be requested to organize educational programs to enable workers' families and all other consumers to differentiate between those proposals which would make effective changes in the health care system and those which would not, and

BE IT FINALLY RESOLVED: That UAW CAP Councils be requested to undertake activities at the city and state levels to bring about passage by the appropriate legislative bodies of resolutions memorializing the Congress to act early and favorable on the Health Security legislative proposals.



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Please Reply To:

Suite 810
1101 17th Street, N. W.
Washington, D. C.
20036

March 5, 1971

Senator Edward Kennedy, Chairman
Senate Subcommittee on Health
U. S. Senate
Washington, D. C.

Dear Senator Kennedy:

The enclosed resolution on national health insurance was recently approved by the Board of Directors of the Federation of American Hospitals. This policy statement includes a number of provisions which are contained in several health insurance proposals now pending before the U. S. Congress.

A copy of the Federation resolution is also being sent to all members of the Senate Subcommittee on Health for their consideration and comments.

I would appreciate your making the Federation resolution a part of the Record of hearings before the Senate Subcommittee on Health on the Health crisis in the United States.

Sincerely,

Michael D. Bromberg
Michael D. Bromberg
Director, Washington Bureau

MDB:rt
Enclosure



FEDERATION OF AMERICAN HOSPITALS

Please Reply To:

Suite 810
1101 17th Street, N. W.
Washington, D. C.
20036

RESOLUTION ON NATIONAL HEALTH INSURANCE

Adopted by Board of Directors
FEDERATION OF AMERICAN HOSPITALS

February 18, 1971

We believe that all Americans should have access to quality health care and that incentives should be built into the program to reward efficiency and encourage the development of new delivery systems.

NOW THEREFORE BE IT RESOLVED that FAH support a program of National Health Insurance which recognizes the desirability of a pluralistic health care delivery system providing both patient and provider with freedom in selecting the method of delivering or receiving health care.

The National Health Insurance program should include the following elements:

1. Federal payment from general revenues for health insurance for the poor and in part of the near poor.
2. Federal payment from social security taxes for catastrophic insurance for all Americans.
3. Employer-employee payment for basic qualified health insurance plans approved by the Federal Government for all working Americans with a bonus provision (such as lower deductible or lower coinsurance) for those employer-employee plans which utilize the services of less costly health maintenance organizations. Minimum benefits would be set forth in Federal Legislation and Federal Regulations would be issued to define criteria for "qualified plans". Employers would absorb the major cost of purchasing a qualified plan and employees would select the qualified plan. Employers may purchase health insurance; provide health benefits directly; enter into prospective contracts with providers; enter into contracts for comprehensive pre-paid care plans; or a combination of the above or by other Federally-approved methods.
4. Continue Medicare, as now financed, for persons over 65, with an option for retired persons under age 65 to purchase Medicare benefits.
5. Incentives for the development of Health Maintenance Organizations, including experimentation with Federally-chartered health care corporations.

CLAUDE PEPPER
11TH DISTRICT, FLORIDA

CHAIRMAN
SELECT COMMITTEE
ON CRIME

COMMITTEE ON RULES
COMMITTEE ON INTERNAL
SECURITY

CAMERA COPY—PLEASE SHOOT
(Hold Page Numbers Thruout)

MRS. MILDRED WALLER
EXECUTIVE ASSISTANT

432 CANNON HOUSE OFFICE BUILDING
WASHINGTON, D.C. 20515

DISTRICT OFFICE:
ROOM 823 FEDERAL BUILDING
MIAMI, FLORIDA

**Congress of the United States
House of Representatives
Washington, D.C. 20515**

May 13, 1971

My dear Senator:

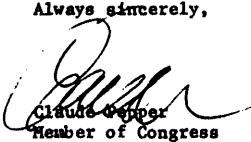
You will please find enclosed copy of a statement entitled "Health Care -- A System in Crisis," prepared by Mrs. Jeanne Levey, Chairman of the Board, National Parkinson Foundation, Inc., of Miami, Florida.

You will favor me by including this statement in the record of your committee's current hearings on the Health Care Crisis in America. Mrs. Levy expresses great admiration for your leadership on the Senate-side in our endeavor to provide for adequate health services and insurance for all Americans.

Warmest personal regards, and

Believe me,

Always sincerely,


Claude Pepper
Member of Congress

Senator Edward M. Kennedy
Chairman, Health Subcommittee
Labor and Public Welfare
Suite 426 Senate Office Building

cc: Mrs. Jeanne Levey
Chairman of the Board
National Parkinson Foundation, Inc.
1501 N.W. Ninth Avenue
Miami, Florida 33136

by Mrs. Jeanne Levey, Chairman of the Board,
National Parkinson Foundation, Inc; of Miami, Fla.

HEALTH CARE -- A SYSTEM IN CRISIS

For the great majority of Americans, the obstacles to obtaining adequate health care are enormous. Health care is scarce and expensive to begin with. It is dangerously fragmented and usually offered in an atmosphere of mystery and unaccountability. Except at a diminishing number of charitable facilities, health care is a commodity purchased at unregulated, steadily increasing prices in which people too rich for Medicaid, too poor for Blue Cross and too young for Medicare have no health insurance protection at all, while those with coverage find it partial and inadequate with little or no provision for visits to the doctor, as opposed to hospital stays. If laboratory tests or specialists are needed and the cost is more than they can afford, they wait for an illness to become serious enough to warrant hospitalization, preferring the risk of critical illness with insurance coverage to submitting to the humiliation of welfare assistance or going into debt.

With the widespread publicity of the TV series on hospitals and treatment, a new folklore of medicine has emerged, rivalling that of the old witch doctors. Medical technology seems as complex and mystifying as space technology. Physicians are presented as steely-nerved, omniscient, medical astronauts. The patient is usually sick-feeling, often undressed, a nameless observer in a process he can never hope to understand. He has been led to expect some small miracle in his own case, a magical new prescription drug or an operation which will cure everything.

Even when confronted with what seems to be irrational therapy, most patients feel helpless to question or complain. Everything about the medical

Page two

system seems calculated to maintain the child-like, dependent and de-personalized condition of the patient. He is given no means of judging what care he should get or evaluating what care he has received. He cannot participate in any way in treatment or care which may be a matter of life and death to him.

The public has always assumed that the function of the American health industry is to provide adequate health care to the American people. But the American medical industry has many items on its agenda other than service to the consumers. Analyzed in terms of all its functions, the medical industry emerges as a coherent, highly organized system. One particular function, patient care, may be getting slighted, and there may be some problems in other areas as well, but it remains a system and must be analyzed as such.

Its most obvious function, other than patient care, is profit making. When it comes to making money, the health industry is an extraordinarily well organized and efficient machine.

The most profitable small business around is the private practice of medicine. The most profitable big business is the manufacture and sale of drugs. Rivalling the drug industry is the expanding hospital supply and equipment industry with the fledgling nursing homes moving in for their piece of the action. Even the stolid insurance companies gross over ten billion dollars a year in health insurance premiums. In fact, the health business is so profitable, even the "non-profit" hospitals make profits, which are used to finance the expansion of medical empires. These non-profits buy real estate, stocks, plus new buildings and expensively salaried professional employees.

Next is the medical system's list of priorities in research. Although the vast federal appropriations for biomedical research are primarily motivated by the hope of improving health care, only a small fraction of the work leaks out to the general public as improved health care. But medical research has a function wholly independent of the delivery of health services, as an indispen-

Page three

sable part of the nation's giant research and development enterprise. The vast machinery for research and development in all areas -- physics, electronics, aerospace, as well as biomedical sciences, is financed largely by the government and carried out in universities and private industry.

The medical system is important to this growing research and development effort, because it is the place where research and development in general comes into contact with human material. Medical research is the link. The nation's major biomedical research institutes are affiliated to hospitals because they require human material to carry out their own, usually abstract, investigations. For instance: Investigations of the pulmonary disorders of patients in Harlem Hospital may provide insights for designing space suits or it may contribute to the technology of aerosol dissemination of nerve gas.

Human bodies are not all that the medical care system offers up to research and development. Who knows what ends are met by the routine neurological and drug research carried out on the nation's millions of mental hospital inmates?

Finally, an important function of the medical care system is the reproduction of its key personnel, physicians. The medical schools graduate each year just a few more doctors than are needed to replace the ones who retire, and far too few to keep up with the growth of population. A growing proportion of graduates go straight into academic government or industrial biomedical research, and never see a patient. The rest have been educated chiefly in academic medicine (a mixture of basic science and "interesting" pathology) and aren't trained to take care of patients. But this is not as irrational as it seems. The limited size of medical school classes has been maintained through the diligent and systematic efforts of the American Medical Association. Too many or even enough doctors would mean lower profits for those already in practice. And the research orientation of medical education

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simply reflects the medical schools' own consuming preoccupation with research.

Profits, research and teaching are independent functions of the medical system. But they do not go on along separate tracks removed from patient care. Patients are the indispensable ingredient of medical profit making, research and education.

Different groups of patients serve in different ways. The rich can afford luxury, so for them the medical system produces a luxury commodity, the most painstaking, super-technological treatment possible. The poor serve chiefly to subsidize medical research and education with their bodies. City and county hospitals and the wards and clinics of private hospitals provide free care for the poor, who in turn provide their bodies for young doctors to practice on and for researchers to experiment with.

The middle class patient has enough money to buy his way out of being used for research, but not enough for luxury care. He waits in crowded waiting rooms, receives brusque, impersonal attention from a doctor who is quicker to farm him out to a specialist than take the time to treat him himself, and is charged all the market will bear. Preventive care is out of the question. It is neither very profitable nor interesting to the modern science oriented M.D.

The crisis in health care can be traced directly to the fact that the patient care is not the only or even the primary aim of the medical care system. But what has turned the individual private nightmare into a great public health care crisis is that the other functions of the system are in trouble. Profit making, research and education are all increasingly suffering from financial shortage on the one hand and institutional inadequacies on the other. The solutions offered by the growing chorus of medical reformers are, in a large measure, survival measures, aimed at preserving and strengthening the medical

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system as it now operates as much as they are aimed at improving patient care.

What the health care consumer is up against now, what he will be up against even after the best-intentioned reform measures, is a system in which health care is itself only a by-product, secondary to the priorities of profits, research and training. The danger is that when all the current reforms are said and done, the system as a whole will be tighter, more efficient and harder to crack, while health services will be no less chaotic and inadequate.

There will be great changes in methods and categories eligible for financing once the National Health Insurance bill passes. Regardless of amendments, which most likely will liberalize benefits, Blue Cross will play the major role in administrating and funding the program and must have contingency proposals set up. It is very likely preventive medical measures will receive at least partial benefits -- outpatient treatment, nursing, custodial care centers and organized home care unquestionably will come into this category.

The proper study of the American health system is no longer medicine but medical institutions. Based in local networks of hospitals and medical schools, backed up by a highly technological health commodities industry, represented nationally by the American Hospital Association, Blue Cross and the American Association of Medical Schools, the heart of the new system is no longer the private practitioner, but the local, medical-school-centered, medical enterprise.

Medical care has become vastly more specialized and dependent on technology. With the expanding technology of patient care, doctors find that more and more of their private patients require the personnel and equipment resources of a hospital. While technology made hospitals important to doctors, the growth of health insurance plans made hospitals independently viable insti-

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tutions with doctors more dependent on them than ever before.

The only place you can do research is in a large university-based medical school center. That's where the Grants are, the equipment, and the colleagues who make research fun and productive. A whole new breed of doctors, spawned by the hospitals and medical schools, is growing up with no other home than the large teaching hospital and its labs.

But, just as doctors had become dependent on hospitals, individual hospitals were becoming dependent on the medical schools and major teaching hospitals. Community hospitals found they couldn't attract the best young interns and residents, or older private doctors, unless they had some sort of an affiliation with a medical school or major teaching hospital. To attract top professors, top physicians and top researchers requires having something to offer them -- spacious facilities, the latest equipment and plenty of patients to use as research and teaching material. In every major city, these medical enterprises are growing, sweeping up hospitals, health centers, doctors and patients, gaining control over local health resources and leading inevitably to a controlling voice in the politics of local and national health policy. Wherever local decisions about hospital planning and financing are made, as on the boards of directors of Blue Cross and hospital planning agencies, their representatives can be found, in City Hall or Washington, serving as consultants, as members of official commissions, or even as public officials themselves, outnumbering and outweighing the representatives of small, independent hospitals and county medical societies.

Blue Cross and other hospital financing agencies find these enterprises attractive on economic grounds. Blue Cross, acting alone or through local quasi-official hospital planning agencies, has encouraged the centralization of medical technological resources in a few major institutions, leaving smaller institutions to affiliate with the larger, or be left outside the

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mainstream of medical technology.

The heavy equipment manufacturers, the companies which make and build hospital computers, hyperbaric chambers, defibrillators and the like, represent a new outside force which takes a kind view of the growth of medical empires. Solo doctors and small community hospitals do not buy seventy thousand dollar cobalt units, or even thirty thousand dollar scintillation counters. Major medical centers are the only market for many of the products of the fast-growing hospital equipment industry.

When the government, with Medicaid and Medicare, underwrote the health costs of millions of former charity patients, providing the financial fuel for the expanding medical enterprises, prominent deans of medical schools, directors of major teaching hospitals, et cetera, began to play a larger role at congressional hearings, on presidential commissions and in the politics of Health, Education and Welfare. A new national health establishment was emerging representing institutionalized medicine; the American Hospital Association, National Blue Cross and the American Association of Medical Colleges, and they were beginning to exert their weight. The American Medical Association was no longer the dominant organization in health politics.

The American Medical Association, conceding the growing dependence of its members on hospitals, is throwing its energies into a battle with the American Hospital Association -- demanding greater power for physicians within the hospitals, but the percentage of physicians who are A.M.A. members is dropping, and the American Medical Association's public credibility has dropped even faster. There is no going back for the American health system. The age of the guild-dominated, individual medical craftsman is over.

Blue Cross is the central mechanism for financing hospital care in America. The entire structure of the hospital system -- its finances, manpower policies and often even its medical policies -- rests upon Blue Cross as

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a base. Blue Cross insures the hospitals they will have a reasonably stable income. It insures the hospital supply companies and drug companies of a stable market. It insures the urban medical schools and their affiliated hospitals that their research and training priorities will not be challenged by their sources of financing.

There are 75 Blue Cross plans in the United States. Each plan is independent, providing hospitalization insurance in a certain geographical area, usually a state or city. The Blues are non-profit, tax exempt organizations. They are usually set up under special state legislation which exempts them from certain provisions of the state insurance laws but which subjects them to regulation by a state agency, often the state insurance department. The plans are linked by the National Blue Cross Association, which represents them in national affairs, provides services in marketing research, professional and public relations, and operates an interplan bank which provides coverage for Blue Cross subscribers using hospital benefits outside the area of their own plan. Together, the Blue Cross plans provide hospitalization insurance for sixty-eight million Americans, as well as insurance supplementary to Medicare for another six million people over age sixty-five. Almost seven billion dollars a year passes through Blue Cross. (Blue Cross pays only hospital bills; doctors' bills, even in the hospital, are covered separately by its companion organization, Blue Shield).

Blue Cross Trustees sit on business, university and hospital boards. Its officers sit on local, state and federal councils on health issues. Blue Cross has the position and power to play a major role in coordinating the health interests of these various sectors. In this role, it acts as the collective representative of the long-term interests of the hospitals.

The plans also provide most of the machinery for operating the Medicare and Medicaid programs. The government pays the bill for medical

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services offered under both, but it does not ordinarily pay the hospitals directly. It funds the intermediary, usually Blue Cross, which in turn pays the hospital. The exact rate of pay is negotiated between the hospitals and the intermediary. This puts Blue Cross in a key position to determine how the Federal Programs are run. More than ninety percent of the hospitals' Medicare bills are paid through Blue Cross. In eighteen states, Blue Cross is also the intermediary through which Medicaid bills are paid. Federal programs account for almost half of the Blue Cross operations.

The Blue Cross benefit structure has helped promote overly high medical care costs for consumers. Benefits apply essentially only to in-patient care. They don't cover use of out-patient departments or doctors' offices, nursing homes, chronic care homes, organized home care, et cetera, so patients have a "dis-incentive" to use these types of care. Twenty percent of the patients now in general hospitals could be treated just as well in these other ways, at great financial saving to the patient.

Blue Cross fails to control hospital costs for its subscribers simply because Blue Cross is controlled by the hospital establishment. The hospitals created it during the depression to ensure their bills would be paid. The trademark, "Blue Cross" is itself owned by the American Hospital Association. The influence of the hospitals in Blue Cross can be seen in the way the plans are controlled. The typical plan provides for a Board of Trustees on which doctors hold one-third of the seats, hospital administrators and trustees another third, and lay representatives the final third. In some plans, the local medical society and the hospital association choose their trustees, and those trustees, in turn, choose the public representatives. Public representatives on Blue Cross Boards are not only usually a minority, but they're chosen by the hospital medical establishment. The result is that when hospitals negotiate their reimbursement contracts with Blue Cross, they are essentially

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negotiating with themselves.

Another source of the hospitals' control over Blue Cross is their contracts with it. A Blue Cross contract with a hospital specifies that it will pay the hospital a certain allowable cost for each day of hospital service used by a Blue Cross subscriber. The allowable cost is less than the total cost of the hospital for providing service. Such items as research, overhead, educational costs for a residency or intern program, or for a hospital school of nursing, and the cost of providing service for patients who fail to pay their bills are not included in the bill to Blue Cross, although part of these costs would be included in the bill of a person paying his hospital bill himself or with the aid of a commercial insurance policy. In giving Blue Cross this special rate, hospitals are assured of a stable income from the many patients who might otherwise fail to pay their bills. It also gives the hospitals an effective clout over Blue Cross -- they can withdraw the preferential rate and demand Blue Cross pay them their full charges. If any substantial number of hospitals in a given area did this, Blue Cross would either have to pay full charges or default on paying full benefits for patients in those hospitals. Either course would destroy Blue Cross' competitive position with respect to the commercial health insurance companies.

The alliance of Blue Cross and the hospitals was illustrated at the hearings held by the New York State Insurance Superintendent on August 4, 1969. In opposition to the Blue Cross proposal for an increase in rates was every group that could be construed as representing consumers, voluntary community service groups and the New York City Department of Consumer Affairs and Department of Health. Speaking in support of Blue Cross were only the hospital administrators and Blue Cross itself.

If Blue Cross fails to represent the public with respect to the

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hospitals, the public agencies which regulate Blue Cross don't help much either. Closeness between Blue Cross and the public officials who supposedly regulate it, encouraged by the possibility of a prestigious Blue Cross position as a reward later on, is said to be common. For example, critics allege that Thomas Thacher, New York State Superintendent of Insurance from 1959 to 1963 was extraordinarily sympathetic to some of Blue Cross' legally more questionable demands and practices. Thacher now sits on the Board of New York Blue Cross.

Periodic gusts of public dissatisfaction have not slowed the impressive growth of Blue Cross. Like other non-profit institutions such as universities and medical schools, Blue Cross is forever seeking to expand its operations. It behaves like a hungry corporation, the difference being that its profits are all plowed back into the business.

Blue Cross has its sights set on controlling any future expansion of Medicare or a national health insurance plan. President Nixon's appointment of Walter McNeerney, President of the Blue Cross Association as Head of the "Task Force on Medicaid and Related Programs" was read by many as auguring a proposal featuring Blue Cross management of Medicaid.

The task force was also charged with making proposals for a national health insurance system. According to Health, Education and Welfare officials, the plan that is likely to emerge would use Federal money along with payroll taxes on employers and employees to buy insurance from private companies. Blue Cross, with its favored position in the hospitals, would have the inside track and a good prospect of monopolizing the business.

Senator KENNEDY. The subcommittee will stand in recess.
(Whereupon, at 12 o'clock noon, the subcommittee recessed subject to call of the Chair.)

