FOUR YEARS OF THE EMIC PROGRAM*

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Four years ago Congress made the first appropriation for "medical, nursing, and hospital maternity and infant care for wives and infants of enlisted men in the armed forces of the United States of the fourth, fifth, sixth, or seventh grades." The following month, April 1943, plans for the operation of the Emergency Maternity and Infant Care (EMIC) program were approved by the Children's Bureau for 13 States, and within a year all 48 States, the District of Columbia, Alaska, Hawaii, and Puerto Rico were operating programs under approved plans.

Before the EMIC program went into effect, Washington was the first State to set up a program for the care of wives of servicemen. This was done in 1941 as a small project under the Maternal and Child Health program of the State Department of Health. Other States followed with similar projects, but these were necessarily limited in scope because of the insufficiency of Federal and State funds available under Title V, Part 1, of the Social Security Act. It was not until Congress, in 1943, began to make special appropriations for grants to States† for emergency maternity and infant care that it became possible for all States to set up State-wide programs providing for all necessary maternity and infant care for wives and infants of servicemen in the four lowest pay grades.

The primary purpose of the EMIC program was to raise the morale of enlisted men by relieving them of concern over the uncertainty of the availability of maternity care for their wives and medical and hospital care for their infants, and of anxiety as to how the cost of this care would be met. Under this program, enlisted men who are in one of the four lowest pay grades know that their wives are entitled to complete maternity care and also that their babies up to one year of age are entitled to all necessary medical, hospital, and nursing care. Furthermore, both maternity and infant care are given without a means test and

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†"States" as used in this paper includes the 48 States, the District of Columbia, Alaska, Hawaii, and Puerto Rico.

irrespective of race, creed, or place of residence. The service is available after the serviceman is discharged if the pregnancy occurred before his discharge.

To date nearly 1,200,000 wives and their newborn infants have been beneficiaries of this wartime maternity service and over 200,000 infants have had additional care during the first year of life. Starting in a very small way to meet an urgent local need near a military establishment, the EMIC program ultimately became the largest single public maternity care measure so far undertaken in this country. Without the cooperation of the thousands of individual physicians who gave their time and interest generously and unfailingly this wartime civilian program would not have met with the success it has. To these physicians, to the hospitals, nurses, social workers, and laboratory workers, and to the personnel of the State and local health agencies who have organized the work, handled the records, and are keeping the accounts goes the Nation's gratitude. The Surgeons General of the Army and Navy testified in 1944 that the morale in the armed forces had been raised by the knowledge of the benefits of this program, especially in those cases —which are a great majority—where the family income had been materially lowered by induction into the armed forces.

Administration of the program

The EMIC program has been administered from the beginning within the framework of Title V, Part 1, of the Social Security Act, and operated with special funds made available by Congress to the Children's Bureau for grants to the State health agencies. The program in each State is operated by the State health agency under State plans approved by the Chief of the Children's Bureau in accordance with general policies established by the Children's Bureau. Such national policies were necessary for this wartime program to assure as great a degree of uniformity in the availability of good care for the wives and infants of servicemen as was feasible under the conditions in the various States and communities in which they were living.

Participation by physicians and hospitals

The wife of an eligible enlisted man may apply for maternity care for herself or for medical care for her infant using any physician or hospital of her choice, provided that the physician and hospital have agreed to participate in the program and have met the standards set by the State health agency. During the fiscal year 1945 (July 1, 1944, to

June 30, 1945) over 48,000 physicians were authorized to give care under EMIC, representing at least one-half of all civilian physicians in active practice in the United States during that time.* In almost two-thirds of the States there was more than 50 per cent participation by physicians. In addition, approximately 2,500 osteopaths participated in the program in those states where osteopaths were allowed to provide obstetric care under EMIC. The figures quoted are exclusive of Army and Navy physicians who gave medical care under the program. The number of cases cared for by individual physicians has varied greatly from a very few to as many as 300 a year. During the fiscal year 1945 approximately 17.5 million dollars were paid for medical care. In the same year, over 5,000 hospitals, or nine-tenths of all registered hospitals (exclusive of nervous and mental, and tuberculosis hospitals), were authorized to give care to EMIC patients. In only 11 States did fewer than 75 per cent of the hospitals participate under EMIC. There were also some 450 maternity homes which were authorized to give care under the program. During the fiscal year 1945 almost 21 million dollars were paid for hospital care.

Method of payment

Under the program, payment for services is made by the State health agency directly to hospitals, physicians, nurses, or others rendering services under the program. No cash payment is made to the recipient of service. This policy is in accord with the intent of Congress to provide care rather than cash allowances, and is the only way whereby there can be assurance that all necessary care will be provided and paid for, especially in cases where unusually serious or prolonged illness leads to costs which are often prohibitive to the average person. There have been a number of cases where doctor and hospital bills paid by the State health agencies have amounted to more than $1,000. Moreover, physicians and hospitals accepting patients under the program must agree to accept payment from the State health agency as full reimbursement for services rendered without making any supplementary charge to the patient. This policy has been adopted in furtherance of the purpose of the program, namely, to provide maternity and infant care to the wives and infants of servicemen in the four lowest pay grades at public expense and to relieve servicemen of worry over the cost of the care.

* There were during this period approximately 65,000 physicians enrolled in the armed forces of the United States and approximately 95,000 in active civilian practice.

Payments to physicians for maternity care are usually made on the basis of complete care during pregnancy, labor, and in the postpartum period; in other words, on a "case" basis. The maximum rate of $50 for such maternity care, when given by a general practitioner, is now in effect in all States. In a few States where more than 80 per cent of cases are given complete care, this rate is paid for all cases. In other States, deductions are made when care is incomplete. Additional payments may be made for medical care of intercurrent non-obstetric conditions. State agencies may establish differential rates of payment for general practitioners and for specialists. Special rates of payment on a fee-for-service basis are provided for consultants. Payment for medical care of sick infants is also made on a case basis, the amount of payment varying with the number of weeks the infant is under care and on the need for consultation. At the option of the State agency a procedure may be adopted that provides additional payments in unusual cases that require an exceptional amount of care by the physician.

Hospital care is purchased on a cost per patient-day basis at inclusive rates based on operating expenditures in each hospital. Reimbursable per diem costs are calculated from annual cost-accounting reports submitted by participating hospitals to the State health agency. Some States have set up maximum per diem rates for the purchase of hospital care covering the majority of hospitals in the State. The proportion of hospitals showing costs above such maximum rates is small.

Standards of care and scope of services provided

The EMIC program is intended to provide complete medical, nursing, and hospital care in so far as it is or can be made available in the community where the family lives. State plans include the provision of medical and surgical services for complete maternity care and for intercurrent conditions not attributable to pregnancy. Medical and surgical services are provided to sick infants, and immunization against smallpox, diphtheria, and whooping-cough, is made available either through private physicians or through well-child conferences held under the auspices of the State or local health agencies. Some States provide for health supervision of infants in well-child conferences or in offices of private physicians. Consultation services are provided as necessary and available. Hospital care, in so far as available, is provided for both maternity patients and for infants as often and for as long a period as necessary. Bedside nursing care is purchased for maternity and infant

patients when necessary. Other miscellaneous services, such as blood for transfusions and ambulance service, are also provided as necessary and available. Public health nursing services are provided wherever available by State and local health agencies, and the cost of this type of service may be supplemented from EMIC funds if other funds are not adequate.

Some State and local health agencies make available medical-social personnel to give advice and assistance in the social problems that arise among women receiving care under the program. Many of the mothers are young and inexperienced, awaiting their first babies away from home and family, often with the husband overseas, and sometimes in financial difficulties. Medical-social services make it possible for these women to take advantage of the resources available in the community, such as public and private welfare agencies, Army and Navy relief societies, and the American Red Cross.

Expectant mothers are encouraged to apply for care early in pregnancy, and since the EMIC program makes complete maternity care available at no cost to them, there is no financial handicap to deter them. Similarly, in families of restricted means, there is no longer the temptation to defer medical care for sick infants until the illness has progressed to a dangerous stage. Preventive pediatrics for infants eligible under the program is encouraged.

The quality of medical care for both mother and infant has been improved by the use of consultation services of specialists, special nursing services, X-ray and laboratory services, blood for transfusions, ambulance services, and by the provision of hospital care. Financial considerations do not prevent the use of whatever medical or related service the physician finds necessary. Although the rates of payment are fixed in the State plans for each kind of service, there is no limitation placed on the amount or variety of service to be provided, or upon the total amount paid for all kinds of services.

The Children's Bureau at the beginning of the program set up minimum requirements for hospitals participating in the EMIC program. State health agencies have established their own standards at or above this level and are responsible for inspection of the hospitals. This was of special importance during the war period because of overcrowding and understaffing of hospitals. Some hospitals had to make basic physical improvements before being accepted for participation in the program; for example, separate facilities for the care of obstetrical

patients, running water in the delivery-room, screening, etc. The rate of payment to hospitals is such that two-bed or even single room accommodations may be provided for patients when this is indicated for medical reasons, although the same per diem payment is made to the hospital whether the patient is hospitalized in multiple- or single-bed accommodations.

For the population as a whole, in 1944, 93 per cent of the births had a physician in attendance, whereas practically all the women delivered under the EMIC program were attended by a physician at delivery with only a fraction of one per cent delivered by midwives or others.

During the period from January, 1944, through June, 1946, 92 per cent of the maternity patients delivered under EMIC were delivered in hospitals. Chart I gives a comparison of the proportion of births in hospitals and at home for total births in the United States in 1944 (the latest year for which census figures are available at this time) and for births under the EMIC program in the same year. During this calendar year, 91 per cent of the EMIC maternity cases were delivered in hospitals, compared with 76 per cent hospital births in the total population. The proportion of hospital deliveries among EMIC beneficiaries varied among the States from 66 to 100 per cent, with almost three-fourths of the States showing over 90 per cent hospital deliveries under EMIC, and only six states having less than 76 per cent (the national average for all hospital births) hospital deliveries under EMIC. In some states, the proportion of hospital births under the EMIC program has been more than double that for all births in these states. In Mississippi we have a striking example of the effect of the program in raising the number of hospital deliveries; in 1944 in that State approximately 30 per cent of the total births took place in hospitals, and almost 70 per cent at home. Under the EMIC program the situation was reversed, with more than 70 per cent of the EMIC beneficiaries delivered in hospitals, and less than 30 per cent delivered at home.

Extent of the program

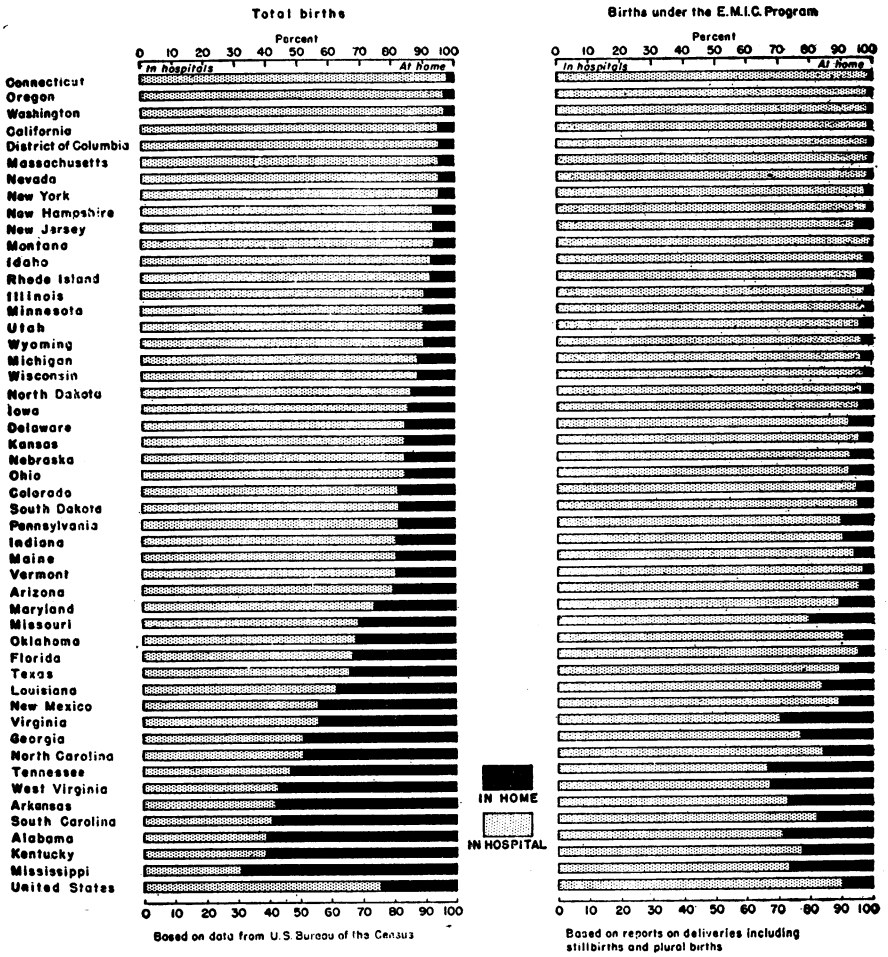
Appropriations by Congress: As State after State began operations during the spring of 1943, the program grew rapidly to large proportions. The first appropriation of $1,200,000 for the last 3 months of the fiscal year 1943 was soon exhausted, and during the next fiscal year appropriations amounting to $29,700,000 were made. For the fiscal year 1945, $45,000,000 were appropriated. Appropriations in subsequent years brought the total from the beginning of the program

CHART I

PROPORTION OF BIRTHS IN HOSPITALS AND AT HOME

TOTAL BIRTHS AND BIRTHS UNDER THE EMERGENCY MATERNITY AND INFANT CARE PROGRAM

By State — 1944



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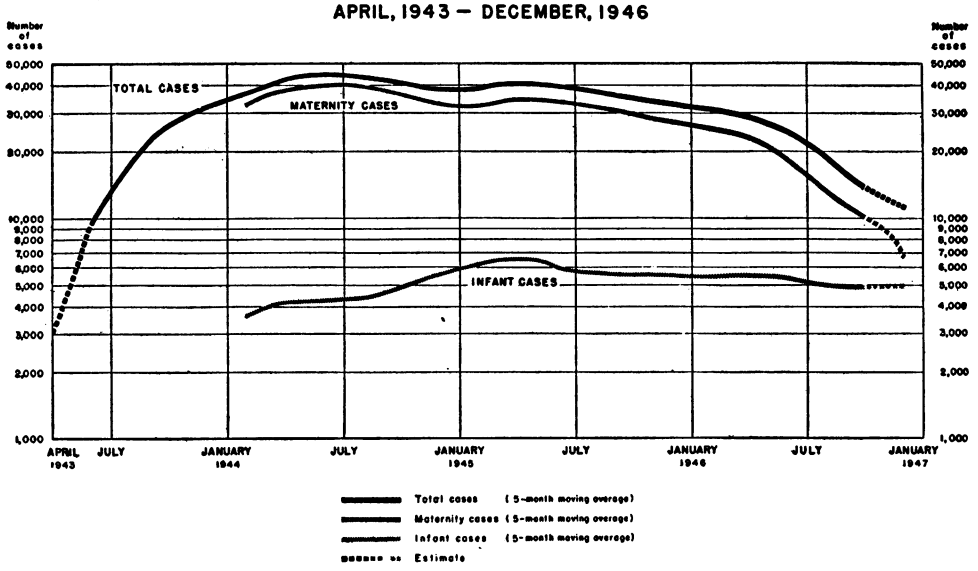
through the end of June, 1947, to over $130,000,000. Almost all of this money has been allotted to the States for medical, nursing, and hospital care. Since July 1, 1944, about $2,500,000, or approximately 2.5 per cent, of the appropriations since that date, have been allotted to

the States for the administration of the program. Preliminary investigations into the cost of administering the EMIC program indicate that the actual cost of administration is considerably higher. During the war period, however, when shortage of personnel was a serious problem, and when the magnitude and emergency nature of the EMIC program overshadowed the regular social security maternal and child-health programs, much of the administrative work pertaining to the EMIC program was taken over by maternal and child-health personnel working under the regular program.

Number of cases authorized for care: The trend in the number of cases authorized under EMIC is shown in Chart II. The program reached its peak around the middle of 1944; in June of that year almost 47,000 maternity and infant cases were authorized for care. During 1944 and the first six months of 1945, over 40,000 cases on the average were accepted each month. Since that time, the number of new cases has been declining, at first gradually, and recently more markedly. The decrease in cases authorized did not keep pace with the rapid demobilization of

CHART II

EMERGENCY MATERNITY AND INFANT CARE
TREND IN NUMBER OF CASES AUTHORIZED
APRIL, 1943 – DECEMBER, 1946



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Based on data from monthly reports from State Health Agencies

the armed services after V-E day and V-J day, since eligibility of both the wife and infant for care continues after the serviceman's discharge from the armed forces if his wife became pregnant before her husband's discharge. During the last few months of 1946, the number of cases being authorized per month dropped to between 10,000 and 15,000 cases. At the present time new cases are still being accepted for care; the date of the termination of the program will be fixed by Congress.

TABLE 1

DISTRIBUTION OF CASES BY STATES

Number of maternity and infant cases authorized from the time of approval of the State plan through November 30, 1946, by states (preliminary).

State	*No. of cases*	*State*	*No. of cases*
Total	1,353,311	Montana	6,864
Alabama	20,446	Nebraska	17,413
Alaska	654	Nevada	2,566
Arizona	8,980	New Hampshire	4,808
Arkansas	20,469	New Jersey	33,866
California	100,918	New Mexico	9,700
Colorado	15,493	New York	128,609
Connecticut	16,614	North Carolina	40,289
Delaware	3,219	North Dakota	4,695
District of Columbia	12,072	Ohio	58,502
Florida	25,333	Oklahoma	29,380
Georgia	22,647	Oregon	13,508
Hawaii	2,774	Pennsylvania	78,607
Idaho	7,268	Puerto Rico	6,203
Illinois	69,391	Rhode Island	7,055
Indiana	40,261	South Carolina	21,435
Iowa	25,069	South Dakota	7,117
Kansas	27,553	Tennessee	18,594
Kentucky	26,281	Texas	69,300
Louisiana	22,331	Utah	11,701
Maine	8,337	Vermont	5,431
Maryland	18,709	Virginia	27,786
Massachusetts	40,023	Washington	28,050
Michigan	49,479	West Virginia	18,737
Minnesota	28,124	Wisconsin	26,181
Mississippi	22,333	Wyoming	2,867
Missouri	39,269		

From April, 1943, through November, 1946, more than 1,350,000 cases were authorized for care under EMIC (table 1). About 85 per cent were maternity cases and 15 per cent were infant cases. The pro-

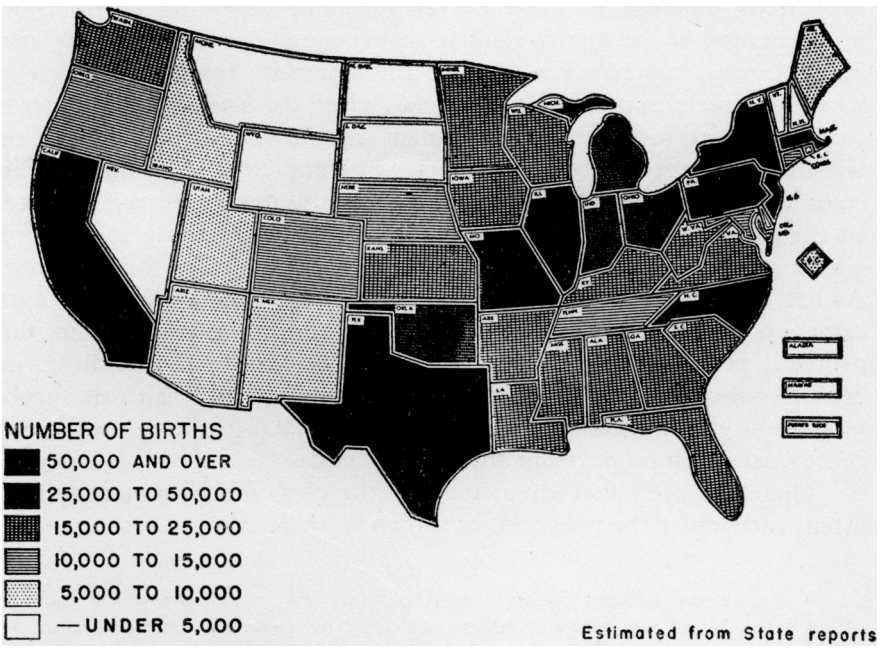
portion of infant cases, however, has been increasing steadily. In the period January-June, 1944, the number of infant cases authorized represented 10 per cent of the total cases authorized; a year later, in the period January-June, 1945, infant cases were over 15 per cent of the total cases authorized, and in the same period of 1946 the percentage of infant cases authorized had risen to almost 20 per cent. By the last half of 1946, infant cases represented over 30 per cent of the total cases authorized.

There are a number of factors influencing the increase in the proportion of infant cases. In the earlier period it was not generally understood that the benefits of the program were available for infants as well as mothers. As this knowledge spread the number of infant applications increased. The introduction of programs of health supervision and office medical care of infants toward the end of 1944 accounted for a further increase in the number of infants receiving care under the program. More recently the increase in the proportion of infants can be explained by the fact that eligibility of a mother or infant for care depends upon whether the husband was in the armed services and in one of the eligible pay grades at any time during the wife's pregnancy or during the infant's first year of life. Since infants remain eligible for care for a longer period than wives after the serviceman's discharge, proportionately more infants are eligible for care as the size of the armed forces decreases. In this connection it is interesting to note that the decrease in total cases authorized has been due almost entirely to the falling off in the number of maternity cases; the average number of infant cases accepted monthly decreased very gradually from about 6,500 in the spring of 1945 to approximately 5,000 at the end of 1946.

By November, 1946, it was estimated that 1,000,000 babies had been born under the EMIC program. Chart III shows the distribution of the million EMIC births by States, classified according to the number of EMIC births in each State. Almost one-third of the births occurred in the five States of New York, California, Pennsylvania, Texas, and Illinois, each of which had 50,000 or more EMIC births in this period. More than one-half the EMIC births took place in the 23 states each of which had between 15,000 and 50,000 births. The remaining 24 states, with less than 15,000 births each, accounted for about one-seventh of the total EMIC births. The distribution of EMIC births was influenced not only by the population and birth rates in the respective states, but also by the location of military camps.

CHART III

DISTRIBUTION OF 1,000,000 BIRTHS UNDER THE EMERGENCY MATERNITY AND INFANT CARE PROGRAM FROM ITS BEGINNING TO NOVEMBER, 1946



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Cost of care under the program

Data on EMIC costs and services represent care purchased from EMIC funds and do not include care which was provided to EMIC beneficiaries through community health departments, Army and Navy physicians, hospital clinics, nursing agencies, and other community resources, for which no payments were made from EMIC funds.

From January 1, 1944, through June 30, 1946, approximately 940,000 cases, of which nine-tenths were maternity cases, were completed with payment under the EMIC program. There is an upward trend in the proportion of infant cases completed, from 5 per cent in the first quarter of 1944 to 15 per cent in the second quarter of 1946, similar to the trend shown in the proportion of infant cases authorized,

but with a lag due to the fact that most cases are not completed until 7 to 10 months after care has been authorized.

During the second quarter of 1946, the average cost of completed maternity cases under EMIC was running somewhat over $100, and the average cost of completed infant cases was almost $61. The limitations inherent in these averages should be borne in mind in interpretation of the figures relative to the actual cost of maternity and infant care in general. The average for maternity costs includes cases where complete maternity care was not given as, for example, when a woman applied for care late in pregnancy, or moved out of the State, or withdrew her application before care was completed. In some of these cases, the total cost included only a part of the maximum medical fee. In the case of infant costs, the figures apply only to those infants for whom separate applications for care were made under the program. As has been pointed out, a comparatively small proportion of infants came under the program for care in addition to that given in the neonatal period as part of the maternity care, presumably those, in general, whose illness led to more than nominal costs. Health supervision and immunizations were often furnished through well-child conferences with no payment from EMIC funds.

There has been a steady increase in the cost of both maternity and infant care under the program, as shown in table 2.

TABLE 2

COST OF MATERNITY AND INFANT CARE PER CASE

Average cost of maternity and infant cases completed under the EMIC program, January 1, 1944—June 30, 1946, by quarters. (In dollars.)

Quarter ending	*Maternity care*	*Infant care*
March 31, 1944	77.00	39.50
June 30, 1944	81.00	39.10
September 30, 1944	84.90	48.10
December 31, 1944	86.90	51.40
March 31, 1945	90.40	53.90
June 30, 1945	91.20	57.30
September 30, 1945	90.60	59.80
December 31, 1945	92.70	60.90
March 31, 1946	97.00	60.00
June 30, 1946	100.40	60.70

The increases in cost under the program reflect the influence of a variety of factors, such as: rise in per diem hospital costs, increased length of hospitalization, increases in fee schedules, introduction of differential rates of payments for specialists, introduction of extra payments for non-

obstetric intercurrent conditions and exceptional cases, earlier application for care, and the increase in the proportion of cases for whom various types of services were purchased.

Although the average number of days of hospitalization for maternity cases completed in the period January 1, 1944—June 30, 1946, remained fairly constant at about 9½ days, infant cases showed an increase from about 13 days of hospitalization at the beginning of the period to almost 16½ days in the second quarter of 1946. Average per diem payments to hospitals in the second quarter of 1946 for both maternity and infant cases were approximately one-fifth above such payments in the first quarter of 1944 (see table 3). The rise in the per diem payments for hospital care resulted in the first instance from the increasing number of hospitals presenting cost statements as a basis for payment, in contrast to the many hospitals that were paid a flat per diem rate established by the State agency in the early stages of the program. Even after most hospitals were being paid on the basis of actual costs, per diem payments continued to rise due to the continuing increase in the operating costs of hospitals as reflected in their succeeding cost statements.

TABLE 3

COST OF HOSPITAL CARE

Average per diem payments to hospitals for maternity and infant cases completed under EMIC January 1, 1944—June 30, 1946, by quarters. (In dollars.)

Quarter ending	*Maternity cases*	*Infant cases*
March 31, 1944	5.40	5.00
June 30, 1944	5.60	4.80
September 30, 1944	5.80	4.90
December 31, 1944	5.70	5.40
March 31, 1945	5.80	5.30
June 30, 1945	6.00	5.20
September 30, 1945	6.00	5.40
December 31, 1945	6.20	5.60
March 31, 1946	6.30	5.90
June 30, 1946	6.60	5.90

Of the total cost of maternity care for cases completed under EMIC during this period, 53 per cent represents payments for hospital care, 45 per cent represents payments for physicians' services, and 2 per cent for other special services (consultation services, bedside nursing care, care in clinics, blood for transfusions, ambulance service, and drugs).

The distribution of the cost of infant cases shows that 66 per cent of the cost represents hospital care, 27 per cent represents payments to physicians, and 7 per cent represents the cost of other special services (consultation services, bedside nursing care, care in clinics, immunizations, blood for transfusions, ambulance service, and drugs). There was a steady increase in special services during this period, notably consultation services and immunizations. The proportion of the total maternity cost that represents the cost of special services doubled from the first quarter in 1944 (1.3 per cent) to the second quarter of 1946 (2.8 per cent); the increase in the proportionate cost of special services to infants was still greater—from 3.0 per cent in the first quarter of 1944 to 7.5 per cent in the second quarter of 1946.

The proportion of women and infants who received various types of services purchased under the program is shown for the fiscal year 1946 in table 4.

TABLE 4

TYPE OF CARE PURCHASED

Proportion of maternity and infant cases completed July 1, 1945—June 30, 1946, for whom specified types of care were purchased under EMIC. (In per cent.*)

Type of care purchased	*Maternity care*	*Infant care*
Both physicians' services and hospital care	79.0	36.8
Physicians' services without hospital care	13.8	45.5
Hospital care without physicians' services	7.0†	6.8
Consultation service	3.4	5.9
Bedside nursing	1.6	1.0
Care in clinics	1.1	2.6
Immunizations and health supervision	—	19.4

* The percentages in each column add up to more than 100 per cent because some cases received more than one type of care. There is no duplication in cases receiving physicians' services, hospital care, or both, but cases reported in the other categories may also be included under the first three types of care.

† In military hospitals largely, where there was no charge for physicians' services.

Conclusion

The EMIC program has turned out to be the largest single public maternity care measure so far undertaken in this country. At the height of the program, it is estimated that approximately one out of every seven births was an EMIC birth.

The success of the program has been due in very large part to the cooperation of private practitioners, hospitals, nurses, social workers, and laboratories who have provided untiringly the individual care to these young and often disturbed and unhappy wives of men who were overseas. To them go the thanks of the Nation which made the service

possible. To provide care for the 1,400,000 wives and infants of servicemen all over the country involved the cooperation of the staffs of State and local health agencies, voluntary agencies, and thousands of participating physicians and hospitals, in the face of many wartime and postwar difficulties, such as shortages of health agency personnel, physicians, nurses, and hospital space. Because of the program, there has been no residue of unpaid maternity bills facing servicemen returning to civilian life from World War II as there was after World War I. Physicians have been paid for their services and though in some areas of the country fees have been less than is customary in private practice, in other areas the rates have been better than the prewar average. Doctors have not had to write off some of their accounts as "bad bills." Hospitals have been paid on a cost basis, and they too have no "bad bills."

The benefits of the program extend beyond the direct services furnished to its beneficiaries. Thousands of other mothers and infants benefited indirectly through the improvement of hospital facilities and through the educational value of learning from EMIC patients what is involved in good medical care for the mother throughout pregnancy, at delivery, and after the baby's birth, and what is involved in good medical care and health supervision for an infant. In addition, much has been learned from the operation of this emergency program that will be of value to any agency planning and administering a program of medical care in the future.

As experience under the program is analyzed, it will be possible to evaluate its effect in other ways, including maternal, neonatal, and infant mortality rates, still-birth ratios, and prematurity. In the meantime, it can be said that the primary purpose of the program has been fulfilled —that the provision of maternity and infant care to wives and infants of servicemen as a right that was theirs without question of financial status, place of residence, race, or creed, gave them greater confidence in the security of their families, and was one of the benefits most deeply appreciated by enlisted men and their wives.