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PUBLICATIONS
OF THE
NATIONAL BUREAU OF ECONOMIC RESEARCH, INCORPORATED

NUMBER

20

THE PURCHASE OF MEDICAL CARE
THROUGH FIXED PERIODIC PAYMENT

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THE PURCHASE OF
Medical Care
THROUGH FIXED PERIODIC PAYMENT

by

PIERCE WILLIAMS

of the staff of the

NATIONAL BUREAU OF ECONOMIC RESEARCH
INCORPORATED

assisted by

ISABEL C. CHAMBERLAIN

New York

NATIONAL BUREAU OF ECONOMIC RESEARCH, INC.

1932

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FIRST PRINTING, JUNE, 1932

X : 958(L) of 6.73. N3
61759 G2

PRINTED IN THE UNITED STATES OF AMERICA
BY J. J. LITTLE & IVES COMPANY, NEW YORK

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Resolution Adopted Oct. 25, 1926.

PREFACE

THE Committee on the Costs of Medical Care was organized in 1927 by a group of leading physicians, public health specialists and economists, in order to study a problem which, according to Secretary Olin West of the American Medical Association, is the great outstanding question before the medical profession today. This is "the delivery of adequate scientific medical service to all the people, rich and poor, at a cost which can be reasonably met by them in their respective stations in life." The primary purpose of the Committee is to formulate a comprehensive series of studies on the economic aspects of medical service, and to execute these studies with the aid of various interested research organizations.¹

In the autumn of 1929 the Committee invited the National Bureau of Economic Research to make a survey of the extent to which the people of the United States make use of the principle of insurance in order to secure medical and hospital care.

The emphasis placed by the Committee on medical and hospital care "in kind" explains why accident and health insurance receives only minor consideration in this investigation. The standard "benefit" under individual and group health insurance policies issued by commercial companies in the United States is the payment of a stipulated amount of money in a certain number of instalments as indemnification for loss of earnings. Certain types of policies also provide for payment of a fixed amount to the insured to help him defray the expense of medical care actually received.

The report which follows describes in detail several plans by

¹ For a more detailed statement of the origin, scope and aims of the Committee's work, see *The Five Year Program of the Committee on the Costs of Medical Care, adopted February 13, 1928*. Publication No. 1. Washington, D. C.

PREFACE

which individuals, in consideration of a fixed amount paid periodically to some organization, are assured of medical or hospital care from that organization, in case of incapacity due to injury or disease not already covered by workmen's compensation laws. As the reader doubtless knows, laws in force in all states of the Union, excepting Arkansas, Florida, Mississippi and South Carolina, require employers to provide medical care to employees injured while at work. The security which the employer is required to furnish for the payment of compensation and the provision of medical care to injured employees amounts practically to compulsory group industrial accident insurance. Workmen's Compensation is discussed in this report only insofar as the administration of the law in several states is intimately related to the provision of medical care for non-compensable causes in certain industries.

Funds for this study were provided jointly by the Committee on the Costs of Medical Care, the Social Science Research Council, and the National Bureau of Economic Research.

METHOD OF INVESTIGATION

The material presented in this report was gathered chiefly by correspondence, the limited funds available not permitting of extensive field work. Published reports yielded little about plans of fixed payment medical service or medical and hospital insurance, as distinct from plans of "income protection." Visits by the authors to coal mining and industrial centers in the states of Pennsylvania, Illinois, West Virginia and Alabama, and personal interviews with railroad officials in eastern cities and Chicago, brought out additional information. Secretaries of county medical societies and workmen's compensation officials in many states supplied valuable information about industrial plans of employee group medical service. To these officials, to heads of mining companies, to trade union officials, to state and county medical society secretaries, the thanks of the National

PREFACE

Bureau are hereby tendered for assistance rendered. Special acknowledgment is made to the directors of the Seattle Community Fund for the valuable services of Miss Arlien Johnson, assistant secretary, who gathered much of the information about the system of employee group medical service in operation in the state of Washington. The final chapter, dealing with accident and health insurance, is the work of William H. Wandel.

The National Bureau of Economic Research takes no position as to the relative efficiency, from the medical standpoint, of any of the plans of service described in this report. Appraisal of the quality of the medical service rendered under the various plans was beyond the scope of this investigation.

PIERCE WILLIAMS

New York City
June, 1932

CONTENTS

	PAGE
PREFACE	v
CHAPTER I	
SUMMARY	I
INSURANCE OF MEDICAL AND HOSPITAL CARE NOT EXTENSIVELY FOUND IN UNITED STATES	I
OUTSTANDING EXAMPLE IS "COMPANY" MEDICAL SERVICE TO EMPLOYEES	2
MINING AND LUMBER COMPANY PLANS COVER 540,000 EMPLOYEES	3
RAILROAD HOSPITAL ASSOCIATIONS INCLUDE 530,000 EMPLOYEES	4
AN ADDITIONAL SMALL NUMBER OF PERSONS SECURE MEDICAL AND HOSPITAL INSURANCE FROM: (1) PRIVATE GROUP CLINICS; (2) COMMUNITY HEALTH ASSOCIATIONS; (3) COMMUNITY (NON-PROFIT) HOSPITALS; (4) MEDICAL BENEFIT CORPORATIONS	5
COMMERCIAL ACCIDENT AND HEALTH INSURANCE PAYS CASH BENEFIT; DOES NOT PROVIDE MEDICAL CARE	6
EMPLOYEE MUTUAL BENEFIT ASSOCIATIONS AND TRADE UNION SICK BENEFIT FUNDS RARELY PROVIDE MEDICAL CARE	7
CLOSE ADMINISTRATIVE TIE-UP BETWEEN STATE WORKMEN'S COMPENSATION LAWS AND COMPANY MEDICAL SERVICE PLANS	8
DIFFERENCES IN SCOPE OF SERVICE AND COST TO EMPLOYEES IN DIFFERENT REGIONS	9
WASHINGTON	9
OREGON	9
CALIFORNIA	10
ROCKY MOUNTAIN MINING INDUSTRY	11
COAL INDUSTRY OF THE CENTRAL STATES	11
LAKE SUPERIOR IRON AND COPPER MINING INDUSTRIES	12
COAL MINING INDUSTRY OF THE APPALACHIAN STATES	13
THE HOSPITAL CONTRACT SYSTEM IN SOUTHERN WEST VIRGINIA COAL FIELD	14

CONTENTS

	PAGE
FIXED PAYMENT MEDICAL SERVICE RARE IN INDUSTRIES OTHER THAN MINING, LUMBER AND RAILROAD	15
INDUSTRIAL HEALTH SERVICE MUST BE DISTINGUISHED FROM EM- PLOYEE MEDICAL INSURANCE	16
EMPLOYEE MEDICAL SERVICE IN SOUTHERN TEXTILE INDUSTRY	17
INDUSTRIAL CORPORATIONS PROVIDING MEDICAL CARE GRATUITOUSLY	22
LINE OF POSSIBLE FUTURE DEVELOPMENT IN THE FIELD OF MEDICAL INSURANCE	23
SPECIAL PROBLEMS OF THE RURAL COMMUNITY	23
POSSIBILITY OF ENACTMENT OF COMPULSORY SICKNESS INSURANCE LAWS	26
WAY OPEN FOR DEVELOPMENT OF VOLUNTARY MEDICAL INSURANCE IN URBAN COMMUNITIES	27
ATTITUDE OF MEDICAL PROFESSION TOWARD CONTRACT PRACTICE	30

CHAPTER II

THE AMERICAN CAMPAIGN FOR COMPULSORY SICK- NESS INSURANCE	34
JUSTICE BRANDEIS' PLEA FOR WORKINGMEN'S INSURANCE, 1911	35
INFLUENCE ON AMERICAN OPINION OF INTRODUCTION OF COMPUL- SORY HEALTH INSURANCE IN GREAT BRITAIN, 1911	35
AMERICAN CAMPAIGN LAUNCHED 1913 BY AMERICAN ASSOCIATION FOR LABOR LEGISLATION	36
THE PERIOD OF EDUCATIONAL PREPARATION	36
ARGUMENTS ADVANCED FOR COMPULSORY SICKNESS INSURANCE	37
THE PREPARATION OF THE "STANDARD BILL"; ITS PROVISIONS	40
INCREASING INTEREST OF THE AMERICAN MEDICAL PROFESSION, 1913- 1914	44
THE PERIOD OF LEGISLATIVE CONSIDERATION, 1915-1920	46
CALIFORNIA	46
OHIO	47
PENNSYLVANIA	47
ILLINOIS	48

CONTENTS

	PAGE
MASSACHUSETTS	49
NEW JERSEY	49
WISCONSIN	50
CONNECTICUT	50
NEW YORK	51
NATURE AND STRENGTH OF ORGANIZED OPPOSITION	51
LACK OF ORGANIZED EFFORT FOR COMPULSORY SICKNESS INSURANCE SINCE DEFEAT OF NEW YORK BILL, 1920	54

CHAPTER III

FIXED PAYMENT MEDICAL SERVICE IN THE LUMBER AND MINING INDUSTRIES OF WASHINGTON, OREGON AND CALIFORNIA	58
A. WASHINGTON	59
"STATE PLAN" AND "CONTRACT PLAN"	59
SERVICE OFFERED BY COMMERCIAL HOSPITAL ASSOCIATIONS	64
RATE OF EMPLOYEE CONTRIBUTIONS	66
MEDICAL SERVICE IN COAL MINING INDUSTRY	69
MEDICAL OPINION AS TO "CONTRACT" PRACTICE	73
CONTRACT MEDICAL SYSTEM EXTENDING	76
ESTIMATED NUMBER COVERED BY CONTRACT PLAN	77
B. OREGON	77
STATE SUPERVISION OF MEDICAL SERVICE CONTRACTS	79
CONTRACT SERVICE OFFERED BY INCORPORATED HOSPITAL ASSOCIATIONS	80
NATURE OF CONTRACTS AND SCOPE OF MEDICAL SERVICE GUARANTEED	81
COST TO EMPLOYEES	84
ATTITUDE OF MEDICAL PRACTITIONERS	85
THE PHYSICIANS AND SURGEONS HOSPITAL ASSOCIATION, SALEM	86
C. CALIFORNIA	88
EMPLOYERS' HOSPITALS UNDER STATE SUPERVISION	89

CONTENTS

	PAGE
COST TO EMPLOYEES	92
METHOD OF REMUNERATION OF MEDICAL STAFF	92
NUMBER COVERED BY HOSPITAL SERVICE	94

CHAPTER IV

FIXED PAYMENT MEDICAL SERVICE IN THE METAL MINING INDUSTRY OF THE ROCKY MOUNTAIN STATES	95
INFLUENCE OF COMPENSATION LAWS ON COMPANY PLANS OF MED- ICAL SERVICE TO EMPLOYEES	96
TYPICAL COMPANY PLANS	98
IDAHO	98
MONTANA	99
NEVADA	100
ARIZONA	102
NEW MEXICO	105
UTAH	106
COLORADO	109
MEDICAL SERVICE IN IDAHO LUMBER INDUSTRY	110

CHAPTER V

FIXED PAYMENT MEDICAL SERVICE IN THE COAL MINING INDUSTRY OF THE ROCKY MOUNTAIN STATES	112
ANNUAL WAGE AGREEMENT IN WYOMING INCLUDES PROVISION OF MEDICAL SERVICE TO EMPLOYEES AND DEPENDENTS	113
EMPLOYEE MEDICAL SERVICE IN COLORADO COAL INDUSTRY	117
MEDICAL PROGRAM OF COLORADO FUEL & IRON COMPANY	117
OTHER COAL COMPANY PLANS	119
EMPLOYEE MEDICAL SERVICE IN UTAH AND MONTANA COAL MINING INDUSTRY	120

CONTENTS

CHAPTER VI

	PAGE
FIXED PAYMENT MEDICAL SERVICE IN THE COAL AND METAL MINING INDUSTRIES OF THE CENTRAL STATES	124
A. COAL.	
1. THE INTERIOR COAL PROVINCE: (MICHIGAN, ILLINOIS, INDIANA)	124
2. THE SOUTHWESTERN COAL FIELD (OKLAHOMA, MISSOURI, ARKANSAS)	128
B. METALS.	
1. ARKANSAS BAUXITE INDUSTRY	132
2. LAKE SUPERIOR IRON MINING INDUSTRY	133
3. MICHIGAN COPPER MINING INDUSTRY	138

CHAPTER VII

FIXED PAYMENT MEDICAL SERVICE IN THE COAL MINING INDUSTRY OF THE APPALACHIAN STATES	139
PENNSYLVANIA	141
OHIO	144
WEST VIRGINIA	146
VIRGINIA	148
KENTUCKY	151
MEDICAL PROGRAM OF THE CONSOLIDATION COAL COMPANY (PENNSYLVANIA, MARYLAND, WEST VIRGINIA, KENTUCKY)	152
TENNESSEE	156
ALABAMA	156
MEDICAL PROGRAM OF TENNESSEE COAL, IRON AND RAILROAD COMPANY (ALABAMA)	159
OTHER ALABAMA MANUFACTURING COMPANY PLANS	161
SUMMARY	163

CONTENTS

CHAPTER VIII

	PAGE
THE HOSPITAL CONTRACT SYSTEM IN THE SOUTHERN WEST VIRGINIA COAL FIELD	165
HOSPITAL CONTRACT SYSTEM EXTENSIVE IN SOUTHERN WEST VIRGINIA FIELD; NOT FOUND IN NORTHERN FIELD	166
PREDOMINANCE OF PRIVATELY OWNED HOSPITALS IN SOUTHERN FIELD	170
ORIGINS OF WEST VIRGINIA HOSPITAL CONTRACT SYSTEM	172
SCOPE OF SERVICE PROVIDED UNDER HOSPITAL CONTRACTS	173
ANALYSIS OF HOSPITAL COSTS	178
DIFFERENCES OF OPINION AS TO HOSPITAL CONTRACT SYSTEM	181
CRITICISM BY MEDICAL PROFESSION	183
CLAIM THAT SYSTEM SHIFTS BURDEN OF MEDICAL CARE FOR INDUSTRIAL INJURY TO EMPLOYEE	185
INVESTIGATION OF HOSPITAL CONTRACT SYSTEM BY STATE LEGISLATURE, 1931	189
UNSUCCESSFUL ATTEMPT TO AMEND COMPENSATION LAW	192

CHAPTER IX

FIXED PAYMENT MEDICAL SERVICE FOR RAILROAD EMPLOYEES	193
HOSPITAL ASSOCIATIONS FOUND ON TWENTY-SEVEN TRUNK-LINE SYSTEMS	193
MEMBERSHIP AUTOMATIC	194
COMPANY OWNED AND "DESIGNATED" HOSPITALS	194
CASH BENEFITS PAID BY ONLY TWO ASSOCIATIONS	195
APPROXIMATELY 570,000 EMPLOYEES COVERED	196
FORM OF ORGANIZATION OF HOSPITAL ASSOCIATIONS	201
MEMBERSHIP CONDITIONS AND DUES	203
COMPANY CONTRIBUTIONS TO HOSPITAL ASSOCIATIONS	205
SCOPE OF MEDICAL AND HOSPITAL SERVICE PROVIDED	206
RAILROAD "RELIEF" DEPARTMENTS (CASH BENEFITS ONLY)	211

CONTENTS

CHAPTER X

	PAGE
FIXED PAYMENT MEDICAL SERVICE OFFERED BY GROUP CLINICS, COMMUNITY HEALTH ASSO- CIATIONS, COMMUNITY HOSPITALS AND MED- ICAL BENEFIT CORPORATIONS	216
DETAILED DISCUSSION OF SCOPE AND COST OF SERVICE PROVIDED BY:	
1. PRIVATE GROUP CLINICS	220
2. COMMUNITY HEALTH ASSOCIATIONS	227
BRATTLEBORO, VT.	227
NEW BEDFORD, MASS.	232
3. COMMUNITY HOSPITALS	235
BAYLOR UNIVERSITY HOSPITAL, DALLAS, TEXAS	236
GRINNELL, IOWA, COMMUNITY HOSPITAL	237
ROANOKE RAPIDS, N. C., COMMUNITY HOSPITAL	239
4. MEDICAL BENEFIT CORPORATIONS	244
CONCLUSIONS	249

CHAPTER XI

MEDICAL AND HOSPITAL BENEFITS PROVIDED UNDER COMMERCIAL ACCIDENT AND HEALTH INSURANCE POLICIES	252
HISTORY OF DISABILITY INSURANCE	253
TYPES OF INSURERS	255
APPLICATION, PREMIUM PAYMENT AND CLAIM PROCEDURE	255
CLASSES OF PUBLIC SOLICITED	256
RATES	257
THE MEDICAL BENEFIT CLAUSES—CASH PAYMENT ONLY; MEDICAL SERVICE NOT PROVIDED	258
CAUSES OF DISABILITY EXCLUDED FROM COVERAGE	264
NON-CANCELLABLE ACCIDENT AND HEALTH INSURANCE	265
SCHEDULE OF OPERATIONS—SURGICAL BENEFITS	266

CONTENTS

	PAGE
INDUSTRIAL DISABILITY INSURANCE	268
FRATERNAL INSURANCE	270
PERMANENT AND TOTAL DISABILITY CLAUSES IN LIFE INSURANCE	271
GROUP DISABILITY INSURANCE	271

CHAPTER XII

INDUSTRIAL ESTABLISHMENT MUTUAL BENEFIT ASSOCIATIONS PROVIDING MEDICAL AND HOSPITAL CARE	278
ANALYSIS OF CASH BENEFITS PROVIDED	279
MEDICAL AND HOSPITAL CARE RARELY PROVIDED	280
MUTUAL RELIEF ASSOCIATIONS AMONG GOVERNMENT EMPLOYEES IN WASHINGTON, D. C.	283
EXAMPLES OF MUTUAL BENEFIT ASSOCIATIONS PROVIDING MEDICAL CARE "IN KIND"	288
NUMBER OF INDUSTRIAL EMPLOYEES GUARANTEED MEDICAL CARE BY BENEFIT ASSOCIATIONS NEGLIGIBLE	290

CHAPTER XIII

TRADE UNION SICK BENEFIT FUNDS PROVIDING MEDICAL AND HOSPITAL CARE	291
NUMBER OF TRADE UNIONISTS WHO SECURE MEDICAL CARE UNDER UNION SICK BENEFIT PLANS NEGLIGIBLE	291
EXAMPLES OF UNION SICK BENEFIT PLANS PROVIDING MEDICAL CARE:	
1. UNITED MINE WORKERS OF AMERICA, DISTRICT 22, WYOMING	291
2. SILVERTON (COLO.) MINERS' UNION	291
3. NEW YORK LETTER CARRIERS' ASSOCIATION	292
4. EMPLOYEES' MUTUAL BENEFIT ASSOCIATION, MILWAUKEE, WIS.	293
5. WOMEN'S LOCAL UNION, BUREAU OF ENGRAVING AND PRINTING, WASHINGTON, D. C.	294
6. UNION LABOR BENEFIT LEAGUE, LOS ANGELES	295
SUMMARY OF CASH BENEFITS PAID BY NATIONAL TRADE UNIONS	299

**THE PURCHASE OF MEDICAL CARE
THROUGH FIXED PERIODIC PAYMENT**

CHAPTER I

SUMMARY

MEDICAL care may be purchased in either of two ways: (1) through direct payment by or on behalf of the patient to the medical practitioner rendering the specific service; (2) through insurance. Under the insurance plan, some organization undertakes to provide medical or hospital care to certain designated individuals in case they require it, in consideration of the payment of a fixed amount, by them or on their behalf, at periodic intervals.

Insurance, as applied to industrial injury, and to some extent, occupational disease, is practically compulsory in all modern industrialized countries. The cost of such insurance is paid by the employer, on the theory that industry should bear the burden of industrial accident. All states of the American Union, excepting Arkansas, Florida, Mississippi and South Carolina, have workmen's compensation laws, under which employees in many occupations are not only guaranteed indemnification for loss of earnings due to injury while at work, but medical and hospital care as well. Railroad and other employees engaged in interstate commerce are not ordinarily subject to state compensation laws. There is no Federal workmen's compensation law relating to employees engaged in interstate commerce.

Insurance against sickness is compulsory in the chief countries of Europe, among them: Great Britain and Northern Ireland; Irish Free State, France, Germany, Austria, Hungary, Czechoslovakia, Soviet Russia. In the former Austrian and Hungarian provinces of Italy sickness insurance is compulsory; in the rest of the country only tuberculosis and maternity insurance are compulsory. Under the compulsory system, the employer deducts a

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

stipulated amount periodically from the wages due each employee. To the employee's contribution the employer adds a fixed amount, and remits the entire sum to the insurance institution set up to administer benefits. In some countries the State contributes, either directly, or by assuming certain of the expenses of administration. The benefits include not only payment of a cash allowance to cover loss of earnings caused by illness, but medical care "in kind." In Soviet Russia the entire expense of sickness insurance is borne by the State, as employer. In Belgium, Finland, Denmark, Sweden and Switzerland, the system of sickness insurance is technically voluntary. Mutual benefit associations, aided by state subsidies, guarantee indemnification to the working population for loss of earnings due to sickness, and provide them with medical care.

"COMPANY" MEDICAL SERVICE

In the United States, up to the present time, insurance has been applied to the purchase of medical or hospital care to an exceedingly limited extent. In order to find any considerable group of persons who may be said to secure medical care through the method of fixed periodic payment, one is obliged to take the long-established plans of employee group medical service in the mining, the lumber, and the steam railroad industries. In these industries, this type of fixed payment medical service for employees is of long standing and has developed out of the isolation of the communities in which workers live. Practically all state workmen's compensation laws authorize employers furnishing satisfactory evidence of their financial ability, to "self-insure," i.e., pay compensation direct to injured employees and provide the medical, surgical and hospital treatment required under the state law. Under the "self-insurance" clause of the state workmen's compensation laws, a great many companies in the mining and lumber industries throughout the United States employ one or more physicians, to render treatment to employees disabled by an industrial injury.

SUMMARY

Hospitals are operated by relatively few of these "self-insuring" mining and lumber companies. In case hospitalization is necessary for an employee injured in the course of his employment, it is provided in an independent hospital. Usually, the provision of service is covered by a contract between the company and the hospital.

Medical care for injury and disease not coming under the state workmen's compensation law is made available by the company to the employee, in consideration of a fixed, periodic payment deducted from his wages. In many concerns the payroll deduction entitles dependent members of the employee's family to medical service.

The number of mining and lumber employees covered by payroll deduction medical service plans in April 1930, when the Federal Census was taken, is estimated by the National Bureau of Economic Research at approximately 540,000. No estimate has been attempted of the approximate number of dependent members of employees' families who are normally entitled to medical service under company plans.¹ Chapters III to VIII inclusive are devoted to a detailed description of these company plans of medical and hospital insurance.

¹ At the end of this chapter will be found a table giving the 1930 Census statistics of persons gainfully employed in the mining and lumber industries of 21 states, which are the basis of the above estimate.

Note by Mr. Hugh Frayne, Director: In giving my approval to the publication of "MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT," as a document of the National Bureau of Economic Research, such approval must not in any way be construed to mean that I am in accord with this form of medical care for workers.

I am firmly convinced that these methods are compulsory and deny the workers from participating in making or setting up these plans. The American Federation of Labor is deeply interested in medical and general health care of workers, whether they are members of our unions or not. It is opposed to and will continue to oppose all forms of compulsory medical care through employers, which we consider a form of paternalism.

In localities where the workers are well organized, especially in coal fields where the miners have strong unions (and there are many other cases that can be cited), the union representatives participate in setting up and developing these plans for medical care and hospitalization, whether it be a small community or a state activity.

A comparison of these methods will prove the correctness of these statements.

Much more could be said upon this subject but I shall refrain from doing so, as I believe I have made clear my position and that of those I represent.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

RAILROAD EMPLOYEE HOSPITAL ASSOCIATIONS

On 27 of the important trunk-line railroad systems of the United States, a fixed regular payment in the form of a deduction from wages entitles the employee to complete care in the hospital operated by the employee hospital association. Treatment is provided for both "duty" and "non-duty" injury and sickness. Of these 27 railroad employee hospital associations, twenty are connected with railroads operating west of the Mississippi River. Only two pay cash disability benefit.

Membership in the hospital association is usually automatic, all employees from the president down belonging. The hospitals in which disabled employees receive care are in most instances owned by the railroad companies. The governing body of the association, to which the operation of the hospital is entrusted, is made up of representatives of the employees and of the railroad management. In April 1930, the total number of employees of railroads with hospital associations was estimated at 530,000, or 34 per cent of the total average number of employees of Class I steam railroads reported for that month.² Dependent members of railroad employees' families are not entitled to free service, but enjoy special rates in case they make use of the hospital facilities.

The absence of any compensation law covering employees engaged in interstate commerce doubtless explains why there is no universal rule as to the basis on which expense for medical treatment arising out of a "duty" injury is assumed by railroads having hospital associations. Some railroads pay the hospital association for industrial accident care on a case-by-case basis. Others contribute a lump sum annually toward the operating budget of the hospital association. Chapter IX is devoted to a detailed consideration of fixed payment medical service in the railroad industry.

Participation in the above described types of "insurance" plans is usually automatically related to the employment. The right of

² Figures for April 1930 are used because that was the month in which the Federal Census was taken.

SUMMARY

an employee and his dependents to medical care ceases technically when he goes off the payroll. This point is important in a time of wide-spread unemployment like the present. The number of persons covered by these two informal types of medical insurance as these lines are written in May 1932, is considerably smaller than the number estimated for April 1930.

FOUR OTHER TYPES OF FIXED PAYMENT MEDICAL SERVICE

Four other types of plans under which individuals, acting singly or in groups, make certain of medical and hospital care through the principle of insurance have been found in the course of this investigation. While the industrial plans are found in isolated communities in which medical service would be lacking unless organized by the employer, these four plans are found in urban places where, presumably, medical facilities already exist. The simplest way of identifying them is by the organization undertaking to provide care in return for a fixed periodic payment. They are as follows:

1. *Private Group Clinics.* A number of private group clinics at present offer medical service in return for a fixed, periodic payment. The characteristic features of the private group clinic are these: its physicians use office, laboratory and medical facilities in common; most of the medical staff are associated with the clinic on a full-time basis; services usually include one or more medical specialties; patients are the responsibility of the entire group; income is "pooled," and members contract among themselves as to remuneration; the business administrator is usually a layman.

2. *Community Health Associations.* In Brattleboro, Vt., and New Bedford, Mass., non-profit associations offer medical and hospital insurance to residents of the community, in return for the regular payment of dues in the association.

3. *Non-Profit Community Hospitals.* In a few cities, what is in effect hospital insurance is offered to residents of the community. Any individual who pays the stipulated amount

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

periodically to the hospital is entitled to care in the institution in case he needs it, without further payment.

4. *Medical Benefit Corporations.* In California, certain incorporated business concerns are permitted to issue contracts guaranteeing medical and hospital service to individuals, in consideration of a fixed, periodic payment. These medical benefit corporations arrange with independent medical practitioners and hospitals to provide service to any contract-holder who requires it.

The service guaranteed under the above four plans relates only to disease or injury for which the person is not already entitled to care under the state compensation law.

Although the total number of persons who at present secure medical or hospital care under the above-mentioned plans is relatively small, these plans are, nevertheless, among the most significant experiments in voluntary sickness insurance now going on in the United States. For this reason their future development should be observed carefully. More detailed information about them is given in Chapter X.

"INCOME PROTECTION" ACCIDENT AND HEALTH INSURANCE

It is important for the reader to distinguish between the types of fixed payment medical service plans mentioned above and ordinary accident and health insurance. The plans which are the chief concern of this report undertake to provide medical care "in kind" but not to pay a cash benefit to cover loss of earnings. Commercial insurance policies undertake to pay a cash benefit, but not to provide medical or hospital care "in kind." The standard "benefit" of American health and accident insurance policies is a stipulated amount for a certain number of weeks in case the insured is deprived of income by sickness or accident. In addition to this standard benefit, many health insurance policies provide for the payment of a fixed monetary benefit in case the insured has incurred expense for medical, surgical or hospital care. The amounts payable are specifically listed in the policy.

Group health insurance policies are taken out by many large

SUMMARY

industrial employers for the benefit of their employees. Under group contracts, the insurance company agrees to pay a stipulated cash benefit for a certain number of weeks to any employee of the policy-holder disabled by sickness or injury not already covered by the workmen's compensation law. The premium for group insurance is in some instances paid entirely by the employer; usually, however, the employee pays a share by means of an authorized deduction from his wages. Group insurance policies neither provide medical nor hospital care "in kind," nor pay a monetary benefit to the employee for medical expense incurred by him. In this respect, group health insurance policies differ from group industrial accident insurance policies issued by casualty and employers' liability insurance companies to employers, to secure their liability under workmen's compensation laws. These policies undertake not only to compensate an injured employee for loss of earnings, but to provide him with whatever medical, surgical or hospital care he is legally entitled to. The chief features and benefits of accident and health insurance, with special reference to medical and hospital benefits, are summarized in Chapter XI.

MUTUAL BENEFIT ASSOCIATIONS AND TRADE UNION BENEFIT FUNDS

Industrial establishment mutual benefit associations and trade union sick benefit funds are two other examples of voluntary sickness insurance whose chief function is income protection. Participation in the former is limited to employees of the particular plant; in the latter to members of the union in good standing. Although there are several hundred establishment mutual benefit associations and trade unions providing sick benefit in cash, only a few provide medical and hospital care "in kind." The number of persons who secure medical and hospital care through this form of voluntary insurance is negligible. However, in order that the reader may visualize these two types of sickness insurance schemes in relation to medical and hospital care insurance, more

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

detailed information about them is given in Chapters XII and XIII, respectively.

CLOSE TIE-UP BETWEEN COMPENSATION LAW AND INDUSTRIAL EMPLOYEE FIXED PAYMENT MEDICAL SERVICE

Returning to a consideration of the company plans of fixed payment medical service for employees and their dependents in the mining and lumber industries, it should be pointed out that in practice there is a close tie-up between the provision of medical care at the employer's expense for industrial injury, and of medical care at the employee's expense for non-industrial injury and disease. For this reason, this informal type of insurance cannot be clearly visualized without some understanding of the compensation laws in the 21 states where employee group medical service is extensively found.

The system of payroll deduction for medical care was already of long standing in the mining and lumber industries when state compensation laws were passed. Although the new laws placed upon the employer the burden of expense of medical care for industrial injury, they were careful not to disturb the existing machinery by which the employee and his dependents obtained medical care.

One of the earliest workmen's compensation laws was that of the State of Washington, passed in 1911. The original act did not require the employer to provide medical care to the employee, but only to pay him compensation for loss of earnings. This defect was corrected by the passage of the Medical Aid Act in 1917. That act authorized the employer to collect from the employee through payroll deduction a certain amount as a contribution toward the cost of medical care necessitated by industrial injury. The Oregon law passed in 1913 contained a similar provision. The Nevada, Arizona, Montana and Idaho laws were passed respectively in 1911, 1912, 1915 and 1917. These laws sanctioned the existing system of payroll deduction, but expressly stipulated that the deduction might be made solely on condition

SUMMARY

that the medical and hospital service provided by the employer covered not only compensable injury, but sickness not related to the employment, as well. The New Mexico act, passed in 1917, is silent on the subject of payroll deduction.

While the compensation laws of these states did not specify the proportions of the total cost of medical and hospital care that should be borne by employer and employee respectively, presumably the intent was that the employer's share should cover the cost of care arising out of industrial (i.e., compensable) injury, and that the employee's share should cover the cost of care arising out of disease not due to the employment.

The compensation laws passed by California (1911), Michigan (1912), Minnesota (1913), Colorado, Oklahoma and Wyoming (1915), Kentucky (1916), Utah (1917), Virginia (1918), Tennessee and Alabama (1919), also recognized the existence of the payroll deduction method of purchasing medical and hospital care, but took a different attitude toward the system. They expressly forbade any deduction from the employee's wages unless the amount deducted was commensurate with benefits conferred in addition to those guaranteed by the compensation law. The Pennsylvania law (1915) says nothing about payroll deductions for medical care. The West Virginia law (1913) is worded in such a way as to make participation by employees in a system of hospital insurance (practically universal throughout the southern West Virginia coal field) ground for refusal by the state workmen's compensation insurance fund to pay for hospital care provided to an employee injured while at work.

DIFFERENCES IN SCOPE OF SERVICE IN DIFFERENT REGIONS

Differences in the conditions prevailing in the lumber, the metal and coal mining industries have resulted in variations in the systems by which employees and their dependents secure medical care in return for a fixed, periodic deduction from wages. In certain industries medical service is rendered by personnel engaged by the company; in others, by independent practitioners

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

under contract to the company. Hospital care is in some companies provided in a company-owned hospital; in the majority, it is provided in independent, privately owned hospitals under contract to the employer. For greater clarity, the information as to fixed payment medical service in the mining and lumber industries (Chapters III to VIII) is presented by regions. The following summarizes the salient points of difference in company medical service plans in different sections of the country.

THE CONTRACT SYSTEM IN WASHINGTON AND OREGON

Employer-owned hospitals are rare in Washington and Oregon, and the contract system is the customary method. The compensation laws authorize the employer to contract with physicians, hospitals and incorporated hospital associations to provide care to employees in case of injury occurring at the employment, and to deduct a fixed amount periodically from the employees' wages to apply on the cost of such care. In these two states separate contracts are sanctioned between employers and hospital associations (conditioned upon acceptance of the plan by the employees) for the provision of hospital care for injuries and diseases not due to the employment. To cover the cost of such care the employer makes a special deduction from the employees' wages. The employer pays no part of the cost of this "non-industrial" contract medical service. The operation of the system in Washington and Oregon is set forth in detail in Chapter III.

EMPLOYER-OWNED HOSPITALS IN CALIFORNIA

In certain California industries, chiefly lumbering, public utilities and railroads, and in a few manufacturing concerns, large companies operate their own hospitals. These are sanctioned by the compensation law of the state, and special regulations are made for their control and supervision by state authorities. If a deduction is made from wages, the company must show that it was not applied on the cost of providing care for industrial injury. The California system is also described in Chapter III.

SUMMARY

THE ROCKY MOUNTAIN MINING INDUSTRY

A few of the largest mining companies in the Rocky Mountain states own and operate hospitals. In these companies the total amount collected from employees is applied on the cost of operating the medical and hospital department. However, most of the large mining companies in the Rocky Mountain states contract with independent hospitals to provide service for both industrial injury and sickness at a fixed amount per employee per month. In one district of the Colorado metal mining region, a hospital for providing service to mining employees is operated by a local union of metal miners. In another mining district, a hospital is operated coöperatively by an association of metal mining companies. The total amount per capita paid over to the contract hospital is composed of a fixed amount per employee paid periodically by the employer, to cover the cost of treatment arising out of industrial injury, and a fixed amount contributed by each employee to cover the cost of non-industrial medical care.

In the Wyoming coal field, the provision of medical and hospital service for industrial injuries, non-industrial injuries and sickness, is covered by the annual wage agreement between the coal operators and the United Mine Workers of America. Into a special fund at each mining community each operator pays a certain amount per ton of coal mined, and each miner pays a fixed amount per month. The system of employee group medical service in the mining industries of Idaho, Montana, Nevada, Arizona, New Mexico, Utah, Colorado and Wyoming is described in detail in Chapters IV and V.

THE CENTRAL INTERIOR COAL FIELD

In the central part of the United States there are three fairly distinct coal fields; Iowa, Kansas and Missouri constitute the western interior coal field; Oklahoma and Arkansas, the middle western interior coal field; Indiana, Illinois and western Kentucky, the eastern interior coal field. In these coal fields the

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

"check off," or deduction from wages, is found only to a limited extent. The physician or surgeon engaged by the company renders first aid in industrial accident cases. In the event that hospitalization is needed by an employee injured at his work, it is provided at company expense in some local hospital. There are no company-owned hospitals in these three coal fields.

With respect to hospital care for non-compensable injury and disease, there are a few instances in the Oklahoma-Arkansas and Illinois coal fields of contract arrangements between local coal miners' unions and independent hospitals and hospital associations. When specifically authorized in a written request by the employee, the employer will deduct the stipulated amount from the employee's wages and turn it over to the hospital association. In the extensive lead and zinc mining industry of Kansas, Missouri and Oklahoma, the system of payroll deductions for medical care is not found. In the bauxite mining industry of Arkansas (where no workmen's compensation law has been enacted) the leading producer owns and operates a hospital, in which both industrial accident cases and non-industrial cases are handled. A fixed deduction from employees' wages is applied by the employer on the cost of medical and hospital care. The group medical service prevailing in the central mining states is treated in Chapter VI.

LAKE SUPERIOR MINING REGION

Several of the mining companies in the Lake Superior iron mining region (Minnesota and Michigan) own hospitals, but they are usually operated by surgeons under contract with the companies. These "base" hospitals, strategically located, provide medical and surgical care to the local population. For industrial injuries the mining company pays to the hospital or medical "contractor" a fixed amount per employee per month. To cover the cost of medical or hospital care not arising out of the employment, a fixed amount is deducted from the employees' wages each month, and likewise paid over to the hospital. The system in operation in the iron and copper mining industries of Minne-

SUMMARY

sota and Michigan furnishes a significant example of how medical care can be provided on the insurance basis to an industrial population living in small, scattered communities. A description of this system will also be found in Chapter VI.

THE APPALACHIAN COAL REGION

A variety of practices is found in the Appalachian coal field (Pennsylvania, Ohio, Kentucky, Tennessee, Maryland, Virginia, West Virginia, Alabama). The system in the various coal mining districts is described in detail in Chapter VII. There is no "check-off" for company doctor in the Pennsylvania anthracite coal field. This is true also of the Maryland coal field and of a few districts of the Westmoreland-Connellsville districts in the Central Pennsylvania coal field. Elsewhere in the Pennsylvania bituminous field, and in the Ohio, West Virginia, Virginia, Kentucky, Tennessee and Alabama fields, the deduction from employee's wages for company doctor service is customary. The company doctor's duties include the rendering of first-aid in the event of industrial accident and physical examination of employees.

Throughout the Pennsylvania bituminous field, hospital care, either for industrial injury or for sickness not covered by compensation law, is provided in local, state-subsidized hospitals. Usually this hospital receives financial support from the local coal mining companies in the form of an annual contribution. The expense of hospital care necessitated by an industrial injury is placed on the employer by the Workmen's Compensation law. If the employee, or a dependent member of his family, requires hospital care arising out of a cause not covered by the compensation law, the head of the family is expected to make his own arrangements. It is uncommon in this region for the employer to make a regular deduction from wages to cover the cost of hospital care for non-compensable disability. The same statement holds good for the Ohio coal fields, the Western Kentucky field and the older coal field in the northern part of West Virginia.

One large bituminous coal mining company in the Central

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

Pennsylvania field operates its own hospital, in which care is provided both for industrial accident and for non-industrial cases. A fixed regular deduction from wages entitles the employee of this company to hospital care arising out of disease or injury not covered by the compensation law.

THE HOSPITAL CONTRACT SYSTEM IN WEST VIRGINIA

In contrast to the northern coal fields, most of the companies in the southern West Virginia region make a second deduction from the employee's wages to cover the cost of hospital care for sickness and injury not covered by the compensation law. No coal company in the southern West Virginia coal field has its own hospital, and hospital service, both for industrial injury and disease, is provided by an independent hospital under a contract between it and the coal company. The employee from whose wages the periodic deduction is made for hospital care is not a party to the contract nor has he any voice in the selection of the hospital.³

The hospital contract system as it operates in West Virginia has been severely criticized on the ground that it relieves the employer of the expense of hospital care due to an injury sustained by an employee in the course of his employment. It is claimed that nothing is collected from the employer by the contract hospital to cover the cost of care arising out of industrial injury. A committee of the West Virginia Legislature which investigated the hospital contract system in January 1931, recommended "that the contract hospital service be discontinued insofar as it relates to industrial accidents and affects the employees whose employers are subscribers to the compensation fund." An unsuccessful effort was made at that session of the Legislature to have the workmen's compensation law amended so as to leave no doubt as to the intention of the law that the cost of hospital care received by an injured employee in case of industrial accident

³ It should be mentioned in this connection that workmen's compensation laws in most states leave only a limited free choice of physician and hospital to the injured employee.

SUMMARY

should be paid by the employer. The West Virginia situation is discussed in detail in Chapter VIII.

FIXED PAYMENT MEDICAL SERVICE RARE IN OTHER INDUSTRIES

Information received from county and state medical societies in practically all states of the Union indicates that the system of providing medical service to employees in return for a fixed periodic payment is rarely found in industries other than mining, lumbering and steam transportation. Where an industry is carried on in an urban place, it would be possible, under normal circumstances, for employees and their families to purchase medical care directly from established local practitioners and hospitals. Exceptions to the foregoing statement are found in companies which, in addition to carrying on mining, operate their own smelters and refineries. There are several such companies in the Rocky Mountain region; one on the Lake Superior Iron Range; and several in Alabama. A small number of iron and steel manufacturing companies in that state have company medical service plans similar to those commonly found in the Alabama coal mining industry. These are referred to in Chapter VII.

INDUSTRIAL HEALTH SERVICE

The system by which employees secure medical and hospital care from medical personnel employed by or under contract to the employer in consideration of a fixed periodic deduction from wages, should be distinguished from industrial health service. This latter type of service aims to prevent sickness and accidental injury, and is maintained entirely at the expense of the employer. A report recently published by the National Industrial Conference Board gives valuable information as to the objectives, scope and administrative methods of industrial health service. These objectives are stated to be: "(1) to place individuals in the work for which they are best fitted; (2) to procure and maintain fitness for work; (3) to educate the worker in personal hygiene and the

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

prevention of accidents; (4) to reduce loss of time, absenteeism, and short work spans.”⁴

The staff engaged in industrial health work in a large plant will usually include one or more physicians, several trained nurses, and, in some instances, dentists, oculists, and other specialists and technicians. The equipment of the medical department ranges all the way from a simple first-aid kit to a well-organized dispensary or fully equipped hospital.

The Conference Board found that in 1930, as compared with 1924, when a similar study was made, “much more attention was being devoted to preventive work and health education as contrasted with curative work in industrial medical departments.”

The total number of companies supplying data to the Conference Board was 443, and the estimated total number of employees covered was 1,125,830. These companies represented many lines of industrial activity, but chiefly manufacturing. Out of 303 companies submitting data as to health service to employees, only 27 reported that they gave treatment for disease in return for an employee contribution. The 27 companies which furnished medical treatment going beyond preventive work employed a total of 130,934 workers. This represented 21 per cent of the total reported for the 303 companies. In 13 of these companies, medical treatment and care were available to dependent members of employees' families.⁵

It should not be concluded, however, from the foregoing, that industrial health service is by any means general in American industry. An investigation by the National Safety Council shows that “of a group of 3,580 selected industrial establishments, only 191, or 5.3 per cent, have reported some form of medical and health supervision of their employees. Estimates show (as far as the membership of the National Safety Council is concerned)

⁴ *Medical Supervision and Service in Industry*. National Industrial Conference Board, New York, 1932.

⁵ It should be noted in this connection that the sample studied by the Conference Board was a highly selective one, since its questionnaires were sent to companies that were believed to have medical programs.

SUMMARY

that approximately 3,406,000 employees are not under health supervision, while 1,615,193 are." ⁶

HEALTH AND MEDICAL SERVICE IN SOUTHERN TEXTILE INDUSTRY

A few words should be said about the health work carried on in many of the larger textile manufacturing companies in Georgia, North and South Carolina. One of the chief concerns in South Carolina writes that some years ago it was the practice to collect a fixed amount from each mill family as remuneration to a local physician. However, the system did not prove satisfactory, either to the doctor or to the contributors. The former felt he was being called on unnecessarily for service; the contributor, on the other hand, felt he was not getting his money's worth unless he called in the physician frequently. Today, the contributory system is found to an exceedingly limited extent.

Its place has been taken by a special form of health service largely the outgrowth of the peculiar conditions prevailing in the southern textile industry. In the North, textile manufacturing is carried on for the most part in communities which either are of considerable size, or are in close proximity to large towns. The southern textile industry, on the contrary, is to a large extent carried on in small communities, in which the mill employees and their families constitute practically the entire population. Many of these mill villages are incorporated as municipalities, with their own local government. In many of these "company towns" the local church building and the land on which it stands have been donated by the company; in some instances, the school system is aided by grants from the employing concerns. Welfare activities are largely under the supervision of the textile companies.

In South Carolina, the medical care of textile employees is being developed along the lines of preventive medicine under the supervision of a local physician conducting a private practice. The

⁶ See *Prevailing Practices in Industrial Health and Medical Service. Health Service Policies. Health Practices Pamphlet No. 12*, National Safety Council, Chicago, 1930.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

physician does all curative work and directs nurses in the preventive work. This work is in conjunction with the County and State health departments. The nurses are paid by the company, which also pays the physician fees for certain types of service, such as physical examination of employees, and for treatment of cases of accident occurring to employees in the course of their work. (It should be noted in this connection that South Carolina has no workmen's compensation law compelling the employer to provide medical, surgical and hospital care to an injured employee.)

The scope of the service in one of the pioneer textile companies of South Carolina is indicated by the following: The activities of the physician and nurses (two nurses for a population of 2,000) are carried on in a modern building, which is known as the medical center. In this building a dentist conducts his own practice, equipment and quarters, however, being furnished free of charge by the company. The medical center has ten beds, six for white and four for colored patients. All services of hospitalization, including nursing, but excluding meals, are furnished free of charge. Meals are furnished by the family of the patient. Containers for transporting the food are provided by the company. In cases requiring special diet, cooking arrangements are provided by the company, and the cooking is either done or supervised by the company nurses.

MEDICAL SERVICE IN GEORGIA TEXTILE INDUSTRY

The scope of medical service available to employees in the Georgia textile industry is indicated by a survey of industrial relations made by the Georgia Cotton Manufacturers' Association, following a conference held in Atlanta in July 1928. Workmen's compensation has been in force in Georgia since 1920. Data for the survey were supplied by mills reporting slightly more than half the number of spindles operated in the state. From the health section of that survey the following summary has been made.

All types of mills are represented in the survey, from those

SUMMARY

having a full-time doctor with several trained nurses, to those having no regular nursing service, and employing a physician for only a short time each week. Usually, the extent of the health program depends on the size of the mill. Several mills began their health program with a physical examination of applicants for employment. While these vary in scope, they all include examination of eyes and teeth, blood tests, diagnosis of existing physical defects, clinical history, vaccination and inoculation for certain diseases.

Practically all the mills have requirements regarding the prevention of contagious diseases. In some companies vaccination of employees against smallpox, typhoid fever and diphtheria is compulsory. Persons not submitting are required to move out of the mill village; those who acquire venereal disease are also required to seek other employment. In other mills these rules are less rigid. Usually, the precautionary serums are furnished free of charge by the mills. In villages owned by the mills the rules apply to the families of employees who live on company property, but where the mills have no villages, these rules cannot be extended beyond actual operations. This is true of some of the city mills.

EMPLOYEE CONTRIBUTORY FEATURE NOT FOUND

Most of the mills reporting have some sort of medical service, or medical clinic. In many instances the mill employs a doctor for one or two hours a day, where employees may have injuries and certain illnesses treated; sometimes his services are available to the families of employees. As a rule the doctor has an office and dispensary at some convenient point in the mill; sometimes he also visits among the families in the village. Other mills employ doctors for full-time service to employees and their families; nurses are employed to assist the doctors, some giving full time at the clinics, others doing welfare visiting in the villages. One mill in particular has an elaborate clinic with full-time doctor and clinic nurse, first-aid room, operating room, dental and optical clinics, maternity ward and nursery, and several rooms

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

for regular hospital service. All latest modern surgical instruments and testing apparatus have been installed. A full-time visiting nurse is also on the staff. Practically all mills have a more or less fully equipped first-aid room, usually in charge of a company nurse. As a rule the service is free to employees and in some companies to their families. A few mills make a small nominal charge for some special feature of the service.

In one Georgia textile company the doctor is employed for full time on a minimum and maximum basis each month. He is guaranteed a minimum amount, but is not allowed more than a certain amount, regardless of the number of visits he may make. If he is not on call, he designates another doctor, whom he pays himself. Several mills keep complete health records of all employees and their families. Considerable attention is being given to the teeth of employees and their families, especially school children. Dental clinics are frequently operated in connection with the medical clinics. In some instances, dental service is free, in some a nominal charge is made.

Sanitation, hygiene, proper diet, pure water supply, ice, milk, mill cafeterias, baths, safety organizations, health instructions for adults and children, etc., are other features of the health programs described in the report of the Georgia Cotton Manufacturers' Association.

In connection with the foregoing summary of medical service, Mr. B. F. Forbes, Secretary of the Cotton Manufacturers' Association of Georgia, states: "the employee's contributory feature is practically non-existent in medical service in the Georgia textile industry."

MEDICAL SERVICE IN NORTH CAROLINA TEXTILE INDUSTRY

In North Carolina, the situation as to employee medical service in the textile industry is in general similar to that in Georgia and South Carolina. The earlier system of payroll deduction to remunerate a local physician has largely given way to a system of company maintained health service. In some concerns

SUMMARY

a periodic contribution is still made by employees, but this is intended to cover the cost of doctor service available to dependent members of the employee's family. The salary of the physician is usually paid by the company.

The enactment of the workmen's compensation law in North Carolina in 1929 (effective July 1) has resulted in the greater assumption of responsibility on the part of employers for the health program as a company activity, without any contribution on the part of the employee.

The inclusion of hospitalization in company medical plans in the southern textile industry is necessarily limited by the meagerness of hospital resources in the regions where cotton manufacturing is carried on. Industrial injury cases are cared for in the nearest general surgical hospital, at the expense of the employer. (Generally speaking, this also holds good for South Carolina, even though no workmen's compensation law has been enacted in that State.) If hospital care is needed for a cause not covered by the workmen's compensation act, it is a matter of private arrangement on the part of the employee.

Roanoke Rapids, N. C., with approximately 10,000 inhabitants, is unique in its plan of hospital service on a fixed payment basis. The local hospital was built and equipped in 1917 at the expense of the six leading employers. It is now owned and operated by a non-profit corporation. The bulk of the employed population of the town and the neighboring mill villages secures hospital service for non-compensable disease, in case they require it, by means of a fixed periodic payment deducted from their wages by their respective employers, and paid over to the hospital corporation. The cost of hospital care necessitated by occupational injury is borne by the local employers. This plan of hospital insurance is the outgrowth of company plans of contributory employee medical service like those described above. More detailed information about the Roanoke Rapids hospital insurance plan will be found in Chapter X, along with descriptions of two other plans of service on a fixed payment basis by non-profit community hospitals in Dallas, Texas, and Grinnell, Iowa.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

INDUSTRIAL CONCERNS PROVIDING MEDICAL CARE GRATUITOUSLY

Two instances of manufacturing concerns which provide medical and hospital care gratuitously are the Endicott-Johnson Corporation of Endicott, N. Y., and the A. O. Smith Corporation, of Milwaukee, Wis.

The Endicott-Johnson Corporation's medical service was inaugurated in 1913 to meet the requirements of the Workmen's Compensation Law of New York State, and in the beginning it provided only for first-aid to injured workmen. It now includes care for non-industrial injury and ordinary sickness. There are three medical centers, two maternity hospitals, two nose and throat hospitals, all fully staffed. In addition, employees are cared for in local community hospitals, at the expense of the company. No monetary contribution toward the cost of any of this service is made by the employees.⁷

The "Department of Preventive Medicine" of the A. O. Smith Corporation was established in March 1925. According to Dr. T. L. Squier, of the Department, "the objective was twofold; first, the discovery and elimination of disease, and more especially, the precursors of disease, with the group of employees and dependent members of their families. Second, a study of the pre-clinical signs of degenerative diseases, with the ultimate goal of adding to the present rather meager knowledge of the relation between apparently minor defects and future systemic deterioration." At the A. O. Smith Corporation there is the usual first-aid department, but its organization and personnel of doctors and nurses is entirely separate from and independent of the Department of Preventive Medicine. In that Department, the service is chiefly diagnostic, with special emphasis on the examination of the supposedly healthy. The only therapeutic function actually performed is the extraction of diseased teeth. The Department endeavors to aid the family physician in his care of his patients.

⁷ A full description of the Endicott-Johnson medical service is contained in Publication No. 5 of the Committee on the Costs of Medical Care, Washington, entitled *Medical Care for 15,000 Workers and Their Families*.

SUMMARY

Expectant mothers, wives of employees, are offered hospitalization at the company's expense, provided six months' notice is given and adequate pre-natal care instituted. The employee chooses his own physician and pays the medical fees. He may also choose any one of the Class A hospitals of Milwaukee. The hospital bill is paid by the company, and if necessary, a housekeeper is engaged at the company's expense to care for the home during the mother's absence. During the year 1930, 65 per cent of all babies born to A. O. Smith employees were delivered under this plan. The service of the Department of Preventive Medicine as above outlined is available without monetary contribution to all employees and their dependents, after six months' service with the company.

LINES OF POSSIBLE FUTURE DEVELOPMENT IN MEDICAL INSURANCE

Recommendations as to public policy in regard to sickness insurance in the United States are outside the scope of this report, which is limited to depicting the actual situation. However, certain possible lines of future development may properly be pointed out. Before doing this, the difference between urban and rural communities in respect to the problem of providing medical care should be emphasized. For the average urban community in the United States, the adoption of the insurance method of purchasing medical care is chiefly a matter of satisfactory agreement between groups of would-be purchasers on the one hand, and physicians, surgeons and hospitals on the other, for the provision of treatment on the basis of fixed periodic payment. A great many rural communities, however, cannot adopt the insurance method until they solve a still more fundamental problem. That problem is how to attract and hold in their midst a sufficient number of practitioners to supply even the minimum medical demands of the population.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

A study made by the Committee on the Costs of Medical Care shows great unevenness of geographical distribution of physicians, dentists, trained nurses and hospitals throughout the United States. "In 1927 South Carolina and Montana had only 71 physicians per 100,000 people. California, at the other extreme, had 200. Various state surveys show clearly that the larger cities have more doctors compared to population than the smaller towns and rural districts. Comparatively few recent graduates of medical schools are located in the small communities; the proportion settling in the larger cities is becoming progressively greater." Dentists likewise are unevenly distributed over the country; some urban communities have one dentist to every 500 persons, while some rural communities have only one dentist to every 4,000 persons. As with doctors and dentists, there is a considerable variation in the distribution of graduate nurses. The number ranged in 1929 from 39 per 100,000 people in Mississippi and Arkansas, to 297 per 100,000 in California. "Trained nurses, like other professional groups, are concentrated in the larger cities, while rural sections are comparatively under-supplied." The same uneven distribution exists with respect to hospital facilities. Over 40 per cent of the counties in the United States have no hospitals for general community use. "The individual states show a range of from one bed per 154 persons in Wisconsin to one bed per 749 persons in South Carolina. Smaller cities have in proportion to population fewer hospital facilities than larger cities."⁸

To what extent rural communities can profit by the experience of the isolated industrial communities in the mining and lumber industries is a question. In these last mentioned places, the initiative in organizing and maintaining medical and hospital service has come from the employer. The existence of a fairly numerous and homogeneous group in the community, i.e., the employees of the company and their families, has also facilitated the prob-

⁸ *A Survey of Statistical Data on Medical Facilities in the United States*, by Allon Peebles. Publication No. 3 (October 1929). Committee on the Costs of Medical Care, Washington, D. C.

SUMMARY

lem of medical organization in mining villages and lumber camps. Lacking an organized employee group, the rural community may need to devise some other convenient group, if it desires to apply the principle of insurance to the problem of securing medical care for the local population.⁹

MEDICAL INSURANCE IN THE URBAN COMMUNITY

In considering the possible lines of development of medical care insurance in communities which already have a sufficient number of medical practitioners and a reasonably adequate number of hospital beds, three indispensable elements should be kept in mind. These are: (1) a number of individuals desirous of assuring medical care to themselves, and willing to make the requisite fixed periodic payments to maintain the fund out of which the cost of medical service actually rendered is paid; (2) a properly constituted organization to (a) collect the periodic payments from those desiring the protection, and (b) remunerate practitioners and pay hospitals for medical care provided; (3) a sufficient number of doctors, surgeons and other practitioners willing to provide service on the basis of the changed relationship between physician and patient which a plan of medical care insurance almost inevitably creates. To what extent do these three elements in medical care insurance already exist in the typical American city?

⁹ The Committee on the Costs of Medical Care suggests that the municipal doctor system in rural Saskatchewan may contain something of value for American rural communities that are without physicians. The rural municipality in the Province of Saskatchewan corresponds generally to the county in the United States. Twenty of these rural municipalities employ physicians on a full-time salary basis to provide medical service without charge to all taxpayers and their families residing within the municipality. Twelve other municipalities in Saskatchewan make grants of money to physicians (i.e., subsidize them) to engage in practice in the community. Nominal fees for specified services are established in some communities. The scope of the medical care given by the municipal physician is that of a general practitioner. It usually excludes all major surgery, as well as many types of minor surgery, and the treatment of obscure conditions requiring the services of specialists. The municipal doctor also serves as the medical health officer for the community in which he resides. See *The Municipal Doctor System in Rural Saskatchewan*, by C. Rufus Rorem, Ph.D., C.P.A. Publication No. 11, 1931. Committee on the Costs of Medical Care, Washington, D. C.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

POSSIBILITY OF COMPULSORY SICKNESS INSURANCE LEGISLATION

In approaching the matter from the standpoint of the first element mentioned above, the question immediately arises whether the number of persons desiring sickness insurance is sufficiently large to justify the expectation that the legislature of any state of the Union will in the near future enact a law making sickness insurance compulsory. Under the American constitutional system, the enactment of sickness insurance legislation like the enactment of workmen's compensation, is a matter for each individual state to decide for itself. Legislation making sickness insurance compulsory for employees engaged in interstate commerce could only be enacted by the Federal Congress. No prediction as to the future action of individual states or of Congress can be made, and the fact that at the present moment no organized effort in favor of compulsory sickness insurance is under way in any state of the Union should not be taken to indicate that this form of social legislation will not be passed.¹⁰

The reader may need to be reminded that compulsory sickness insurance, modeled on European lines, has received legislative consideration in several States of the Union. During the years 1915 to 1920, a well-organized campaign of education was carried on under the leadership of the American Association for Labor Legislation. The Standard Bill prepared by that Association was introduced in a number of State legislatures, and the subject was investigated by official commissions in eleven. Four of these reported favorably to the principle. In March 1919, a bill to establish compulsory sickness insurance was passed by the Senate of the State of New York, but was defeated in the Assembly. The widespread interest engendered by that campaign, notwithstanding its failure to achieve its goal, has special significance in connection with this study. In order that the reader may appraise that movement for himself, an account of it is given in Chap-

¹⁰ The American Medical Association informs us that during the past three years no bill for compulsory sickness insurance has been reported from any State legislature.

SUMMARY

ter II. The exposition there given will enable the reader to compare the basic principles, methods of organization, and scope of benefits of the type of compulsory sickness insurance proposed for American wage-earners fifteen years ago with the existing plans of medical and hospital insurance on a voluntary basis.

FACTORS IN EXTENSION OF VOLUNTARY INSURANCE

Whatever the future course of developments with regard to compulsory sickness insurance, the way lies open for interested groups to encourage the adoption of the fixed payment method of purchasing medical care throughout the United States. The group which appears to lend itself most conveniently to the administration of sickness insurance is the group of employees of a particular industrial, financial or mercantile establishment. The local trade union is another type of group which experience has demonstrated is suitable for the purpose of medical care insurance. Other types of organized groups, professional, fraternal, social, existing in urban communities are equally capable of being utilized for the purpose of voluntary medical insurance. Group disability insurance, as the name indicates, is written by life insurance companies to employers for the benefit of their employees, and utilizes the entire body of employees of a particular concern as the unit of insurance against non-compensable disability. Likewise, a policy issued to an employer to secure his liability under a state workmen's compensation law makes use of the entire group of employees for purposes of insuring them against industrial accident. One advantage of some form of organized group over individuals insuring singly is in the matter of expense. Experience with commercial health and accident insurance has demonstrated that it is relatively costly for the company to acquire and hold its business when clients have to be solicited one by one. The more the insurance carrier has to expend in getting and holding policyholders, the less there is available for benefits. Chapter XI sheds light on this point.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

TYPES OF VOLUNTARY INSURANCE ORGANIZATIONS

The existing types of medical and hospital insurance in the United States do not afford much experience to help in deciding what type of voluntary organization for collecting the periodic payments and arranging for medical service would be most satisfactory. In the mining and lumber industries, the employing concern itself collects the periodic contributions and administers the medical care fund. Few of these company plans provide for any participation by employees in the administration. The trunk-line railroad plans of hospital care, on the other hand, are administered by associations governed jointly by employees and railroad officials. As Chapter XII shows, employee mutual benefit associations paying cash sickness benefit exist in many industrial establishments. Although few of these associations provide medical and hospital care "in kind" as a benefit of membership, there would seem to be no inherent reason why more of them should not do so, assuming they can secure the coöperation of medical practitioners.

The possibility that commercial insurance companies now issuing "income protection" accident and health insurance may at some time in the future find themselves in position to offer policies which undertake to provide medical and hospital care "in kind" should not be ignored. In case this development comes about, a new form of group sickness insurance paralleling group industrial accident insurance, would be available. There would seem to be no reason why an employee mutual benefit association, a local trade union, or some other organized group, should not enter into an insurance arrangement with a commercial insurance company authorized to sell medical service contracts as well as cash benefit policies. It must be recorded, however, that the medical benefit corporations of California have so far had little success in writing group medical and hospital service contracts to employee beneficial associations. The incorporated hospital associations which operate in Washington and Oregon (Chapter III) are examples of a type of commercial organization providing

SUMMARY

what is in effect group medical and hospital insurance for industrial employees.

INFLUENCE OF INDUSTRIAL HEALTH PROGRAMS ON EMPLOYEE GROUP MEDICAL INSURANCE

The extent to which existing employee mutual benefit associations may broaden their present cash benefits to include the provision of medical and hospital care "in kind" for disease and injury not already covered by the state workmen's compensation law, may be influenced by the future development of industrial hygiene. It has been shown earlier in this chapter how in many large industrial plants, employee health service, aiming at the prevention of accidents and increased efficiency, is carried on wholly at the expense of the employer. In most instances, the service provided by the employer does not follow the employee beyond the walls of the plant. However, the attitude of employers toward the provision of medical and hospital care to employees for non-industrial injury and disease may in turn be influenced by the trend of workmen's compensation legislation with respect to occupational disease. A gradual broadening of the scope of compensation to include more and more types of disease is noted by persons closely in touch with this field of insurance. To some extent this broadening of scope is due to legislative enactment; to a greater degree it is due to day-by-day interpretation of the law by state workmen's compensation commissions. To the extent that the range of diseases compensable under state laws is widened and the employer's responsibility for providing medical care automatically increased, the range of diseases for which the individual must purchase medical care on his own account is correspondingly narrowed. It is within the bounds of possibility that more and more large concerns with well-organized medical departments may make the services of plant physicians and nurses available to employees in their homes, in case of non-compensable disability. Workmen's compensation laws of many states specif-

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

ically authorize agreements between employers and employees for the provision of benefits additional to those conferred on the employees by the compensation act itself. Medical and hospital treatment arising out of non-compensable injury and disease are among the benefits envisaged. The agreement may provide for payment of the entire expense of the service by the employees, or for the sharing of the expense between employees and employers.

THE MEDICAL PROFESSION AND INSURANCE PRACTICE

It remains only to discuss briefly the third essential element in any successful plan of medical insurance, viz., the medical practitioner. The attitude of the rank and file of the American medical profession towards medical insurance constitutes the crux of the problem. It is not too strong a statement that the future of fixed payment medical service in the United States is largely in their hands. Will the average practitioner lend his coöperation in working out a mutually satisfactory basis for the provision of medical and hospital care to persons desirous of purchasing service on the insurance plan? It is perhaps not necessary again to emphasize that the insurance plan of providing medical service fundamentally alters the traditional relation between the physician and the patient. Instead of receiving payment directly from the person to whom the service is rendered, the physician is remunerated by the organization to which the fixed periodic payment has been made. This is equally true whether the scheme of insurance be voluntary or compulsory. The physician may be employed by the insurance organization on a salary; he may be retained by it under a contract to render service to members of the insured group at stipulated fees; or he may be under agreement to perform service at a fixed amount per person per month. "Contract practice" as defined by the American Medical Association is "the carrying out of an agreement between a physician or group of physicians as principals or agents, and a corporation, organization or individual, to furnish partial or full medical

SUMMARY

services to a group or class of individuals for a definite sum or for a fixed rate per capita."¹¹

It is the necessity for medical coöperation if a plan of medical or hospital insurance is to succeed that gives special significance to the fixed payment medical service which is being offered by a number of private group clinics in various cities of the country.¹² Increase in the number of private group clinics is evidence of recognition on the part of the medical profession of the need for an improved form of organization for rendering efficient medical service. In their endeavor to adapt the group form of medical practice to the plan of group purchase through fixed periodic payment, medical men are supplying valuable experience by which further developments in the field of medical insurance can be tested.

Another experiment in group medical organization, involving a transformation in the traditional economic basis of medical service is the plan of clinics operated by the county medical society. In order to relieve the individual physician of the responsibility and expense of rendering free service, it has been proposed that the county medical society should organize and maintain a clinic, where patients unable to pay for service received, would be treated by members of the medical society assigned in rotation to clinic duty. This experimental application of the group practice idea may also lend itself to the rendering of service on the basis of a fixed periodic payment.

The growing interest of non-profit community hospitals in the possibility of offering care on a fixed payment basis (Chapter X) is further evidence of the desire of physicians to lend their coöperation in testing the feasibility of the insurance principle. However, the number of community hospitals at present offering care on this basis is too small to justify any generalization as to future possibilities. It should be mentioned that the Judicial Council of the American Medical Association has recommended caution on the part of non-profit hospitals in undertaking to provide treatment on the basis of fixed periodic payment.¹³

¹¹ Quoted in an article on "Contract Practice," by R. G. Leland, M.D., in the *Journal of the American Medical Association*, March 5, 1932; Vol. 98, pp. 808-815.

¹² See Chapter X. ¹³ See *Contract Practice*, by R. G. Leland, M.D., cited above.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

Whatever the lines of experiment that may be pursued in the attempt to provide medical care to the American people at a cost within the reach of the masses, the cooperation of the medical profession is essential.

TOTAL OF GAINFULLY EMPLOYED PERSONS IN VARIOUS INDUSTRIES IN STATES (1930) IN WHICH SYSTEM OF FIXED PAYMENT MEDICAL SERVICE IS FOUND

State	Industries	Number
Washington	Forestry	30,566
	Saw and Planing Mills	40,220
	Extraction of Minerals	6,862
Oregon	Forestry	19,277
	Saw and Planing Mills	25,191
	Extraction of Minerals	2,644
California	Forestry and Fishing	14,292
	Saw and Planing Mills	18,094
Idaho	Extraction of Minerals	6,574
	Forestry and Fishing	6,011
Montana	Coal Mining	2,421
	Other Mines and Quarries, excluding Oil and Gas Wells	14,135
Nevada	Extraction of Minerals	6,055
Arizona	Extraction of Minerals	17,566
New Mexico	Coal Mining	3,392
	Other Mines and Quarries	3,817
Utah	Coal Mines	3,282
	Other Extraction of Minerals	9,231
Colorado	Coal Mines	11,612
	Other Extraction of Minerals	8,432
Wyoming	Coal Mines	5,062
Oklahoma	Coal Mines	5,997
Arkansas	Coal Mines	3,751
Minnesota	Extraction of Minerals	14,570
Michigan	Extraction of Minerals	26,375
Pennsylvania	Coal Mines (bituminous)	131,774
West Virginia	Coal Mines	109,391
Virginia	Coal Mines	13,846
Kentucky	Coal Mining	59,792
Tennessee	Extraction of Minerals	16,039
Alabama	Coal Mining	27,112
	"Other Extraction Minerals"	7,847
Total		670,963

(Note: The classification "extraction of minerals" comprises the following industries in the various states: Washington, Oregon, Tennessee, chiefly coal mining; Idaho, Colorado, chiefly precious metal mining; Montana, Nevada, Arizona, New Mexico, Utah, chiefly copper mining; Minnesota, Michigan, Alabama, chiefly iron ore.)

SUMMARY

In arriving at the total estimate of 540,000 given earlier in this chapter, the Census figures have been reduced by 20 per cent, in order to allow for the following factors:— (a) inclusion in the California and Idaho figures for “forestry and fishing” of the fishing industry, where the system of fixed payment medical service is not found; (b) inclusion in the figures for “extraction of minerals” of employees of numerous mining companies which do not have a company doctor, due to the small number of persons employed, and the intermittent character of the mining operations; (c) inclusion in the figures for “saw and planing mills” of employees of companies which operate planing mills close to urban centers and do not provide medical service to employees; (d) inclusion in the figures for bituminous coal mining in Pennsylvania of employees of companies in certain districts where no payroll deduction for medical service is made.

CHAPTER II

THE AMERICAN CAMPAIGN FOR COMPULSORY SICKNESS INSURANCE LEGISLATION (1914-1920)

THE group of disinterested persons who conducted the campaign for compulsory sickness insurance during the years 1914-1920 insisted that the existing types of voluntary sickness insurance in the United States afforded inadequate protection to the mass of American wage-earners. That conviction supplied the driving force of the movement, which before its termination in 1920, compelled attention on the part of legislatures of several states of the Union. In this chapter the various phases and developments of that unsuccessful effort will be discussed.

In December 1907, at the first annual meeting of the American Association for Labor Legislation held in Madison, Wisconsin, the late Professor Henry R. Seager outlined a program of social legislation with special reference to wage-earners. He emphasized that "provision against illness not directly traceable to the employment must be sought either in compulsory illness insurance or in subsidized and state directed sick insurance clubs." It is interesting to note, however, that Professor Seager indicated his belief in the latter plan as better adapted to American conditions than compulsory sickness insurance.

The year following Professor Seager's pronouncement was marked by increasing interest in compulsory insurance on the part of social scientists and professional social workers throughout the United States. In 1908 the Russell Sage Foundation sent the late Dr. Lee K. Frankel, at that time a social work administrator, and Miles M. Dawson, a consulting insurance actuary,

THE UNSUCCESSFUL CAMPAIGN FOR COMPULSORY INSURANCE

to Europe to study the various systems of social insurance in operation in different countries. The results of their studies were published by the Foundation in 1910 under the title *Workingmen's Insurance in Europe*.

JUSTICE BRANDEIS' PLEA FOR "WORKINGMEN'S INSURANCE," 1911

At the National Conference of Charities and Corrections (now the National Conference of Social Work), held in Boston in June 1911, social workers listened to an address by Louis D. Brandeis entitled "Workingmen's Insurance: The Road to Social Efficiency." In his address, Mr. Brandeis urged the social justice and economic wisdom of social insurance against sickness, invalidity, old age, and unemployment. The Conference appointed a committee on Standards of Living and Labor whose function was "to consider and formulate standards of occupational life which are necessary to prevent social distress." A year later, at the Conference of Charities and Corrections held in Cleveland, this Committee brought in its report, consisting of six minimum standards. The last of these was "some effective system of compensation or insurance" for the heavy losses due to accident, sickness, old age and unemployment. The report as a whole was accepted by the Conference. Immediately thereafter the report was taken by certain members of the committee to the National Convention of the new Progressive Party in Chicago, where it was embodied in the platform as the party's plank on social legislation. In May 1913, the Conference of Charities and Corrections, at its meeting held in Seattle, heard Mr. Frank Tucker, in his presidential address on "Social Justice," emphasize the necessity for provision for sickness.

ENACTMENT OF NATIONAL HEALTH INSURANCE IN GREAT BRITAIN

It seems reasonable to assume that the growing interest in sickness insurance in the United States and the decision by the American Association for Labor Legislation in 1912 to under-

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

take an active campaign for compulsory sickness insurance, were related to the introduction in that year of compulsory health insurance in Great Britain.

The opening gun of the American campaign for compulsory sickness insurance may be said to have been fired in December 1912, when the Labor Legislation Association at its sixth annual meeting, appointed its Committee on Social Insurance. The personnel of the Committee was as follows:

Chairman—Edward T. Devine—Professor of Social Economy, Columbia University; Director, New York School of Philanthropy; Editor, *The Survey*; Author, *Misery and Its Causes*; General Secretary, Charity Organization Society, New York.

Miles M. Dawson—Actuary and Attorney-at-Law; Joint Author, *Workmen's Insurance in Europe*.

Carroll W. Doten—Professor of Economics, Massachusetts Institute of Technology; Chief Investigator, Massachusetts Commission on Workmen's Compensation.

Henry J. Harris—U. S. Bureau of Labor; Translator, *German Insurance Code of 1911*.

Chas. R. Henderson—Professor of Economics, University of Chicago; Author, *Industrial Insurance in the United States*.

Frederick L. Hoffman—Statistician, Prudential Life Insurance Company. (Mr. Hoffman retired from the Committee shortly after its appointment.)

Isaac M. Rubinow—Physician; Statistician, Ocean Accident and Guarantee Corporation; Lecturer on Social Insurance, New York School of Philanthropy; Contributing Editor, *The Survey*.

Henry R. Seager—Professor of Political Economy, Columbia University; Vice Chairman, New York Commission on Employers' Liability.

John B. Andrews—Economist; Executive Secretary, American Association for Labor Legislation; Editor, *American Labor Legislation Review*.

Others later added to the Committee were:

Dr. Alexander Lambert—Bellevue Hospital; Professor of Clinical Medicine, Cornell University; Chairman, Social Insurance Committee, American Medical Association.

Dr. S. S. Goldwater—Formerly Health Commissioner, New York City; Superintendent, Mt. Sinai Hospital.

Lillian D. Wald—Head Resident, Henry Street Settlement; Honorary President, National Organization for Public Health Nursing.

THE UNSUCCESSFUL CAMPAIGN FOR COMPULSORY INSURANCE

ARGUMENTS ADVANCED FOR COMPULSORY INSURANCE

The arguments advanced by the proponents of compulsory sickness insurance may be summarized as follows. They are from the *Brief for Health Insurance* published by the American Association for Labor Legislation at a later stage in its campaign.¹

1. High sickness and death rates are prevalent among American wage-earners.
2. More extended provisions for medical care among wage-earners are necessary.
3. More effective methods are needed for meeting the wage loss due to illness.
4. Additional efforts to prevent sickness are necessary.
5. Existing agencies cannot meet these needs.
6. Compulsory contributory health insurance providing medical and cash benefits is an appropriate method of securing the results desired.

Taking up these six points in detail:

1. While complete statistics as to morbidity are lacking, all available evidence shows that the amount of disability due to sickness is high; further, that the death rate from tuberculosis and from degenerative diseases in middle life, and the infant mortality rate, are all excessive among the industrial class.
2. Better provision for medical care is necessary because wage-earners are unable to meet expenses of proper care. Free hospital and dispensary facilities are not sufficient and are objectionable to many workers as charity; obstetrical and other home nursing care is insufficient, facilities for laboratory diagnosis and specialist service are demanded by the advance of modern medicine.
3. More effective methods are needed for meeting wage loss due to illness, which amounts to millions of dollars annually, since savings of workers are totally insufficient to meet this loss, and existing voluntary systems for insuring against it are not fulfilling requirements; the great majority of workers are un-

¹ *Labor Legislation Review*, New York, June 1916.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

protected; the lowest paid, who most need protection, are least likely to have it.

4. All measures for more adequate medical care and financial protection are wasteful unless accompanied by additional, energetic efforts for the prevention of sickness; factory legislation and inspection have proven insufficient to secure hygienic working conditions; infectious diseases are not being prevented as they might be; deaths from degenerative diseases are rapidly increasing, largely by reason of lack of early diagnosis.²

5. The American Association for Labor Legislation was emphatic in stating that existing agencies do not meet these recognized needs for the cure, financial relief, and prevention of illness among wage-earners. It claimed that they have inherent weaknesses which render them incapable of developing properly to meet them. Philanthropic medical and relief organizations cannot be expected to provide an adequate solution even if their extension were wholly desirable. Establishment sick benefit funds are excellent in their limited field, but in the absence of state regulation or control, socially disadvantageous conditions are often unavoidable. Commercial health insurance is high in cost in proportion to benefits; in particular, the cost of providing medical benefit remains prohibitive for commercial industrial insurance companies. Fraternal orders have not a wide enough appeal to meet the needs of wage-earners. The "contract doctor" system of furnishing medical care practiced by some fraternalists seems not to be adequate, the members not receiving proper attention nor the doctor adequate pay; many of these

²The campaign for workmen's compensation, with its guarantees of indemnification and medical care to a workman injured in the course of his employment, appeared to be won by the time the campaign for compulsory sickness insurance was launched. The American Association for Labor Legislation had been active in that movement. Although the first New York act passed by the legislature in 1910 had been declared unconstitutional, the New Jersey act passed in 1911 had been upheld by the courts. The principle of workmen's compensation was endorsed and its desirability admitted by leading social and industrial organizations. By the end of 1912, workmen's compensation was operative in the states of California, Illinois, Kansas, Massachusetts, Nevada, New Hampshire, New Jersey, Ohio, Washington and Wisconsin. Laws enacted during 1912 in Arizona, Michigan and Rhode Island were to come into operation during 1913. Bills providing for workmen's compensation were before the legislatures of several other states.

THE UNSUCCESSFUL CAMPAIGN FOR COMPULSORY INSURANCE

orders are financially insecure, and state regulation is urged. Trade union sick benefit funds cover only a small number of workers, and an increase seems unlikely; the main efforts of American unionism are now toward organization of unskilled, low-wage trades, whose workers cannot afford the high rates required to cover even the present low scale of benefits; many union men believe benefit funds to be a handicap to organized labor in its efforts to better working conditions. Voluntary state-subsidized insurance, as practiced in certain European countries, is stimulating to the growth of health insurance, but the increase is slow, leaving large numbers without protection. On the preventive side, voluntary subsidized societies are at a disadvantage because they cannot enter the field of industrial hygiene.

6. Compulsory sickness insurance is urged because it makes certain that all who require protection against sickness will be sure to get it. Under compulsory insurance no expensive reserve fund is necessary; simplified and economical administration is possible; all the needs of the sick wage-earner are supplied, including all medical care for himself and family, as well as income protection; the burden of cost of sickness is distributed fairly among employer, employee and the State, all of whom are jointly responsible for illness, and would profit by its prevention; the distribution of cost puts health insurance within reach of those who otherwise lack it, and offers the advantage of democratic control; the campaign for the prevention of illness will be stimulated.

PERIOD OF EDUCATIONAL PREPARATION

The American campaign for compulsory sickness insurance had two distinct phases. The first was a period of educational preparation, culminating in the publication of the "Standard Bill," in November 1915. The second phase was the period of legislative consideration.

One of the first acts of the Social Insurance Committee of the American Association for Labor Legislation was to arrange for

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

an American Conference on Social Insurance. It was held in Chicago on June 6-7, 1913. Dr. Willoughby, Dr. Rubinow, and others discussed social insurance, with special emphasis on health insurance as the next logical step. Dr. Rubinow, in reviewing the Conference later in *The Survey*, said, "The need now seems to be for wide propaganda rather than for deep investigation."

The December 1913 meeting of the American Association for Labor Legislation, held in Washington, was devoted largely to consideration of health insurance plans. Professor Joseph P. Chamberlain, of the Legislative Drafting Research Association, talked on the "Practicability of Compulsory Sickness Insurance in America."

At the National Conference of Charities and Correction, held in Memphis in May 1914, a foreshadowing of the later opposition to compulsory sickness insurance was contained in the address delivered by Frederick L. Hoffman, Statistician of the Prudential Insurance Company. Mr. Hoffman reviewed the studies of social insurance made by various individuals and public bodies in the United States since 1893, urged careful study of compulsory sickness insurance, and stated his belief that the problem was not as yet a pressing one in the United States. He expressed the opinion that the propaganda in favor of compulsory sickness insurance in certain states was entirely artificial.

At the same conference, John B. Andrews, Executive Secretary of the American Association for Labor Legislation, in an address entitled "Legislation as a Means of Establishing and Maintaining Standards of Living and Labor" said: "Campaigns for insurance against sickness, invalidity and unemployment are close upon us."

THE STANDARD BILL

In July 1915, the Social Insurance Committee of the American Association for Labor Legislation, after two years of preparatory labor, issued for public circulation its nine "Standards" for a health insurance law; in November the first tentative draft of the "Standard Bill" was published. The December 1915 meet-

THE UNSUCCESSFUL CAMPAIGN FOR COMPULSORY INSURANCE

ing of the Association devoted much time to health insurance, and Professor Seager exhaustively analyzed the proposed bill. Its provisions may be summarized as follows:

1. *The insured population; income limits.* Insurance to be compulsory for every employed person earning \$1,200 per year or less. (The New York bill, introduced in the Legislatures of 1916, 1917, 1918, 1919 and 1920, defined employee as an "employed person entitled to compensation for injury under the workmen's compensation act.") The "Standard Bill" contained special provisions to cover casual and home workers, and for those who wished to insure voluntarily under the act. It presumably included the employees of all industries within its compulsory provisions, the only exceptions being in the case of federal, state or municipal employees for whom provision against sickness was already legally made.

2. *Method of meeting the cost of sickness insurance.* The expenses of the insurance scheme to be met by contributions from employees, employers, and the State, in the following proportions: The State to contribute one-fifth of the total expenditure for benefit (subject to certain provisions for a guarantee fund); of the balance, one-half to come from the employer, one-half from the employee; except in the case of those earning less than \$9 per week, for whom a diminishing schedule was arranged, scaling down to no contributions at all for those earning \$5 a week or less. The amount of the contributions to be computed so as to be sufficient to cover payment of benefits, the expenses of administration, and reserve and guarantee funds. The rates of contributions might be different in different industries, according to the sickness experience of the industries.

3. *Cash Benefits.* Beginning with the fourth day of illness, a cash benefit equal to two-thirds of the weekly wage to be paid, for a period not exceeding twenty-six weeks in any one year. A cash benefit of one-third of the weekly wage to be paid to the dependents of an insured person receiving hospital treatment, during his stay in the hospital.

4. *Medical Benefits.* "All necessary medical, surgical and nurs-

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

ing attendance and treatment" to be furnished from the first day of illness, for a period not to exceed twenty-six weeks in any one year. The medical service to be provided by the insurance carriers, who are to "make arrangements for medical, surgical and nursing aid by legally qualified physicians and surgeons, and by nurses or through institutions or associations of physicians, surgeons and nurses." In case the insurance carrier is unable to furnish this service, it is to "pay the cost of such service actually rendered by competent persons at a rate approved by the Commissioner."

Insurance carriers to be permitted four methods of supplying medical service: 1. A panel to which all legally qualified physicians should have a right to belong, and from which the patient might have "free choice" of doctor (subject to the doctor's right to refuse on grounds specified); no panel doctor to have on his list more than 500 insured families or more than 1,000 insured individuals; 2. Salaried physicians in the employ of the carrier among whom the insured should have reasonable free choice; 3. District medical officers, engaged for the treatment of insured persons in prescribed areas; 4. Combinations of above methods.

Medicines, surgical supplies, dressings, eyeglasses, appliances etc., to be supplied, not to exceed a cost of \$50 for any one patient in any single year.

Hospital or sanitarium treatment and maintenance, *instead of all other benefits* (except one-third of the insured employee's wages to his dependents), to be provided when necessary, on approval of the medical officer of the carrier. This benefit might be provided by financial arrangements made by carriers with hospitals and approved by the Social Insurance Commissioners or in institutions built and maintained by the carriers with the approval of the Commissioners.

5. *Maternity Benefits.* Insured women and the wives of insured men to receive maternity benefits to include "all necessary medical, surgical and obstetrical aid, materials, and appliances," and a cash benefit equal to their regular sick benefit

THE UNSUCCESSFUL CAMPAIGN FOR COMPULSORY INSURANCE

to be paid for eight weeks, two prior and six subsequent to confinement.

6. *Funeral Benefit.* The insurance carrier to pay the actual expenses of the funeral of an insured person, up to the amount of \$50.

7. *Additional Benefits.* With the consent of the Commission, the carriers might grant additional or increased benefits.

8. *The Insurance Institutions.* For the purpose of administering compulsory health insurance, the State to be divided (by the Insurance Commission) into districts, each to contain not less than 5,000 insured persons; one or more local or trade funds to be established in each district; each fund must be authorized by the Commission after approval of its constitution and filing of names of officers; funds to have all the powers necessary to the carrying out of their duties under the act; employer and employee members to be equally represented in the governments of the funds; every fund to be required to accumulate a reserve; the State to contribute to every fund one-fifth of its total expenditures for benefits and expenses; two or more carriers in a district permitted to combine for the administration of medical benefits subject to the approval of the Commissioners.

9. *Supervision by the State Government.* Compulsory health insurance to be administered under the central authority of a full-time State Social Insurance Commission, consisting of three persons appointed by the governor, one of the three to be a physician. This Commission to appoint officers and employees, make rules and regulations, and "do all things necessary" for the operation of the act.

A Social Insurance Council of twelve members, six elected by the employer directors of the funds, and six by the employee directors, to approve all reports and recommendations of the Commissioners, or if disagreeing, to submit separate reports and recommendations. All regulations proposed by the Commissioner to be laid before the Council for discussion.

A Medical Advisory Board, chosen by the state medical society, to be consulted on all medical matters. Disputes arising

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

under the act (except medical) to be determined by the Commission, or by a dispute committee assigned by it, from which appeal could be had to the Commission.

Medical disputes to be referred by the Commission to the Medical Advisory Board, which would submit its report to the Commission.

INCREASING INTEREST OF AMERICAN MEDICAL PROFESSION

Increasing interest of the medical profession in the United States was manifested early in 1916, when the American Medical Association appointed its committee on social insurance. The object of this Committee was "to study social insurance in its relation to the medical profession." Dr. Alexander Lambert served as chairman, and Dr. I. M. Rubinow, well known as an advocate of compulsory sickness insurance, as executive secretary. This Committee set up a bureau of information for the medical profession on all questions concerning health insurance, declared its intention to attend all public hearings, and other meetings where health insurance was the subject of discussion. Its first report was presented and accepted at the June 1916 meeting of the Association. The report made no argument either for or against compulsory health insurance, but presented a compilation of facts on the then existing situation, including a discussion of European systems, with special reference to the relation of the doctors to the scheme. The report also presented a special review of the British Act; an analysis of conditions in the United States; gave a summary of the "Standard Bill"; discussed the place of the physician in the proposed United States system and problems that would probably arise. During the spring of 1916, compulsory health insurance was a frequent theme of discussion at state medical association meetings, and many local societies appointed special insurance committees to study this question from the standpoint of the physician.

A special group of the medical profession, viz., the public

THE UNSUCCESSFUL CAMPAIGN FOR COMPULSORY INSURANCE

health physicians, headed by Dr. B. S. Warren of the United States Public Health Service, favored some form of compulsory insurance, to be under the control of the state public health departments. Another group, closely allied in professional interest to the proposals for compulsory sickness insurance, was the National Convention of State Insurance Commissioners. In 1915 this body appointed a standing Committee on Social Insurance, its chairman being Rufus M. Potts, State Insurance Commissioner of Illinois. In 1916 this Committee reported, recommending a national compulsory health insurance system. However, no action was taken by the Convention on this report.

The movement for compulsory sickness insurance reached the Congress of the United States during 1916. A resolution was introduced in the House of Representatives (H. J. Res. 159) to create a Federal Commission to prepare a plan for a national insurance fund against sickness, invalidity and unemployment. Public hearings on the resolution were held, but no action taken. The resolution was brought up again at the next session of Congress, referred to committee, and not heard from thereafter. Samuel Gompers, then President of the American Federation of Labor, was active in opposition to the proposals for Federal legislation for sickness insurance.

The outbreak of the World War had prevented the carrying out of a plan to hold the International Conference on Social Insurance in Washington in 1915. As a partial substitute, a conference was called by the International Association of Accident Boards and Commissions on the American continent, and held in Washington December 5 to 9, 1916. The proceedings of this conference were printed as Bulletin 212 (1917) of United States Bureau of Labor Statistics, the section on health insurance constituting a summing up of the major arguments in favor of and against compulsory health insurance, the details of operation, the relation of the doctor to the system, etc. No formal action for or against compulsory sickness insurance was taken by the conference.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

THE PERIOD OF LEGISLATIVE CONSIDERATION

Among the states of the Union which gave legislative consideration to the question of compulsory sickness insurance were California, New York, Massachusetts, Pennsylvania, New Jersey, Ohio, Illinois, Connecticut and Wisconsin. In all of these except New York, where the Reconstruction Commission made a special study, commissions were created by the legislatures to study the question. In five states bills were introduced in the legislature to provide systems of compulsory sickness insurance. These were: New York (1916, 1917, 1918, 1919, 1920); Massachusetts (1917, 1918); New Jersey (1918); Ohio (1919); Pennsylvania (1917).

THE CALIFORNIA INVESTIGATION

The California Commission provided the earliest and one of the most thorough of the studies. It made scientific investigations of wage rates and earning power; of the cost of medical treatment (which it found more expensive in California than elsewhere); of sickness as a chief cause of dependency; of existing sickness insurance funds (found entirely inadequate for support and care during illness of insured, and furthermore, carried by only one-third of California wage-earners). The Commission concluded that health insurance would offer a "powerful remedy" for these conditions, and recommended that such legislation be prepared for by passing the necessary constitutional amendment. No attempt was made by this first Commission to frame a bill, but the essential features for one were broadly outlined. Objections were made to three points of the "Standard Bill" of the American Association for Labor Legislation: (1) Existing voluntary agencies should be used, not abandoned; (2) Joint control by employers and employees might produce deadlocks in disputes; (3) Success depends on management; the "Standard Bill" gave no assurance that persons of special fitness would be chosen.

The second California Commission continued the work begun by the first, and specifically outlined a suitable act for

THE UNSUCCESSFUL CAMPAIGN FOR COMPULSORY INSURANCE

California. In October 1918, however, the proposed constitutional amendment giving the legislature the right to pass social insurance legislation was voted down by the people of the state two to one.

THE OHIO COMMISSION ON SOCIAL INSURANCE

The Ohio Commission, created in 1917 to study sickness prevention, old age and health insurance, secured the cooperation of social agencies, of the State Manufacturers' Association, of the State Medical Association, and of the State Federation of Labor. In 1919 it submitted a report based on thorough research. Some of its topics were: child welfare, national vitality, sickness and economic distress, losses from sickness, distribution of losses, responsibility and liability for sickness, measures of prevention. A study of health insurance systems in European countries was also made. Compulsory health insurance legislation was recommended as a means, first, of distributing the cost of sickness; second, of providing adequate medical care, adequately compensated. The possible function of health insurance as a means of sickness prevention was not emphasized, this field being specifically cared for in recommendations for the development of a state program of prevention. All of the Commission's recommendations except that for a health insurance bill were immediately passed by the Ohio Legislature.

THE PENNSYLVANIA LEGISLATIVE COMMISSION

The Pennsylvania Commission was handicapped by limited funds and shortage of time. Recognizing this, it devoted its efforts to assembling facts already gathered by public and private agencies. Valuable data were thus brought together on the following subjects: the nature and extent of sickness in Pennsylvania; losses to individuals, employers and the state through preventable sickness; adequacy of existing methods of care and of health insurance; health conditions in the industries; occupational disease;

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

sickness prevention. Its recommendations (submitted in 1919) were for the creation of a special Commission on which the medical, nursing and legal professions, organized labor and organized industry should be represented, to study profoundly possible remedial legislation looking to adequate medical care, meeting of wage loss, and state-wide preventive work.

THE ILLINOIS INVESTIGATION

The Illinois report, published in 1919, for which the investigations were made under the direction of Professor H. A. Millis of the University of Chicago, was the most exhaustive and scientific of all these reports in the data submitted. It contained a wealth of original research, including studies of sickness in a group of some 3,000 families in 41 selected city blocks in Chicago; existing facilities for medical care and preventive work; incidence, duration and cost of sickness among wage-earners, and their effect on standards of living; responsibility for sickness and premature death, and their prevention; vital statistics; causes of disease and death; existing health insurance in the various mutual benefit funds. Reference was made to the 35 per cent found unfit in the first (1917) Army draft, and to the fact that 33 per cent of a group of 69,171 applicants for work in Illinois were diseased or defective. The wage-loss resulting from sickness was carefully tabulated and discussed. Including medical outlay and wage-loss, the cost of sickness was found to be about \$75 per family per year, which was more than 5.8 per cent of income from all sources. Applied to the entire state, the total figure on this basis of the cost of sickness to wage-earners would be \$57,000,000; adding medical care for dependents would bring the total to approximately \$85,000,000 per year. Discussing health insurance as a possible remedy for these conditions, a majority of the Illinois Commission concluded that the application of the insurance principle to the sickness hazard was clearly justified, but that this should be done by individual action rather than by state compulsion, therefore no legislation was recommended. A minority report

THE UNSUCCESSFUL CAMPAIGN FOR COMPULSORY INSURANCE

signed by Alice Hamilton, M.D., and John E. Ransom, social economist, disagreed with the negative recommendation of the majority, and declared for compulsory health insurance as the logical conclusion of the Commission's findings.

THE MASSACHUSETTS COMMISSION

The Massachusetts Commission, created in 1916 to report in 1917, was directed to investigate sickness, unemployment, old age, and hours of labor in 24-hour-a-day industries. Its report submitted 13 statements representing the opinions held by different members of the Commission, formulated after public hearings and conferences with experts on the various subjects; three of these statements were on health insurance. Four of the nine members of the Commission subscribed to the statement that "some plan for health insurance should be adopted as an important early step in the interests of social welfare." The Commission as a whole, endorsing the principle of health insurance, recommended further thorough study by a special commission. The legislature created a second commission which reported in 1918, stating its conclusion that compulsory health insurance was neither needed nor wanted in Massachusetts by the wage-earners, and no legislation was recommended.

THE NEW JERSEY COMMISSION

In November 1918, the New Jersey Commission, originally appointed in 1911 to study old age insurance, finally submitted a report stating its conclusion that protection against sickness should precede any provision for old age. This step, the Commission believed, was the more urgent because of industrial changes following the entry of the United States into the War, causing thousands of new workers, especially women, to be exposed to extra hazards of sickness. The Commission therefore recommended the immediate passage of health insurance legislation,

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

especially emphasizing provisions for sickness prevention. However, no bill was introduced in the Legislature.

THE WISCONSIN SOCIAL INSURANCE COMMISSION

This Commission, composed of five members of the legislature, presented a report setting forth the views of certain groups such as organized labor and the state medical society, gave data on savings in the state, and pointed to the healthful climate of Wisconsin and the hardy strength of its pioneer settlers. The cost of compulsory health insurance, so far as it could be estimated, was declared to be excessive. Furthermore, the Commission stated the proposed measure to be unconstitutional. More liberal appropriations were urged for the support of already existing public health and welfare institutions, and the inclusion of occupational diseases in the provisions of the workmen's compensation act was recommended. One member of the Commission made a minority report declaring his opinion that the law would not be unconstitutional, and disagreeing with the declaration that the "voluntary thrift" of Wisconsin citizens and the health of their forebears was a sufficient protection against the hazards of sickness.

THE CONNECTICUT COMMISSION

The Commission appointed by the Legislature of Connecticut in 1919 was directed to study a large number of subjects, many of them unrelated to social insurance. Of these it reported on five, one of which was health insurance. The report contained a summary of arguments for and against compulsory health insurance, general data on extent of sickness in the state, and several drafts of bills, including one by opponents of health insurance. The Commission definitely recommended against legislation for health insurance, but suggested that more be done by the state to improve living conditions and prevent sickness.

THE UNSUCCESSFUL CAMPAIGN FOR COMPULSORY INSURANCE

THE NEW YORK STATE INVESTIGATION

During the years 1916 to 1919, the New York State Reconstruction Commission carried on certain investigations and held public hearings, after which, in 1919, it declared in favor of the introduction of compulsory health insurance legislation.

Because of its commanding position as a leading industrial state, New York was chosen by the American Association for Labor Legislation as the principal legislative campaign ground. In five successive years a health insurance bill was introduced in the state legislature. The session of 1919 saw the climax of the campaign. On April 10 of that year the bill introduced by Senator Davenport was passed by the Senate, under an emergency message of Governor Alfred E. Smith urging its passage. It was sent to the Assembly, where, after sharp debate, it was defeated. At the session of 1920 Senator Davenport once more introduced a bill for compulsory sickness insurance. It was referred to a committee and was never thereafter heard from. With the defeat of the bill by the New York State Assembly, the campaign for compulsory sickness insurance in the United States came to a halt.

THE OPPOSITION

The forces opposed to compulsory sickness insurance grouped themselves into four general divisions: employers, insurance companies, organized labor, the medical profession. All of these groups voiced their recognition of the need for some organized measures for the solution of the problem of preventable sickness and its burden of human suffering and economic loss. They were opposed to the system of compulsory state-operated health insurance as a means of meeting that need.

Employers objected to the expense of the system, which they considered bore disproportionately on industry; this they claimed could not successfully be distributed in the cost of production and passed on to the consumer; if there was to be such a law, they argued, it should be supported by a tax in which the whole

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

community bore an equal share; they labeled the measure a form of class legislation because it provided for a certain economic group only; they considered the system on the whole out of line with American institutions and industrial development.

The "Standard Bill" for compulsory health insurance expressly excluded the commercial insurance companies as carriers under the act. The writings of Dr. Frederick L. Hoffman of the Prudential Insurance Company, under the general title *Facts and Fallacies of Compulsory Health Insurance*, were given wide circulation. He appeared at legislative hearings, at medical association and other meetings. His chief arguments were that the proposed compulsory system was not based on sound actuarial findings, or correct insurance principles; that the need for a compulsory system in America was not pressing; that voluntary agencies could be developed to take care of cash benefits; that medical care and prevention work were outside the province of insurance; and finally that the whole idea was "un-American." The late Dr. Lee K. Frankel, at that time with the Metropolitan Life Insurance Company, took the stand that insurance is, strictly speaking, indemnity for loss, and that prevention of sickness and provision of medical care come in only incidentally; that the functions of the attending physician are distinct, and should be kept free from insurance claims. He proposed universal rather than compulsory insurance, by a method of taxation of employers and workers which would make it universal, while not legally compulsory.

The attitude of organized labor toward compulsory health insurance legislation was a divided one. As already pointed out, Samuel Gompers, President of the American Federation of Labor, opposed compulsory sickness insurance in principle, as paternalistic, socialistic, and an unjustifiable interference with the individual rights of wage-earners, who should, he believed, be let alone to take care of all such matters through their trade unions. The American Federation of Labor at its annual convention in 1916 declared against "private insurance or insurance for profit, as it may apply to industrial, social or health insurance"; in 1918 it

THE UNSUCCESSFUL CAMPAIGN FOR COMPULSORY INSURANCE

instructed its Executive Council to investigate the subject of health insurance. On the other hand, many of the State Federations of Labor placed themselves on record as favoring compulsory health insurance. The New York State Federation secured a modification of the terms of the "Standard Bill" to meet the demands of the trade unions, the resulting bill being introduced by Senator Nicoll in the 1918 legislature.

The attitude of the medical profession appears to have undergone some transformation between 1913 and the introduction of bills in state legislatures. During 1912, 1913 and 1914, the members of that profession were supplied with a steady stream of information which flowed through the columns of the *Journal of the American Medical Association*. The "London Letter," appearing weekly in the *Journal*, narrated the opposition of the British medical profession to the National Health Insurance Act. These articles reported the progress of the controversy between the British doctors and the government over the medical provisions of the Act, which had aroused the bitter opposition of medical men, even up to the point of a threatened "strike" of the entire profession. More than 27,000 doctors had in fact signed pledges to refuse to work under the Act except on terms acceptable to the British Medical Association; 10,000 contract doctors of the Friendly Societies which were to function as carriers under the Act, sent in their resignations. Throughout 1914 the "London Letter" continued to report on the workings of the Act and on any difficulties that arose in the administration of medical benefit. The cessation of the "Letter" in 1915 was doubtless due to the fact that the war was absorbing the energies of the British nation. On the other hand, a satisfactory *modus vivendi* had by that time been worked out between the British medical profession and the national health insurance administration.

Up to about January, 1917, letters and articles appearing in the *Journal of the American Medical Association* were noticeably favorable to health insurance, both as to principle and as to the system proposed for the United States. From January to June 1917, however, the arguments against the system seemed to

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

occupy chief place. In July 1917, probably due to the preoccupation of American doctors with the war, the discussion in the *Journal* ended abruptly. When, however, early in 1919 a bill for compulsory sickness insurance was under consideration in the New York Legislature for the fourth time, opposition to the bill on the part of the medical profession of New York State was voiced. This notwithstanding certain demands of the doctors had been met by eliminating the local panel system, by providing absolute state-wide free choice of doctor, by making mandatory the appointment of a doctor as head of the state health insurance bureau, and by changes in the system of fees.

LACK OF ACTIVITY SINCE 1920

After 1919 the interest of professional social workers in the movement for compulsory sickness insurance appears to have waned. At the 1917 meeting of the National Conference of Social Work held in Pittsburgh two months after the entry of the United States into the World War, Professor Irving Fisher, in an address entitled "Public Health a Social Movement," had urged the need of universal health insurance. In the section devoted to social insurance, Royal Meeker had urged the enactment of state legislation making sickness insurance compulsory. John B. Andrews had reported progress toward health insurance and cited "the rapidly increasing public demand." On the other hand, A. E. Forrest, President of the Health and Accident Insurance Underwriters' Conference, Chicago, had opposed compulsory sickness insurance. Eugene T. Lies, Superintendent of the United Charities of Chicago, in an address entitled "Sickness Dependency and Health Insurance," had urged compulsory sickness insurance. Two lawyers, Professor Ernest Freund of the University of Chicago, and Professor Joseph P. Chamberlain of Columbia University, had called attention to certain constitutional aspects of compulsory health insurance legislation.

At its May 1918 meeting the National Conference heard from James H. Tufts, Chairman of the Illinois Committee for Social

THE UNSUCCESSFUL CAMPAIGN FOR COMPULSORY INSURANCE

Legislation (then engaged in an investigation of the need for health insurance on the part of the wage-earners of Illinois), a plea for careful consideration before enacting compulsory sickness insurance legislation. At the same Conference Royal Meeker expressed the belief that "social legislation is necessary to bring to the workers better and cheaper food, clothing, houses, medical treatment and insurance."

The subsequent lack of interest in compulsory sickness insurance on the part of professional social workers is further shown by the dearth of major articles dealing with the subject in the *Survey* magazine during the years 1921 to 1931, inclusive. One article appeared in the number for May 15, 1926. It was by Dr. I. M. Rubinow, who, it will be recalled, was Secretary of the American Medical Association Committee on Social Insurance, and an active leader in the American campaign. Dr. Rubinow urged the revival of the movement for social insurance, and suggested that the inertia of social workers in the field of social legislation was partly responsible for the lack of progress. He referred to the "somewhat naïve optimism . . . so rampant a decade ago." While admitting that at the moment there was no sign of any active movement for social insurance, Dr. Rubinow expressed the hope of "a recovery from a reaction which came suddenly after a striking and promising development about a decade ago."

Since the defeat of the New York State bill in 1920, the American Association for Labor Legislation has not been active in behalf of compulsory sickness insurance. The quarterly issues of the *Labor Legislation Review* since 1920 have not contained any major articles dealing with compulsory sickness insurance, or indicating any active efforts on the part of the Association to secure the enactment of legislation.

At the National Conference of Social Work held in Boston in May, 1930, Dr. John B. Andrews, Executive Secretary of the Association, gave a review of progress since Justice Brandeis' address to the National Conference of Charities and Corrections in that city nineteen years previously. On the subject of sickness

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

insurance Dr. Andrews stated: "It is increasingly apparent that the cost of adequate medical care in America cannot be met without insurance against sickness." He reminded his hearers that in 1919 "the campaign for a universal system of workmen's health insurance had been advanced to a point where a well-considered bill was passed by the New York Senate." Dr. Andrews gave no indication of any prospective resumption of the campaign by his Association.

In concluding this recital of the unsuccessful campaign for compulsory sickness insurance legislation, it should be mentioned that the situation as to voluntary sickness insurance and fixed payment medical service in the United States has changed little since 1920. Of the eleven chapters which follow, all but one are given over to a consideration of plans which the proponents of compulsory sickness insurance fifteen years ago regarded as inadequate to protect the average wage-earner. This conviction constituted the chief driving force in their campaign. Chapter X describes four types of fixed payment medical service which have come into operation on a limited scale during the last fifteen years. Fixed payment medical service offered by group clinics, and fixed payment hospital service offered by non-profit community hospitals and by coöperative health associations in a number of American cities, are comparatively recent developments. No great change has taken place in the scope of benefits under commercial health and accident insurance, unless it be the wider utilization by large employers of the plan of group disability insurance. This form of protection, as already emphasized, does not provide medical, surgical or hospital care. Employee mutual benefit associations and trade union sick benefit funds are much the same as they were during the period of the campaign for compulsory sickness insurance, and their number does not appear to have greatly increased.

Industrial medical service for employees, paid for by means of

THE UNSUCCESSFUL CAMPAIGN FOR COMPULSORY INSURANCE

a fixed regular deduction from wages, has been modified to some extent by the enactment of workmen's compensation laws. The chief result of this legislation has been to fix with exactitude the employer's responsibility for providing medical care to an employee injured at his work. In form of organization, administrative methods and scope of medical care available, the company plans have undergone slight evolution.

Railroad employee hospital associations would not in any case have been directly affected by the enactment of compulsory sickness insurance laws by the different states, their members being chiefly engaged in interstate commerce. Apparently, the campaign of the American Association for Labor Legislation did not envisage a Federal law to cover these employees.

The static nature of voluntary sickness insurance in the United States and the slowness of new developments are facts of considerable social significance.

CHAPTER III

FIXED PAYMENT MEDICAL SERVICE IN THE LUMBER AND MINING INDUSTRIES OF WASHINGTON, OREGON, AND CALIFORNIA

IN an address to the International Association of Industrial Accident Boards and Commissions at its 1920 meeting, Dr. John W. Mowell, M.D., Chairman of the Washington Medical Aid Board, explained the development of the contract system of handling medical care of injured workmen.¹ The original workmen's compensation bill of 1911 contained a "medical aid" provision for the payment of medical and hospital bills; the legislature eliminated this and passed the Act without any provision for medical treatment. Between 1911 and 1917 workmen paid their own medical bills for treatment of compensable injuries, either directly to the physician, or by payroll deductions. The men taken care of by contract through the monthly contributions received fairly satisfactory service, but when no such arrangement was made it was difficult, sometimes impossible, for injured men to secure treatment, because their compensation was inadequate to cover both loss of earnings and the extra expense of medical and hospital bills.

The defect in the act of 1911 was remedied by the 1917 legislature, which passed what is known as the Medical Aid Act. That Act provided that the cost of medical and surgical treatment for industrial, i.e., compensable injury, should be borne equally by employer and employee. The amount of this joint contribution varies with the different industries according to

¹ *Proceedings, International Association of Industrial Boards and Commissions, 1920*; Bureau of Labor Statistics Bulletin 281, June 1921.

WASHINGTON, OREGON AND CALIFORNIA

their hazard, and is based on the medical aid cost experience of each industry.

Section 7724 of the Consolidated Laws of the State of Washington provides that any employer engaged in extra-hazardous work may, with the consent of a majority of his workmen, enter into contracts with physicians, surgeons and owners of hospitals operating the same, or with hospital associations, for medical, surgical and hospital care, to workmen injured in such employment, by and under the control and administration of, and at the direct expense of the employer and his workmen. Such contract, to be valid, must provide that the expense incident to it shall be borne half by the employer and half by the employees, and that it shall be administered by the two jointly and equally.

"STATE PLAN" AND "CONTRACT PLAN"

The medical aid act provides two plans under which injured workmen may receive medical and hospital care. The first is known as the "State Plan," under which plan funds contributed by the workmen and the employers are paid into the State Medical Aid Fund; the workman chooses his own physician and his own hospital; the employer furnishes transportation for the injured workman to the place of treatment; the medical bills, hospital bills, and drug bills are paid out of the State fund, upon approval of such bills by the State Medical Aid Board, certified to the Industrial Insurance Commission, which Commission orders the payments made. Where the employer elects the "State Plan," he has no further obligation to provide medical care to an employee injured in the course of employment.

The other plan provided for in the Medical Aid Act is the "contract plan" under which the employer, with the consent of not less than 50 per cent of his workmen, may enter into a contract for medical and hospital care of such men as may be injured. Under this plan, only 10 per cent of the amount paid by the workmen and the employer so contracting is paid into the

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

State Medical Aid Fund; the remaining 90 per cent is paid by the employer directly to the doctor or hospital holding the contract. In either case, however, whether under the State plan or the contract plan, the State Medical Aid Board has supervision of the treatment. This ties the whole subject of medical and hospital treatment of injured workmen to the medical department of the Industrial Insurance Commission.²

It will be noted that the "Contract Plan" authorized by the Washington law relates only to the provision by the employer of medical care to workmen injured in the course of their employment and entitled to compensation. During recent years, however, the contract system has, through coöperative arrangements between groups of employees and their respective employers, on the one hand, and physicians, hospital associations and clinics on the other hand, been extended to include the provision of medical and surgical treatment and hospital care to employees disabled by non-industrial (i.e., non-compensable) accident, or by ordinary sickness. To cover the cost of medical service arising out of these two last mentioned hazards a special contribution is made by the employee, in the form of an authorized deduction from wages.

In considering the present status of contributory contract medical practice in the industries of Washington, a clear differentiation must always be made between the contract authorized by the Workmen's Compensation Law, under which the expense of medical care for injured workmen must be borne jointly by employer and employee, and the contract for medical care for ordinary sickness and non-industrial injury, voluntarily agreed to and paid for entirely by the employee. Although the voluntary contract for non-industrial medical care is sometimes found alone, the Workmen's Compensation Medical Aid contract for the care of injuries received in line of work is almost always accompanied by the other. The two contracts together

² *How Medical Questions are Handled Under the Workmen's Compensation Act in the State of Washington*, by J. W. Brislaw, Industrial Insurance Commissioner of Washington. *Proceedings, International Association of Industrial Accident Boards and Commissions*, 1918. Bureau of Labor Statistics Bulletin 264, October 1919.

WASHINGTON, OREGON AND CALIFORNIA

provide what is sometimes referred to as "complete coverage," or "twenty-four-hour" medical service.

In effect, then, part of the total contribution by the employee is matched by an equal contribution by the employer. This joint contribution, whether paid to the State, or to the contractor undertaking to provide medical service, covers the expense of medical and surgical treatment and hospital care made necessary by industrial or compensable injuries, and provided by a medical "contractor." The remainder of the employee's periodical contribution (which ordinarily is not matched by the employer) covers the expense of medical and surgical treatment and hospital care to be provided by the same contractor in case the employee is disabled by sickness or disease or by a non-compensable accident. Except where specially provided for in the contract between the employer and the medical contractor, dependent members of employees' families are not entitled to free medical service.

Of the two contracts necessary for complete coverage, the one covering industrial cases must be on the form prescribed and supplied by the state and called the "Medical Aid Contract." For non-industrial accident or illness the contract form is drawn by the contractor and varies somewhat with the different clinics and hospital associations. This latter is usually referred to as the "Medical Service Contract."

It should be clearly understood that the Medical Aid Act of the State of Washington did not make it compulsory on employers to provide medical treatment to employees for non-industrial accident or disease. What has happened is that many employers have availed themselves of the special medical organizations sanctioned by the Medical Aid Act, to contract with such medical organizations to provide treatment to employees in the event of ordinary sickness or non-industrial injury.

FORM OF STATE MEDICAL AID CONTRACT

Because of the close tie-up between the two contracts covering medical service to employees in the State of Washington, it is

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

important to summarize briefly their provisions. First, the officially prescribed state "Medical Aid Contract" covering medical service to industrial employees injured in the course of employment and covered by the workmen's compensation law: (Summaries have been made from copies of contracts in the possession of the National Bureau.)

1. *General.* The agreement is made between the employer (first party) and the medical contractor (second party) with the consent of a majority of the employees.

2. *Duration and cancellability.* The term of each contract is clearly specified (usually one to three years). It may be terminated by the supervisor of Industrial Insurance under Section 7724 Remington's Compiled Statutes of the State of Washington, which provides that all contracts must be submitted to and approved by the Supervisor of Industrial Insurance. It is not assignable or transferable except with consent of Supervisor; and is not binding until approved by him.

3. *Method of payment.* Prior to the 15th of each month, the employer must pay the medical contractor 90 per cent of the amount he would have been required to pay for Medical Aid if the contract had not been made; the remaining 10 per cent of such amount must be paid into the Medical Aid Fund; except that during the months when the Medical Aid Department calls for premium to be paid into the Medical Aid Surplus Fund, the employer must pay 89 per cent to the contractor and 11 per cent into the Medical Aid Fund. The expenses incident to the contract must be borne one-half by the employer and one-half by the employees. (No method of collecting the employee's share is specified in the contract.)

4. *Medical services provided.* All proper and necessary medical, surgical and hospital services and care must be provided by the medical contractor for any accidental injury occurring during the duration of the contract, and received while in the employment of the first party, as provided in the law; such care and services are stipulated to be "prompt and efficient without discrimination or favoritism." If proper treatment with reasonable

WASHINGTON, OREGON AND CALIFORNIA

promptness is not given, the Supervisor of Industrial Insurance may provide it, at the expense of the employer, who may charge it against the contract. When in the opinion of the Supervisor the condition of an injured workman warrants it, he may designate a competent specialist to treat or operate, at the expense of the contracting parties.

PROVISIONS OF MEDICAL SERVICE CONTRACT

The provisions of the typical contract between an employer and a hospital association covering the provision of medical and hospital care to employees for causes not related to the employment, may be summarized as follows.

The employer agrees to deduct from the wages of each employee each month the sum of 10 cents a day until a total of \$1 is deducted. When this sum has been deducted, the employer agrees to pay it over to the party of the second part on or before the fifteenth day of the succeeding month. The contract sets forth that the money so collected by the employer shall be deemed a trust fund held by the company for the employees, and shall be a prior lien in case of insolvency of the employer.

The medical contractor, or "party of the second part," in consideration of this payment, agrees "to render and give all necessary care, treatment, medicine, hospital board and room and professional services for all non-incident injuries and sickness with which any employee of the party of the first part may suffer, at the hospital at, Washington, or at a place designated by the party of the second part, save and except those ailments which are above in this contract set forth."

In addition to all acute conditions the contract is interpreted "to include any major or minor operations for any conditions except for complications of the diseases heretofore excepted, regardless of duration of such condition, on any employee who has been in the employ of the aforesaid company more than six months. This contract does not cover chronic medical conditions of long standing."

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

"The party of the second part further agrees to provide dental services to the extent of two cleanings of teeth to each employee each year and all extractions of teeth on the hospital ticket, same to be done by a dentist designated by the second party."

It is specifically set forth in the contract that "venereal diseases or their complications, conditions peculiar to sex, those diseased conditions arising from alcoholic excesses, injuries received in fights or those communicable diseases whose transportation is prohibited by law," are not included in the ailments which the medical contractor contracts to treat, in return for the fixed payment per employee per month.

SERVICE OFFERED BY COMMERCIAL "HOSPITAL ASSOCIATIONS"

The "contractor" with whom the employer enters into an agreement to provide medical service to employees, either for industrial accident or for both industrial accident and ordinary sickness and disease, may be (1) a hospital association (operating for profit); (2) a general hospital (non-profit); (3) an individual physician.

The bulk of the contract medical and hospital service to industrial employees in the State of Washington is provided by a relatively small number of hospital associations or clinics. There are also many individual physicians and surgeons providing service as "contractors." Some of the community hospitals in the larger cities likewise do contract work for industrial concerns. All of the hospital associations except one are controlled by medical men. Of nine visited by the National Bureau field representative, seven were incorporated under state laws. Several employ a layman as business manager. The actual medical service is rendered by medical practitioners who may receive their remuneration either on a profit-sharing basis, on a straight salary basis, or on a basis of rates established by agreement between the practitioner and the association.

Of nine associations and clinics visited by the National Bureau representative, five actually own or lease hospitals representing

WASHINGTON, OREGON AND CALIFORNIA

an approximate total bed capacity of 518. All of the associations (except one) own and operate "clinics" or dispensaries equipped with surgical, X-ray and laboratory facilities, and usually with physio-therapy and electro-therapy apparatus. Those associations serving chiefly the lumber industry maintain first-aid stations in the various logging camps with whose owners they have medical contracts; some of these stations are in charge of physicians employed by the associations. The associations not owning hospitals usually permit the contract patients a choice of the available local hospitals, provided the hospital chosen is one which will accept the rates set by the state for workmen's compensation patients.

The medical staffs of the associations usually include an internist, an eye, ear, nose and throat specialist, one or more surgeons, and a dentist (for diagnostic examinations only). Among the associations making contract medical service their business, fewer specialists and more general practitioners are found. The nine associations visited report a total of 85 medical personnel giving full-time service, and 47 serving part-time.

HOSPITAL ASSOCIATION CONTRACTS

A slightly different type of contract used by one of the large associations, covering medical care for non-compensable disability, may be summarized as follows:

1. *General.* The first party (Hospital Association) agrees to furnish to the employees of the second party (employer), and to bear the expense of, all medicines, medical and surgical services, hospital accommodations, dental and other benefits.

2. *Duration and Cancellability.* Duration is not indicated in specimen contract, blank space being left. (Available information is to the effect that contracts usually run for from one to three years.) No provision for cancellability is included in the body of the sample contract submitted.

3. *Payroll Deduction.* The employer agrees to pay the Association \$1 per month for each employee on his payroll; "said amount may be deducted from the pay account of each employee."

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

Remittance must be made monthly before the 15th. The employer must provide each employee with "a certificate showing such facts."

4. *Services Included.* All necessary medical and surgical treatments required by employees for all sickness and illness, regardless of whether same occur during working hours or not, and for non-compensable accidental injuries. These services to be provided to employees in their homes, if within the corporate limits of the cities where the Association operates (except that house calls are not required if patient is able to visit doctor's office), or in the two hospitals of the Association; or if the patient prefers, he may choose a certain designated local hospital. Ward service is specified, except for severe and critical cases, when the contractor agrees to furnish a special room. In case of serious illness, where diagnosis and treatment is not satisfactory to the patient, he may call any licensed physician of his community for one consultation, expense to be paid by Association. Other services specified are: Ambulance when necessary; dental service "to the extent of extraction of teeth"; examinations for defective vision for diagnosis only.

5. *Services Excluded.* Venereal diseases and tuberculosis are expressly excluded, but when emergency exists temporary care and service are rendered.

6. *Other Provisions.* Service is understood not to extend to conditions existing at time of employment. (An official of the Association states that this restriction is not adhered to.)

AMOUNT OF EMPLOYEE CONTRIBUTION

The amount deducted from an employee's wages to cover the expense of medical care arising out of non-industrial injury or ordinary sickness under a contract between an employer and a medical "contractor" is usually \$1 per month.

The Insurance Department of the State of Washington has informed the National Bureau that hospital associations engaged in this form of contract practice are considered as selling con-

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WASHINGTON, OREGON AND CALIFORNIA

tracts of service and not of insurance. For this reason, their operations are not under the supervision of the State Insurance Department. As already pointed out, contracts covering medical aid for compensable injuries come under the supervision of the State Department of Labor and Industry, and the law permits cancellation of contracts by the Department if treatment is unsatisfactory, the Supervisor of Industrial Insurance having full authority to transfer an injured workman to other hospitals or doctors as he deems advisable. On the other hand, contracts covering medical care to employees for non-industrial injury, sickness or disease are apparently not under state supervision.

TYPES OF MEDICAL SERVICE ORGANIZATION

In general, the hospital associations providing industrial medical service in the State of Washington are similar in organization and operating methods. One medical service organization, however, is different enough to justify special reference. In 1925, twelve lumber companies in the vicinity of Olympia (Thurston County), formed a corporation not for profit, for the purpose of controlling their own medical contracts, both industrial and non-industrial. This corporation now employs four physicians part-time on salary. One of these physicians is a specialist in internal medicine, one is an eye, ear, nose and throat specialist and the other two are surgeons. The corporation owns no hospital, clinic or dispensary, and local hospitals are used when hospital care must be provided. The customary employee contribution of \$1 per month for non-compensation medical care, and the joint contribution prescribed by the state law from employer and employees for compensation medical care are all deposited together in one fund. Salaries of physicians are paid from this fund. The corporation, representing the several employers, contracts with the employees of the individual lumber companies as separate groups, to provide them medical services through the four employed doctors, or hospital service, if required.

One of the Washington hospital associations has perhaps gone

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

further in developing voluntary medical contracts than any other association in the state. This "Clinic" has its headquarters in a town of approximately 8,000 population. Fees have been scheduled according to the type of contract held by the employer; for example, \$1.25 a month per employee where an industrial injury contract as well as a medical contract is held; \$1 a month per employee where a medical contract alone is made; \$2.50 per month per employee for a contract to cover the employee and dependent members of his family. At present, about four hundred men are insured under the family service plan. If a number of single men are employed in the plant, and they object to this assessment for the advantage of married employees, a fee of \$3 a month is scheduled for the married men, and \$1 for the single men.

At the request of employees who have become accustomed to medical contract service, this organization has developed a mutual benefit and health association. The purpose of this organization is to supplement the compensation available under the state law for accidents, and to provide similarly an income during the period of disability arising out of a non-compensable accident or illness. Through membership in the mutual benefit association, in conjunction with the industrial contract, the employee, in effect enjoys complete health and accident insurance. Benefits are paid at the rate of \$2 a day for a maximum of sixty days. In case a member is receiving compensation under the Workmen's Compensation Act he is entitled only to the difference between that amount and the maximum available from the mutual benefit and health association. Membership in the association is voluntary, but collection of dues is made by the employer on the authorization of the employees through a payroll deduction. An entrance fee of \$2 is provided, in return for which disability benefits begin at once. If the member does not wish to pay this entrance fee, there is a sixty-day waiting period before disability benefits begin. One-half of the entrance fee goes into a reserve fund.

The following contract is an example of service to industrial employees for non-compensable disability in return for an author-

WASHINGTON, OREGON AND CALIFORNIA

ized deduction from wages, by a general (non-profit) hospital in a small town of Washington:

"This Agreement, made the day of, 19. ., between the employees of, the party of the first part, and the General Hospital, of, Washington, the party of the second part, for a period beginning and ending That the party of the second part, in consideration of the payment of One Dollar per month by each and every employee of the party of the first part, hereby covenants to furnish all necessary and reasonable medical and surgical care and medicine at the hospital or at our office or the office of the physicians associated with us, and hospital care when it is the opinion of the physician and surgeon that the condition requires hospital treatment or care, and all acute sickness and injuries developing during the terms of this contract. Providing: such sickness or injury is not due to personal difficulties, as assaults or unlawful acts, the use of drugs or intoxicants, insanity or incurable or venereal diseases. And it is further agreed, that the payment of said One Dollar per month shall be made by the accounting department of the said on or before the fifteenth of the month next following the rendering of services by said party of the second part. In witness whereof, the said parties hereunto set their hands the day and year first written above."

MEDICAL SERVICE IN WASHINGTON COAL MINING INDUSTRY

The United States Coal Commission defines three separate coal fields in Washington, as follows: Kittitas County field; Pierce-King (bituminous) field; sub-bituminous field (formerly known as Lewis field). Forty-eight mines operated in these three fields in 1929.⁸ In 1930, according to the annual report of the Chief Mine Inspector, the number employed was 3,110. More than three-fourths of the bituminous coal produced in Washing-

⁸ *Coal in 1929*. U. S. Department of Commerce, Washington, D. C., 1931.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

ton was mined by four concerns. Information received from these four companies may be summarized as follows:

Coal Company "A." This company normally employs about 180 men. It carries the "all-service coverage" as described above, by means of two contracts with an incorporated hospital association. The payroll deduction for this service for industrial injury under the State Medical Aid Contract is three cents per shift per man, which is matched by three cents from the employer. The medical service contract for non-industrial sickness includes the families, the employees having authorized a \$2 a month deduction to cover this. The two contracts together provide the men and their families with medical and surgical treatment and hospital care for all sickness and injury. Hospital care is given in a hospital operated by the Hospital Association with which the company has contracted. A resident physician is maintained at one of the mining towns by the medical contractor. He gives treatment to employees and members of their families either in their homes or at his office.

Coal Company "B." In 1930 this company employed a total average of 240 men. Medical care for non-industrial injury and sickness to employees and their dependents is based on a contract between the company and a physician. A sample copy of this contract furnished the National Bureau by the Company is summarized here as being typical of such contracts in the mining region:

First party (the coal company) hereby employs second party (doctor), and agrees to deduct from the pay and collect from each man working in the mines, \$1.50 a month (10 cents a day from men working less than the entire working time in a month) and agrees to pay all sums so collected to the second party (the doctor) monthly. Second party agrees "to furnish medical aid and surgical care and necessary medicines" to each man and his dependents, and "free hospital in wards for the period of 12 weeks to the contributing head of the families hereby affected."

WASHINGTON, OREGON AND CALIFORNIA

(Hospital rates are to be charged for hospital care for dependents. It is agreed that the minimum fee for confinement cases shall be \$15, complicated cases \$20). Disabilities and diseases existing prior to employment; injuries or sickness due to intoxication; confinement and miscarriage cases are excluded from the contract. Disagreements as to interpretation or administration of the contract are to be settled between the two parties. Contracts may be canceled at any time "for good and sufficient cause" by either party on three months' notice.

In addition to the service furnished under the above contract, there is, of course, the provision for industrial accident care. This particular coal company uses the "State Plan" and not the "Contract Plan." Therefore, the company has no further responsibility for providing medical aid in the event of a compensable injury. The injured workman has the privilege of calling the company physician, or may choose another. The physician bills the State Department of Labor and Industry for professional services rendered. Bills for hospital care or for medicine are also paid by the State.

Under this coal company's plan the cost per month of medical and surgical care to an employee and his family, assuming he worked 25 days in the month, would be as follows:

To the physician, for non-industrial care, as per the contract.....	\$1.50—paid by the employee through payroll de- duction
To the State 25 days at 3 cents.....	.75—paid by the employee through payroll de- duction
To the State 25 days at 3 cents.....	.75—paid by the Company.

Coal Company "C." In 1930 this company mined 831,252 tons of coal and employed an average of 1,126 men. Medical care is furnished the men and their families through a non-profit Hos-

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

pital Association managed by representatives of the Company and the employees. This employee association owns a hospital and employs doctors and other personnel. All employees receive complete medical and hospital care for non-industrial sickness and accident. Their families receive the same care, but a charge is made them for the hospital room. For this service, a payroll deduction of \$2 per man per month is made.

Medical, surgical and hospital care for industrial injury is also provided by the Hospital Association, the association being reimbursed out of the joint contributions of employer and employee to the State Medical Aid Fund. An officer of the company writes the National Bureau that this charge is 8 cents per employee per day at the mines, half from employer and half from the employees.

Coal Company "D." This company in 1930 produced 520,568 tons of coal, and employed an average of 706 men. These employees and their families receive medical care through contracts between the company and an association of the employees. The obligation assumed by the employees' hospital association is to "render all services required by the employees."

Medical, surgical and hospital care for industrial and non-industrial disability is covered by the contracts. The assessment for the industrial (i.e., the compensation) contract is 5 cents per employee per day worked, half paid by the employee and half by the company. To take care of the non-industrial medical service a special hospital fund is created by a monthly assessment of \$1, deducted from each employee's wages.

This contribution provides the worker and his dependents with medical and hospital treatment, which includes "doctor's services, medical treatment, and hospital care." Necessary medicines, dressings, and supplies are included. The usual exclusions are specified, but the rules permit these conditions to be treated by company surgeons at half rates. Local hospitals in Seattle and Tacoma are utilized by the employees' hospital association. Ambulance and specialist services are provided when ordered by

WASHINGTON, OREGON AND CALIFORNIA

company doctors. Ordinary confinement cases in the homes are cared for by company doctors for \$20. Full-time doctors are stationed at each mining camp. Specialists in orthopedics, abdominal surgery, and eye, ear, nose and throat, are maintained at Seattle, where the Chief Surgeon is also located. All examinations of applicants for employment are made in Seattle.

MEDICAL OPINION AS TO CONTRACT PRACTICE

At the time this chapter was written (August, 1931) there was considerable discussion *pro* and *con* in Washington medical circles on the subject of contract practice. One physician frankly stated that the reason the two types of contract are usually found together is that there is no profit for the medical contractor in industrial injury contracts because of the many state requirements, while in the case of the non-industrial contracts the state has not as yet assumed any authority or supervision.

The following extract from a pamphlet: *A Statement of Fact Relative to Contract and State Plan Industrial Medical Practice*, by Dr. A. Macrae Smith, M.D., F.A.C.S., President of the Society of Industrial Surgeons of the State of Washington, and head of the Bellingham Clinic, is cited not only because of the light it sheds on the general scope of the service, but more particularly because it indicates that contract practice has aroused opposition on the part of physicians in that state.

"The policy of the legislature to exact an unusually high professional standard from those engaged in contract practice is seen by the provision of the Medical Aid Law, permitting cancellation of these arrangements where unsatisfactory treatment is rendered the injured workmen, and the *carte blanche* authority of the Supervisor of Industrial Insurance to transfer an injured workman elsewhere for treatment where he deems it advisable so to do.

"It is thus apparent that the contract medical and hospital service is closely supervised by the Industrial Insurance Division, and that the State, the employer, and the employees are watching

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

the operation of this type of treatment to see that the highest possible surgical standards are employed therein. Obviously, if satisfactory treatment is not rendered by the surgeon or hospital association, in addition to facing the alternative above mentioned, the dissatisfied workmen and employer are not likely to renew this arrangement upon its expiration.

"During the past few years there has been a very noticeable trend towards the contract form of treatment by workmen and employers who had previously operated under the 'State Plan.'"

In the earlier years of the State Medical Aid Act, the contract plan was criticized by persons engaged in the administration of the Workmen's Compensation Law of Washington. In an address delivered before the International Association of Industrial Accident Boards and Commissions at its 1918 meeting, Dr. John W. Mowell, M.D., Medical Adviser to the Industrial Insurance Commission of the State of Washington and Chairman of the State Medical Aid Board,⁴ voiced some of the criticisms then current. These referred particularly to the "commercializing" of the contract plan by non-medical men who formed hospital associations, contracting for the services of a surgeon, paying him only a small part of the amounts received from the employers, and keeping the remainder as their own profit. Further, the difficulty of keeping competent physicians in isolated localities under the "free choice" plan, resulted in the contract service being rendered frequently by unskilled or inexperienced men.

A prominent physician who is also at the head of a hospital association serving the lumber industry stated to the field representative of the National Bureau that his personal attitude toward medical contracts is unfavorable. He regards these contracts as a necessity in the locality, but as a physician, feels that they make difficult the right relationship between physician and patient.

A lay official of the same hospital association, on the other

⁴ *Selection of the Physician Under Compensation Laws*, by John W. Mowell, M.D., Medical Adviser to the Industrial Insurance Commission of the State of Washington and Chairman of the State Medical Aid Board. *Proceedings International Association of Industrial Accident Boards and Commissions*, 1918. Bureau of Labor Statistics Bulletin No. 264, October 1919.

WASHINGTON, OREGON AND CALIFORNIA

hand, considers the contract system a factor in public health. Most of the workmen, he says, are too poor to secure proper medical care privately. Under the group contract plan, they have attention before their illness becomes acute. He stated that his association considers it good business to offer more than is stipulated in the contract, such as, for instance, the free care the hospital is giving during the present depression to unemployed men. Also, the three months limit on hospitalization is never adhered to if further care is really needed.

An opinion as to the advantage to the practicing physician is stated in the following extract from a letter from a county medical society secretary in the State of Washington:

"Hospitalization is furnished by the contracting physicians. This has been satisfactory from all standpoints here, although I think it would be more equitable for the hospitalization to come from a separate fund. When a fair monthly fee is charged it is a very pleasant way to practice medicine, when you can hospitalize, take X-rays, and make house calls at will without regard for the patient's ability to pay. This cannot be done when cut rates are in effect. Contrary to the general belief among those inexperienced with contract medical practice, the men do not make undue requests for night calls and house calls and special service."

The secretary of still another county medical society gives his own reaction as a contract surgeon: "I am a surgeon for three of these associations, and work on a fee basis, accepting a rate that is equal to the state rate in the smaller cases, and allowing a discount in the larger cases. These hospital associations handle two contracts, the number one contract being supervised and controlled by the state, and covering industrial accidents only, and the number two contract covering more or less of medical work and non-industrial accident work. My impression is that this is a very good thing for the workmen, and I have urged several employers to give such contracts; I have, of course, decided impressions as to the desirability of the different associations. They issue what they call 'Full Coverage' and 'Limited Coverage'

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

contracts. Here there is some limitation as to choice of surgeons or physicians, but this is not a complete limitation in all cases, as some of the associations allow a free choice; but as there are only three physicians in this sparsely settled territory, that matter is not of great moment. . . . Private practice among the workmen in this territory has become very uncertain on account of the migratory character of the workmen and the great difficulty in making collections, especially in labor (obstetrical) cases and in all other cases where an account of more than twenty dollars or so accumulates. Physicians in this territory have not as yet developed the habit of demanding cash at the time the services are performed, but the newer generation of physicians may find themselves obliged to do so. I consider my straight State and Association work, most of which is done in the summer, to be the backbone of my practice. The difficulty in arranging for any such practice here is that there are but very few large industrial establishments, only one, in fact, in the two counties. When a logging camp and mill has no more than fifteen or twenty men working, it does not interest the Hospital Associations, and if it were not for a fairly rigid system of inspection by the State Department, it is probable that even in the industrial accident cases the injured workmen would not obtain proper care and compensation."

CONTRACT MEDICAL SYSTEM EXTENDING

There seems to be no question that the contract system of medical care is extending in Washington industries. In outlying sections of the state it has been common for at least twenty-five years. More recently, following the opening in Seattle of a branch of one of the large commercial clinics, the system has begun to be used in that city. The local medical association in Seattle is known to be divided in its opinion of the practice. Officials of two of the large associations express the opinion that the service is a public health measure, bound to spread so long as wages

WASHINGTON, OREGON AND CALIFORNIA

remain too low to permit workmen to employ private physicians at regular fees. They consider regulation desirable, and prefer it to come from the medical profession. Leaders among the industrial surgeons hold that unless physicians themselves make provision for cheaper and better medical care, whether through group contract practice or otherwise, "state medicine" will be established. Therefore, they believe it is good policy to set up and maintain a high standard of medical service under the contract plan as it is now developing.⁵

NUMBER COVERED BY CONTRACT PLAN IN WASHINGTON

Officials of five of the hospital associations personally interviewed by a representative of the National Bureau made statements indicating that in December 1929, the number of employees entitled to "complete coverage" service through existing contracts between these five hospital associations and industrial establishments was approximately 47,000. A few of the contracts cover dependent members of the families of contributing employees, but no estimate of their number is possible. The above figure represents 66.4 per cent of the total number of persons reported by the Census of 1930 as gainfully employed in the forestry industry (30,566) and in saw and planing mills (40,220).

EMPLOYEE MEDICAL SERVICE IN OREGON

The Workmen's Compensation Law of Oregon provides for an Industrial Accident Fund made up of contributions from both employees and employers who are subject to the provisions of the act.⁶ The Law requires that the employee shall contribute into this fund one cent for each work day, and that the employer

⁵ Qualitative appraisal of the existing system of contract medical service in industry in Washington is outside the scope of this investigation. In presenting the above opinions of medical people for and against the contract system, the National Bureau aims merely to call attention to the fact that the system is still subject to criticism by medical practitioners close to it.

⁶ Oregon is one of eight states in which the state workmen's compensation insurance fund is exclusive, i.e., monopolistic.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

shall contribute an amount varying from two to five per cent of his payroll, according to the hazard of his operations. From this fund the Industrial Accident Commission pays the expense arising out of industrial accidents, i.e., cash compensation to the injured workman, cost of medical care, and transportation from the scene of accident to the hospital, if necessary. According to R. E. Jackson, Claim Agent of the Oregon Industrial Accident Commission, the experience is that the employer contributes about eighty-five cents of each dollar collected for the Industrial Accident Fund, and the employee the other fifteen cents. The one cent per day collected from the employee entitles him to all the benefits of the Workmen's Compensation Act, which include payment for time lost, permanent disability, and medical aid.

The law further provides that the medical service necessary to care for a workman injured in the course of his employment may be secured by means of contracts with incorporated hospital associations or with individual physicians. These contracts may be entered into either by the Industrial Accident Commission, or by the employer. If the employer elects to make his own contract for medical and hospital care for industrial injury, the Commission pays the employer; if the Commission makes the contract, it pays the hospital association direct. In either case the amount paid ranges from one cent to four cents per day per employee, depending on the hazard of the occupation.

It should be noted that the State Industrial Commission enters into medical service contracts for compensation cases only after the employer has contracted separately with the doctor or hospital association for treatment of injuries sustained by employees away from employment, and for ordinary sickness. By this provision, complete medical coverage for employees is secured. In order to cover the expense of medical and hospital service to employees for non-occupational disability, the law authorizes the employer to deduct fixed amounts from employees' wages. The amounts thus deducted range from \$1.50 to \$2.50 per month from each employee.

WASHINGTON, OREGON AND CALIFORNIA

STATE SUPERVISION OF MEDICAL CONTRACTS

Contracts made by an employer with contractors "with regard to the funds of his employees" collected from wages (i.e., for non-occupational medical care) are subject to the approval and supervision of the Industrial Accident Commission, which has the power to cancel any contract whenever it deems the contracting physician not "reasonably competent" or the service not "reasonably efficient." No contract may be for more than one year, except when the Commission has previously consented to a two-year contract.⁷

From the foregoing it is apparent that there may be two separate contracts covering the employees of a particular industrial concern. One contract (between the State Industrial Commission and the hospital association) covers medical, surgical and hospital care arising out of injury occurring in the course of employment. The other contract (between the employer and the hospital association) guarantees medical and hospital care arising out of ordinary sickness or non-industrial accident. There are, of course, many groups of industrial employees who are covered by contracts between their respective employers and a "contractor" guaranteeing medical care and hospitalization for compensable injury, who are not covered by contracts for medical and hospital care for sickness or non-compensable injury.

The law specifically provides against the possibility of the employer profiting financially, by declaring the money so collected by the employer to be a trust fund, which must be kept in a separate account and promptly paid over for the purpose for which it is collected. Medical "contractors" are also specifically forbidden by the act to rebate, or agree to rebate, to the employer, any portion of the money so collected, and the employer is equally forbidden to receive such rebate.

⁷ Contracts of medical service are provided for in sections 6644 and 6645 of the Consolidated Laws of Oregon.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

INCORPORATED HOSPITAL ASSOCIATIONS

The insurance laws of the State of Oregon make special provision for hospital associations incorporated to provide medical and hospital service under contracts, and to bring such associations under the jurisdiction of the State Insurance Department.

The annual report of the Insurance Commissioner of the State of Oregon for the year 1929 contains a table giving the following information about hospital associations carrying on business in that state:

Name of Hospital Association	Capital Paid up	Income 1929	Disbursements 1929	Admitted Assets	Liabilities, Including Capital	Net Surplus
C. H. Weston Co., Portland, Ore.	\$ 10,000	\$ 31,006	\$ 30,858	\$ 14,037	\$ 10,783	\$ 3,254
Hillside Hospital Co., Klamath Falls, Ore...	59,600	46,982	45,426	65,328	81,443	—16,115
Industrial Hospital Association, Portland, Ore.	10,000	191,058	177,109	60,389	29,045	31,344
Klamath Valley Hospital, Inc., Klamath Falls, Ore.	10,100	80,374	77,885	29,111	11,623	17,486
National Hospital Association, Portland, Ore.	20,000	369,805	341,658	223,638	93,492	130,146
Prudential Hospital Association, Portland, Ore.	5,000	8,583	8,586	8,520	5,500	3,024
Pumphrey Co., Portland, Ore.	5,000	62,581	59,132	18,610	8,485	10,125
Southern Oregon Hospital Association, Roseburg, Ore.	34,800	14,497	14,376	34,936	43,025	—8,089
Totals	\$154,500	\$804,886	\$755,030	\$454,569	\$283,396	\$171,173

Section 2 (6558) of the insurance laws of the State of Oregon (1929) reads as follows: "Corporations organized under the general laws of the state may transact a hospital association business as herein defined upon compliance with the provision of this section; any corporation, association, society, firm, partnership, or individual, contracting or agreeing in this state with individuals, families, employees, associations, societies, or with employers for the benefit of employees, for the furnishing of medicine, medical

WASHINGTON, OREGON AND CALIFORNIA

or surgical treatment, nursing, hospital service, ambulance service, dental service, burial service, or any or all of the above enumerated services or any other necessary services, contingent upon sickness, accident or death; or any corporation making such contracts, or agreements, outside of this state to be wholly, or in part, performed within this state, are hereby declared to be doing a hospital association business, and subject to the provisions of this act."

NATURE OF CONTRACTS

The general scope of the medical service as offered by Oregon hospital associations to employers, under contract arrangements, is indicated in a letter to the National Bureau from one of the associations listed above. This letter states that the company (i.e., the Hospital Association) deals altogether with the employer under a monthly payroll deduction plan. No contracts are issued to individuals. According to the Hospital Association, this enables it to provide a broader coverage at a lower price than would otherwise be possible, since it is probable that if individuals were solicited, those would buy most readily who had some immediate need for medical aid. The result would be a class of risks below the average, thus increasing the rate. For this reason also, the plan is compulsory for all employees of concerns with which this Association contracts. Occasionally, in larger plants, a plan is started with those employees who elect to participate, but the idea is always to make it compulsory sooner or later. This is done either by making it a condition of employment for all new employees, or by putting it to vote of the employees after six months' operation.

Under a contract between a hospital association and an employer, the obligation rests upon the latter to pay to the former once a month the amount due for all employees. The wording of one contract on this point is as follows:

"The contractor (i.e., the employer) promises and agrees as follows: to pay to the company, on or about the tenth day of the month following that for which payment is made, at the rate of

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

one dollar and fifty cents for each and every employee who has worked three or more days before the fifteenth day of the month, and at the rate of seventy-five cents for each and every employee who has worked three or more days commencing after the fifteenth day of the month. For the purpose of auditing the pay-rolls of the contractor, the company (i.e., the hospital association) shall have access to them at all reasonable times."

SCOPE OF MEDICAL SERVICE

The scope of medical service guaranteed employees by the hospital associations may be illustrated by the following summary of the provisions of typical contracts.

1. *A hospital association not operating a clinic of its own.* The Company (i.e., the hospital association) agrees to provide medical, surgical and hospital services, including specialists, dental service, medical and surgical appliances, X-ray and clinical laboratory diagnosis, and physiotherapy as needed for the employees of the contractor (i.e., the employer) as follows:

Office Treatment. The contractor may send his employees to the offices of the doctors of the Company for treatment during office hours. He may also call the doctors in case of emergency. For this purpose, the Company promises to maintain at designated places, duly licensed physicians, surgeons, and specialists. If in emergency none of these designated doctors is available, the employer may call other competent service, for first-aid only.

Medicines. All necessary medicines, medical and surgical supplies and orthopedic appliances prescribed by the Company's physicians are provided, not including artificial limbs, glass eyes, etc.

X-ray, etc. X-ray diagnosis and clinical laboratory findings and physiotherapy are provided, as directed by Company doctors.

Hospital. All necessary hospital services are rendered at "adequate and well appointed hospitals" designated by the Company; service to include medicines, dressings, nursing, board, medical

WASHINGTON, OREGON AND CALIFORNIA

and surgical care, the maximum period in any one case being six months; but at the expiration of this period, necessary medical and surgical care, including medicines, by the Company's doctors, will be continued for another six months. Private rooms and private nursing service will be furnished in critical cases, when ordered by Company doctors, for a maximum period of fifty days. No monthly payment is required of the employee while he is in the hospital.

Unlimited Service. A specific clause in the contract states that the time limits on service do not apply in the case of injury arising out of and in the course of employment, i.e., compensable injury.

Ambulance. Ambulance or other conveyance, and the expenses of an attendant, will be furnished at the direction of the Company doctors.

Medicine Chests, or first-aid kits, are kept by the medical service Company at convenient locations in the factories or establishments of the employer, and re-stocked as needed.

Dental Services. Extraction and cleaning of teeth, treatment for toothache and for acute conditions affecting the gums, are provided by designated dentists.

Excluded Services. Treatment for insanity, pregnancy and disorders due thereto; venereal disease; conditions due to use of intoxicants, narcotics, or drugs; tuberculosis, except diagnosis and laboratory tests; and conditions existing previous to employment, are not included.

2. *A hospital association operating its own clinic.* This association offers service as described in the following summary of one of its circulars:

To groups of employees in all kinds of industrial establishments (including offices and stores) this Association offers a special "full coverage" medical service, which applies to chronic as well as acute conditions and accidents. This service will take care of such conditions as tuberculosis, apoplexy, paralysis, sinus trouble, diseased tonsils, cancer, goitre, stomach ulcers, gall stones,

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

etc., in addition to acute illness and accidental injuries, however or wherever sustained. Surgical operations of all kinds will be provided when needed, including hospital care, anesthetic, and services of the Association's surgical staff. Hospital care is provided when necessary for any condition, up to six months in any one case, including services of physicians, surgeons and specialists for one year; special nurse when required, for thirty days; X-rays; laboratory examinations; physiotherapy; ambulance, or other transportation to hospital; and medicines.

Chronic conditions existing at the time of or prior to the adoption of the Special Full Coverage Service will not be covered; but the Service will apply to all such conditions developing after its adoption. However, the protection of the Service applies immediately for any chronic condition which may become acute after adoption of the Service.

Persons who are employed after the Special Full Coverage Service has been adopted are immediately protected for acute illness or for accidental injuries, but must wait six months before becoming entitled to hospital care and surgical operations for chronic conditions. Credit is given employees changing from one establishment to another having the Service, provided there is no interval.

The fee for this Service is \$2 per month, deducted from wages. If the employee is also under the workmen's compensation law, the \$2 a month covers the one cent per work day that must be paid the state; there is no additional charge.

To make this Service financially possible for the small fee charged, it is agreed that the services as named shall be rendered "only in hospitals appointed by the Association, and by physicians, surgeons, and specialists employed by the Association for this purpose."

The Service does not apply to conditions arising from insanity, venereal disease, use of drugs or narcotics, pregnancy or childbirth. Contagious or epidemic diseases will receive doctor's services and medicines, but not hospital care or transportation.

WASHINGTON, OREGON AND CALIFORNIA

ATTITUDE OF MEDICAL PRACTITIONERS

A letter received by the National Bureau from an official of the Oregon State Medical Society throws light upon certain aspects of group medical service in industry in that state. The writer states that the hospital association type of organization as developed in the West has created a situation in which a large portion of industrial practice may be controlled by a single association operating throughout a state, or in some cases, two or three states. Where this situation prevails, the associations usually appoint a few doctors in each town. Frequently these doctors become in the end nothing more than first-aid men handling minor injuries, the major cases being sent into the center from which the hospital association operates. When this is not done, and the surgical work remains in the hands of the local doctors, their fees are much lower than they ordinarily receive in similar cases in private practice; some of the associations are reported to pay the doctors fees averaging from 25 to 33 $\frac{1}{3}$ per cent below the fees paid by the State Industrial Accident Commission in cases coming under its jurisdiction. Similar reductions in fees are said to be made in cases of major surgery for non-industrial injury.

For many years, the writer continues, physicians not engaging in contract practice have protested against these conditions, but apparently without avail. The system of contract practice appears to be well established, being popular with large employers of labor, as a low-cost, organized method of caring for sick and injured workmen. Recently a counter-movement has been started by the physicians and surgeons themselves, to organize local hospital associations in which all the reputable physicians of a town will be stockholders. Two such associations have been formed in Oregon. They offer to contract with the employer in the same manner as do the older hospital associations, and in addition, give the worker the privilege of choosing any doctor in the group. These physicians' mutual associations employ a business manager, and pay the fees of the member doctors

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

from a central fund. It is apparently not the intention of these newer associations to pay dividends to their stockholders, but only to see that the industrial medical and surgical work is done, so far as is proper, in the local community, and that the fees received by the physicians are on a level with those paid by the State Industrial Accident Commission.

PHYSICIANS AND SURGEONS HOSPITAL ASSOCIATION

One of these new associations is known as the Physicians and Surgeons Hospital Association of Salem, Oregon. It was started in 1929 by medical men at the time engaged in contract practice for the other associations. The number admitted to the Association was gradually enlarged until in the summer of 1931 there were 28 members. Our correspondent states that no physician who has been given the opportunity to join has rejected the offer.

The Physicians and Surgeons Hospital Association will function as a large group practice. Some of the staff will specialize in surgery, some in fractures, some in other branches of industrial work, including the eye, ear, nose and throat.

The service is offered to the workers in Salem, a city of about 26,000 population, and its environs. Industries are a large paper mill, a large saw and planing mill, two linen mills, several wood-working establishments, a foundry, and the usual run of smaller industries. The principal industry, however, during much of the year, is fruit canning and packing. There are about ten establishments, with a season running from May to December. Many people, largely women, are employed in these canneries.

More detailed information as to the service offered by the Physicians and Surgeons Hospital Association is taken from a printed circular published by the Association. In this, the advantages of the service are stated to be: 1. protection against financial loss due to prolonged illness or a surgical operation; 2. complete service, medical, surgical, hospital, etc., for any illness or injury; 3. a wide selection of well-qualified physicians and surgeons,

WASHINGTON, OREGON AND CALIFORNIA

without leaving Salem; 4. low cost; 5. full 24-hour protection, at home, at work, or anywhere.

The service itself consists of the following:

Medical and Surgical Service. All necessary medical and surgical treatment for injuries or sickness (chronic conditions not included), is furnished by Association staff physicians, at their offices, or at home if the patient is unable to go to the office.

Emergency Care. In emergencies, when staff physicians are not available, the nearest available doctor of medicine may be called, at the expense of the Association.

Specialist Care. Services of the Association staff specialists are provided on recommendation of any attending staff physician.

Dental Service. Treatment for acute gum conditions, and extraction of teeth for immediate relief are furnished.

Medicines. All necessary medicines, medical and surgical supplies as they may be used or prescribed by the attending staff physician, are furnished.

First-Aid Supplies. First-Aid Chests are provided and maintained at all establishments having the service.

Hospital Service. Complete hospital service and accommodations, when necessary, are provided by the Association, limited to six months in any one case.

Special Nurse. Services of a special nurse, for a period of not more than thirty days, are provided when ordered by attending physician.

X-ray Service. X-ray service is provided in cases of fracture or suspected fracture, and in other cases when deemed advisable.

Physio-Therapy. Treatments are furnished when advisability of such treatment is indicated.

Ambulance. Ambulance or other transportation service is furnished when necessary, for conveying the sick or injured to hospitals.

Prophylactic Measures. The Association will furnish such prophylactic measures as may be necessary to prevent the spread of disease among groups of persons covered by its contracts.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

The cost of the full coverage service as described is \$2 per month per person. If workers are already covered for industrial accidents, certain deductions are made from this rate.

Like other hospital associations, the Physicians and Surgeons Hospital Association is incorporated under the laws of Oregon, and operates under the supervision of the state insurance department.

EMPLOYEE HOSPITAL SERVICE IN CALIFORNIA

When the California Workmen's Compensation Act was passed (1911), certain concerns in that State, notably transcontinental railroads and lumber companies, were providing care to employees disabled in the line of duty, in their own hospitals. These hospitals were operated either by an employed medical staff or by an employees' association. The Workmen's Compensation Law placed upon the employer (excepting, of course, those not subject to state laws because engaged in interstate commerce), the responsibility for providing at his sole expense, medical aid to employees injured in the course of their employment. It left to employer and employee the privilege of entering into mutual agreements for the provision of medical care necessitated by non-occupational disability, at the expense of the employee.

Section 9, Chapter 586, Laws of 1917, stipulates that "where liability for compensation under this act exists," the employer shall furnish or pay for "such medical, surgical or hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatus, including artificial members, as may reasonably be required to cure and relieve from the effects of the injury." The injured employee is accorded a limited freedom of choice of the attending physician or surgeon, and the services of a consulting surgeon in serious cases.

Section 30-a makes it "unlawful for any employer to exact or receive from any employee any contribution, or make or take any deduction from the earnings of any employee, either directly or indirectly, to cover the whole or any part of the cost of compensation under this act, and it shall be a misdemeanor so to do."

WASHINGTON, OREGON AND CALIFORNIA

Hospitals may be operated by employers for the purpose of providing care to injured employees coming under the Workmen's Compensation Act. Hospitals operated by industrial concerns are under the supervision of the Industrial Commission. Those operated by "Common Carriers" are under the supervision of the State Railroad Commission.

Section 10 of Chapter 586, Laws of 1917, again stipulates that "no part of any contributions paid by employees or deducted from their wages, for the maintenance of such hospital facilities, shall be devoted to the payment of any portion of the cost of providing compensation prescribed by this act." This section of the act goes on to say that the commission shall have power to inspect and determine the adequacy of hospitals and hospital facilities supplied by employers, or by mutual associations of employees, with or without the concurrence of the employer, for the treatment of injuries coming within the provisions of the act. Nothing in the act prevents any hospital association or medical department from furnishing the treatment prescribed in the act free of charge. Every such hospital must make, not less frequently than once a year, or on demand, reports of receipts, disbursements, and services rendered to or for employees. If the Commission finds the services or equipment of any hospital inadequate to meet the reasonable requirements of medical treatment contemplated by the act, it may, after due notice and opportunity for a hearing, declare such facilities to be inadequate, and thereafter the employee may procure treatment elsewhere, and reasonable costs will be charged against the employer. Such findings of inadequacy may be rescinded by the Commission, upon good cause.

EMPLOYERS' HOSPITALS UNDER STATE SUPERVISION

So-called employers' hospitals or hospital funds are further governed by an act approved June 8, 1915, and amended by Chapter 73, Laws of 1917, which provides (sections 2 to 6 inclusive) for further safeguards regarding handling of funds. Every employer who affords or provides hospital service of any

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

sort for his employees, for which any charge is received or collected by the employer, or at his instance or request, must file an annual report containing: (1) a statement of the total amount of hospital charges collected or received, (2) an itemized account of all expenditures, investments, or other disposition of such charges, and (3) a statement showing what balance, if any, remains. This report must be verified by the employer, if an individual; by a member, if a partnership; by the secretary or president, if a corporation, company, association or joint stock association. Every hospital charge demanded, collected or received by an employer must be "just and reasonable." The authority to decide what is an "unreasonable" charge is given to the railroad commission in the case of hospitals maintained by common carriers by rail, and to the Industrial Accident Commission in the case of hospitals "maintained by other than common carriers by rail." All such hospital charges collected or received by an employer must be devoted exclusively to *bona fide* hospital or medical service for employees paying the charge. Every common carrier by rail who is under duty to render such report, is subject to the jurisdiction, control and regulation of the Railroad Commission in respect to auditing and disposition of all books, records and accounts, and is required to enforce the Commission's orders to the extent provided in the public utilities acts of the state. Employers, other than common carriers, who are under duty to render such reports, are subject, with respect to the auditing and inspection of the accounts, to the Industrial Accident Commission, upon which the act itself confers the authority to enforce the provisions of the act. The failure or neglect of an employer to render the report required by the act is declared a misdemeanor, punishable by a fine of not less than \$100 or more than \$1,000 for each offense.

Mr. Will J. French, Director of the Industrial Accident Commission of California, offers the following additional information about employee hospital schemes coming under the supervision of his department: "The employers who operate hospitals in California have had to charge increasing amounts for their medical, surgical and hospital services to employees. This is because

WASHINGTON, OREGON AND CALIFORNIA

of the additional expenses that have come with the years and the higher cost of doing business. The Industrial Accident Commission does its best to make sure that there is no fee charged for medical, surgical and hospital treatment, as set forth in the California Workmen's Compensation, Insurance and Safety Act. There have been disputes at times between employees and employers as to the right amount to be charged for services beyond and in addition to the Act just mentioned. When this occurs, we have made an audit of the books, and in one instance of note in California, we found the employer, 'a railroad company,' was justified in increasing the rate to employees for services rendered outside the Workmen's Compensation Act. In another instance, also dealing with a railroad company, we deemed it necessary to order a reduction in the method of computing fees. This was because of the relation to compensation."

Mr. French goes on to say: "Personally, and speaking out of a long experience on an Industrial Accident Commission, dating as far back as 1911, I am firmly of the opinion that employees in out-of-way places are gainers when good hospitals and medical services are available on the grounds. Not only are workers given attention when they are victims of non-industrial accidents, but sickness is covered, and the wives and children of such employees also receive attention. This is an excellent plan and helps to conserve life and limb.

"The Industrial Accident Commission feels that it is not authorized to participate in any agreement or discussion concerning charges for medical, surgical and hospital treatment that are furnished outside the Workmen's Compensation, Insurance and Safety Act. Unless, as indicated before, costs in relation to compensation enter into the controversy. Our province is to make sure that there is no sum assessed against employees for industrial injuries."

From reports filed with the state authorities and made available to the National Bureau, through the courtesy of the State Industrial Accident Board, the following summary has been compiled.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

Employers to the number of 38 filed reports under the provisions of the law quoted above, covering operations during the year 1930. Twenty-six of these were industrial concerns which reported to the Industrial Accident Commission; the other 12, including 7 steam railroads and 5 electric railways, reported to the Railroad Commission. Of the 7 steam railroads, 4 are Class I roads and subsidiaries of such, coming under the jurisdiction of the Interstate Commerce Commission.⁸ More detailed information about the medical service maintained by hospital associations on trunk-line steam railroads is given in Chapter IX.

Amount of the regular contribution deducted from the payroll for each participating employee. The 38 reports show the following: 24 companies deduct a flat amount of \$1 per month per man, three deduct 50 cents, two \$1.25, one \$1.80, one 65 cents, and in one company the deduction is 15 cents per week. Four of the companies have sliding scales of contributions, based on wages received, and running as follows: 75 cents to \$1.25, \$1 to \$2.50, 60 cents to \$1.80, 50 cents to \$1. In the case of the remaining two companies, the amount of the contribution was not stated in the report.

The method of remuneration of the medical staff. Of the 16 lumber companies, 7 concerns employing a total of 16 physicians, pay a regular salary; 2 concerns pay entirely on a fee basis, employing 3 physicians regularly, and others as needed; 4 concerns simply turn over to the company doctor the entire amount collected from the employees; in one of the lumber companies the medical service is provided by an employees' hospital association, which owns the hospital, and pays the salaries of the two physicians; one lumber company (or group of companies) supports, by company and employee contributions, an incorporated hospital, the hospital paying the salaries of the two doctors. Of the 3 companies engaged in other forms of manufacturing, one pays its 6 physicians on a fee basis; one employs 6 physicians, of

⁸ Los Angeles and Salt Lake Railroad, Santa Fe Coast Lines, Southern Pacific Lines, Western Pacific Railroad.

WASHINGTON, OREGON AND CALIFORNIA

whom 3 are on salary and 3 receive fees; the third company pays on a fee schedule basis, but does not state the number of physicians regularly employed. One of these companies owns and operates a hospital; the other two use independent hospitals.

The 7 mining and quarrying companies remunerate their medical staffs as follows: 3 pay straight salaries; one pays fees only; one company employing 4 physicians pays one a salary and fees, one a salary only, and 2, fees only; one company pays 2 by salary, 2 by fees; the last in this group pays its principal physician \$4 per man per year, and employs 3 others on a fee basis. The 7 mining and quarrying companies employ a total of 17 physicians.

Of the 5 public utilities, only two reported on this point. Of these, one turns over the collections to the company doctor; the other employs 7 physicians on regular salary, and pays others, number not stated, by fee.

Hospitalization. Of the 16 lumber companies, 8 own hospitals outright, and one has a hospital association which owns the hospital; one concern uses independent local hospitals; in 4 instances, the doctor owns the hospital; in one other the incorporated hospital serves a group of lumber companies; in one case, no information is given on this point.

The 3 other manufacturing concerns include one owning its hospital, and 2 using independent institutions.

Of the 7 mining and quarrying companies, 5 own their hospitals and 2 use independent institutions. Of the 5 public utilities, one both owns its hospital, and uses outside facilities; 2 use independent hospitals; 2 do not state their practice.

Type of disability covered. Medical treatment and hospital care for ordinary sickness and for non-industrial injury is the benefit received by the employees of the 38 companies represented by these reports, in return for their periodic contribution. This service is furnished by the same medical staff and hospital facilities used by the employer in providing the medical care required of him by workmen's compensation laws in case of industrial injury to his employees.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

Number of Employees Participating in Fixed Payment Medical Service in California. The 16 lumber companies reported a total of 25,335 employees participating in the contributory medical service plan in 1930. Of the 3 manufacturing concerns, one did not report the number; the two others reported a total of 4,935. Six of the mining and quarrying concerns reported a total of 2,242 employees participating; the seventh company did not report. Of the 5 electric railways, four reported a total of 16,971 employees participating, the fifth not reporting on this point. Steam railroad employees participating in contributory medical service plans are covered in estimates made in Chapter IX, and are therefore not counted here. Excluding steam railroads, these reports to the state authorities give a total of 49,483 employees in California in 1930, who definitely participated in group plans by which they secured medical service for non-industrial injury and ordinary sickness in return for an authorized deduction from wages.

CHAPTER IV

FIXED PAYMENT MEDICAL SERVICE IN THE METAL MINING INDUSTRY OF THE ROCKY MOUNTAIN STATES

THE Census of Mines and Quarries, 1920, showed that this region accounted for approximately 10.2 per cent of the total value of products of the mining industries of the United States. In 1929, of the total copper produced in the United States, Arizona, Utah, Montana, Nevada and New Mexico together produced 84.5 per cent.¹ The Rocky Mountain states are also important producers of gold and silver, lead and zinc.

The Census of 1930 reported the following number of persons employed in metal mining in the Rocky Mountain states:

State	Industry	Number Gainfully Employed
Idaho	Extraction of Minerals (chiefly lead, zinc and silver)	6,514
Montana	Mines and Quarries other than coal (chiefly copper)	14,139
Nevada	Extraction of Minerals (chiefly copper, gold and silver)	6,059
Arizona	Extraction of Minerals (chiefly copper)	17,566
New Mexico	Mines and Quarries other than coal (chiefly copper)	3,817
Utah	Extraction of Minerals (chiefly copper, lead, zinc, gold and silver)	9,238
Colorado	Extraction of Minerals other than coal (chiefly gold and silver, lead and zinc)	8,433

Throughout the Rocky Mountain region metal mining employees secure medical and hospital care for injury and disease not covered by the state compensation law, in consideration of a

¹ *Copper in 1929*. U. S. Department of Commerce, Washington, D. C., 1931.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

fixed regular deduction from wages. In a few companies their dependents are included in the service.²

A few of the larger companies maintain highly organized medical and hospital departments, supervised by a medical director, medical care being provided by full-time employed physicians and surgeons. At least three of these companies have their own hospitals. In one section of Nevada a hospital is operated jointly by a metal mining operators' association. However, the majority of the mining companies in the mountain region contract with independent hospitals to provide care to injured or sick employees at a fixed rate per employee per month, deducted from wages, and turned over to the contracting hospital. In one metal mining district of Colorado, a hospital is operated by a local miners' union. In the Wyoming coal field, provision of medical and hospital care for other than compensable injury is taken care of in the annual wage agreements between the mine operators and the United Mine Workers of America.

INFLUENCE OF COMPENSATION LAWS

The system by which mining employees in the Rocky Mountain region secure hospital care for non-compensable injury and disease in return for the payroll deduction is so much a part of the workmen's compensation system in the various states, that it is necessary to summarize the sections of those laws which in fact constitute the framework of the existing employee group medical service in the Rocky Mountain region.

The compensation laws of the Rocky Mountain states may be divided into two groups. In the first group are those laws which, while requiring the employer to provide care arising out of

² The mining industry of the Rocky Mountain region is characterized by large units. Among the larger companies that have supplied information incorporated into this chapter are the following: Nevada Consolidated Copper Co.; Phelps-Dodge Corp.; Calumet & Arizona Mining Co.; Old Dominion Co.; Miami Copper Co.; United Verde Copper Co.; Calumet & Hecla Co.; Inspiration Copper Co.; Magma Copper Co.; Utah Copper Co.; Colorado Fuel & Iron Co.; American Smelting & Refining Co.; Anaconda Copper Mining Co.; U. S. Smelting, Refining & Mining Co.; Bunker Hill & Sullivan Mining Co.; American Metal Company.

ROCKY MOUNTAIN METAL MINING INDUSTRY

industrial injury, stipulate that the employer may make a deduction from the employees' wages on condition that the medical and hospital service made available by the employer covers sickness as well as injury occurring at the employment. (Injury occurring away from employment is not covered.)

States in this category are Idaho, Montana, Nevada, Arizona and New Mexico. The deduction from the employees' wages must not exceed \$1 per month unless specifically authorized by the state workmen's compensation authority.³

In the second group the laws state definitely that no deduction from employees' wages may be made to cover the cost of benefits conferred by the Act, but only in case additional benefits are provided by the employer. Moreover, any such additional benefits must be commensurate with the deduction from employees' wages.

The states in this category are Colorado and Utah. The practical result is the same in all the states: Employees of the large mining companies secure medical and hospital care in the event either of disabling illness or injury, as long as the disability takes place at the employment, the cost of the total service being shared between employer and employee.

Wyoming is a special case. Section 19 (d) of the Workmen's Compensation Law provides that in all cases of total disability and permanent partial disability, the expense of medical attention and of care in hospital of the injured workman must be paid from the date of the injury, not to exceed \$200 in any one

³ The New Mexico Act is not as clear on this subject as are the others. Section 18 reads as follows: "No compensation shall be allowed for the first ten days after injury is received, nor in any case unless the employer has actual knowledge of the injury or is notified thereof within the period specified in section thirteen hereof.

"During the first ten days after the injury the employer shall furnish reasonable surgical, medical and hospital services and medicine, as and when needed, not to exceed One Hundred and Fifty (\$150.00) Dollars in value, unless the workman refused to allow them to be furnished by the employer. In case, however, the employer has made provisions for, and has at the service of the workman at the time of the accident or subsequent thereto during disability, adequate surgical, hospital and medical facilities and attention, whether such facilities and attention are provided by the employer gratis or are in whole or in part provided under any plan in force between the employer and the workman, then the employer shall be under no obligation to furnish during said first ten days after the injury any other or additional surgical, medical or hospital services or medicines than those so provided."

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

case, unless "*under general arrangement the workman is entitled to medical attention and care in hospital.*" Where death results from an injury, the expense of burial must be paid, not to exceed \$100 in any one case, "*unless other arrangements exist under agreement between employer and employee.*" A letter from the Workmen's Compensation Department of the State of Wyoming states that this clause was inserted in order to cover the special arrangements existing between Wyoming coal operators and the miners' union, by which the provision of medical and hospital care for non-compensable injury and disease is included in the annual wage agreement.

The foregoing summary of sections of the workmen's compensation laws of the Rocky Mountain states will help the reader to visualize the system of employee group medical service as it actually operates in the metal mining industry of the Rocky Mountain region.

TYPICAL COMPANY PLANS IN IDAHO

One of the largest mining companies in Idaho has several subsidiaries operating in various states. In all of these properties, including those in Idaho, the medical service plan is the same. It is described by an official of the company, who states that the service divides into three classes, as follows: 1. First-aid, i.e., service at the plant in emergencies; rendered by doctor, nurse, or first-aid worker; expense borne by the company; 2. Employers' liability (workmen's compensation) service, i.e., medical, surgical, and hospital service to employees for industrial injuries; 3. Workmen's benefit, i.e., service rendered for non-industrial sickness and injury under a system of employees' contributions. The funds are administered by a committee of employees. The company employs one or more physicians at each plant, to care for employees and their families. At some plants surgical and dental care are also provided. Hospital care is usually provided in local independent hospitals on the basis of an agreed rate; at a few plants "where conditions warrant" the company operates its own

ROCKY MOUNTAIN METAL MINING INDUSTRY

hospitals. Usually additional charges are made for surgical operations in non-compensation cases.

An official of a large mining company in Idaho describes the main features of his company's medical service as follows: All employees contribute \$1 a month, except those working less than ten days, who are assessed at ten cents for each day of employment. The company pays an amount equivalent to 62.5 per cent of the sum so paid by the employees. From the fund thus created, injured and sick employees receive complete medical and surgical care, hospitalization, ambulance service, medicines and dressings; also, when necessary, treatment by non-resident specialists for eye, ear, nose and throat, including transportation, hospitalization and all other costs of such specialists' treatment. In addition, by special arrangement between the company and the hospital, orthopedic or bone specialist treatment for bad fractures, or fracture where poor results are had from local treatment, is given to all employees without cost to them, either for the treatment, or for hospital care, medicines, or transportation. Treatment of physical defects existing at the time the employee entered the service of the company is not included in the service, but for treatments of such defects a reduction is made from regular charges, at the rate of 10 per cent a year for each year of employment. For instance, an employee of five years' standing would have an old rupture repaired, or a case of chronic appendicitis operated, at one-half the regular cost. None of the privileges of the service extend to conditions arising from venereal disease, intoxication or fighting; nor are the families of employees included in the service.

METAL MINING COMPANY PLANS, MONTANA

Butte Stationary Engineers' Union No. 83, Butte, Montana, informs us that the contract system is general in the Butte district. An official of the union states that the same conditions prevail in Great Falls and Anaconda, hospitals in those towns

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

contracting with employers to provide service as required by employees disabled by industrial injury or sickness.

A privately owned hospital in Butte describes the system of medical service provided industrial employees under contracts between the large mining and industrial companies of the Butte district and independent hospitals as follows: The arrangement provides for medical, surgical and hospital service for conditions arising during the time of the employment. It does not include treatment of injuries sustained out of employment or from alcoholic intoxication, or treatment for venereal disease. The service is paid for at the rate of \$1 per month, taken from the wages of the employee, and transmitted monthly to the hospital. In the case of smaller concerns, the fee is \$1.25 to \$1.50 per employee per month. The contract is with the employer, not the employee. Dependents of employees are not included in this plan.

By far the largest employer in the metal mining industry of Montana is the Anaconda Copper Company. A letter from an official of the company describes the medical service plan: In Montana, Idaho and Utah, payroll deductions, authorized by the employees, of \$1 per month from each employee, are made over to the hospitals with which the company has contracts. In return for this contribution employees are entitled to treatment for all injuries received, arising out of, and in the course of employment; and also to medical and hospital care for all sickness except venereal diseases and sickness due to intoxication.

While the letter from the company makes no reference to dependent members of employees' families, a letter from a local of the Mill and Smeltermen's Union, whose members are employees of the company, states that "dependent members of the employees are included in the service, that is, wife and children until self-supporting."

THE SYSTEM IN THE METAL MINING INDUSTRY OF NEVADA

Nevada ranks fifth in the copper-producing states; in 1929 its output was 138,990,247 pounds of copper. Most of this was pro-

ROCKY MOUNTAIN METAL MINING INDUSTRY

duced by the Nevada Consolidated Copper Company. This company provides medical service to all employees through a department staffed by full-time salaried physicians and nurses. It owns and operates a general hospital at East Ely. Emergency hospitals are located at all camps. Each employee contributes \$1 per month to the medical fund and the company pays the remainder of the cost of the medical department.

The following description of the medical plan of the Nevada Consolidated Copper Company and Nevada Northern Railway Company (a subsidiary) is contained in a letter from Dr. R. A. Bowdle, Chief Surgeon of the company. Dr. Bowdle writes that the medical care extended to the employees is complete. The only charge made to them (beyond the regular payroll deduction) is for venereal diseases. Medical care at home is given to employees' families without further charge, except for medicines. Should it be necessary for a member of the employee's family to be hospitalized, there is a charge of \$15 per week. For a surgical or obstetrical case there is in addition a minimum charge, otherwise the \$15 covers both medical and hospital care as well as all supplies and drugs used.

This policy, Dr. Bowdle states, is very satisfactory to the employee, but expensive to the employer. Even when working on full production the company pays over \$4 to the employee's \$1 in order to maintain an efficient medical department. However, the company has decided that it is repaid in other ways than money for this expenditure.

Two examples have come to our attention of coöperative medical and hospital service plans, undertaken jointly by mining companies in Nevada. One of these is the Tonopah Mines Hospital, the other is the Goldfield Hospital Association. Regarding the former, Dr. R. R. Craig, Chief Surgeon of the Tonopah Mines Hospital Association, writes that the hospital is owned and managed by the Tonopah Mine Operators' Association. A payroll deduction of \$1 a month is contributed by each employee, which is matched by \$1.25 from the employer. In addition, when this and other income from private non-employee patients is

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

insufficient, the mine operator employers are assessed to cover deficiencies. The ratio of the \$1 paid by the employee to the cost of the service is about one to five. In other words, the employer pays about 80 per cent of the cost of the medical and surgical care, per workman. Dr. Craig states that this approximate percentage obtains in other mining camps. The companies represented in the Tonopah Mines Hospital Association employ a maximum of 2,000 workers.

According to information received from the State Medical Society of Nevada, individual physicians sometimes enter into contracts with the smaller mining companies to provide medical and surgical treatment required by employees injured in the course of their employment. When these smaller companies do not contract with private physicians, as permitted by the State Industrial Accident Law, they contract with the Nevada Industrial Commission for the payment of surgeons' and hospital bills for treatment and care arising out of industrial accidents.

THE SYSTEM IN THE METAL MINING INDUSTRY OF ARIZONA

The Magma Copper Company informs us that it owns and has direct control of the only hospital in Superior, a town of approximately 4,000 people. The hospital building now in use is completely new, having been finished in 1930 at a cost in excess of \$40,000. This cost includes built-in equipment peculiar to hospitals, but does not include the bulk of loose equipment such as X-rays, instruments, etc., that were in use prior to the new construction. The hospital is primarily for employees of the Magma Copper Company, although other patients are accepted at the discretion of the Chief Surgeon. The operation of the hospital is under the direct charge of the Chief Surgeon.

The manner in which the Chief Surgeon is reimbursed for operating the hospital and taking care of patients who are employees of the company, is as follows: The company deducts \$1.50 per month from each of its employees; \$1.35 of this is paid to the Chief Surgeon, who under ordinary conditions pays for

ROCKY MOUNTAIN METAL MINING INDUSTRY

the total operation of the hospital, except for two nurses and a cook, whose combined salaries amount to \$400 per month. This is paid from a reserve account set up by the company. In ordinary times, the monthly sum paid the Chief Surgeon through employees' deductions amounts to an average of approximately \$1,140. Recently these deductions have fallen off, but the company has made up the difference from its reserve account.

In addition to the hospital, the Chief Surgeon operates a dispensary, to which the employees go at specified hours for treatment. The expense of conducting this is included in the employees' deductions. The employees of the hospital and dispensary consist of one Chief Surgeon and an assistant, three nurses, one cook and one receptionist.

The company sets aside a reserve of 90 cents per month per employee; this, together with the 15 cents excess deducted from the employee that is not paid to the chief surgeon, constitutes the credit to the reserve account. Under ordinary conditions the reserve is about \$850 monthly. As indicated, there is a monthly charge against this reserve of \$400 for salaries. At the time the letter was written over \$200 monthly was being paid from this account to the chief surgeon to make his remuneration up to the average month. Also, \$200 monthly is taken from this reserve by the company for hospital rentals; in addition to these charges, the expense of all special treatments occurring from accidents which cannot be treated in the company hospitals is charged to this account. (The special treatment referred to consists almost solely of the work of specialists, since the company hospital and surgeons are equipped to take care of any ordinary case.)

The employee patients received at the hospital average about 90 per cent for accidents and 10 per cent for sickness. However, the time spent by the physician and his assistants considering the dispensary and home calls is about 50 per cent each to accident and sickness. The patients received at the hospital are to a great extent members of the employees' families; as explained, they are handled as private patients by the chief surgeon, at minimum

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

charges. The deduction of \$1.50 from the employee includes the workman only, and not his family.

The chief surgeon furnishes all medicines, bandages, etc. The company furnishes surgical supplies, such as crutches, etc., also X-ray films. The expenses for a typical month, under ordinary conditions, are about as follows:

Receipts:

Employee deductions—860 at \$1.50.....	\$1,290
Magma Copper Co. Set-up—860 at 90¢.....	774
	<hr/>
Total.....	\$2,064

Disbursements:

Payment to chief surgeon—860 at \$1.35.....	\$1,161
Payment to 2 Nurses, 1 Cook.....	400
Hospital Rent	200
	<hr/>

Total Current Expense 1,761

Balance reserved to take care special treatment and surgical supplies \$ 303

The letter explains that the word surgeon is used to mean both physician and surgeon, as the company doctors are well versed in both branches of medical service.

United Verde Copper Company. Dr. A. C. Carlson, Chief Surgeon, informs us that this company owns and operates a hospital. It also provides medical and surgical care through full-time salaried physicians. A payroll deduction is made for every employee, \$2 per month for single and \$2.50 for married men. "The employee receives all medical and surgical care for all conditions acquired after entering the employ of the company, with the usual exceptions of venereal disease or accidents received in drunken brawls. The family of the employee receives free medical attention for all conditions except confinement, obstetrics fees being \$15 for normal and \$25 for abnormal cases. Hospitalization is given the family of employees at the rate of \$2.50 per day for private rooms. Surgical fees to the family of the employee are 50 per cent of the regular fee, but never to exceed \$75."

ROCKY MOUNTAIN METAL MINING INDUSTRY

Calumet and Arizona Mining Company. The hospital building is owned by the company; the equipment by the surgeon, who operates the hospital under contract with the company. The deductions (\$1.50 for single, \$2 for married men) are turned over to the hospital, and in addition, the company pays the hospital \$1 per month per man. The staff includes four full-time physicians, four nurses, a matron, a technician and an X-ray operator. The hospital maintains a dispensary in the mining district, where out-patient service is given. Employees receive medical and hospital care without further charge, but are charged for major surgical operations (maximum fee \$135); dependents receive medical care (including obstetrical cases) without further charge, but are charged for surgical treatment and hospital care.

Phelps-Dodge Corporation. It is the practice of this company to make payroll deductions authorized by employees, with which to provide medical care and hospitalization. In the Copper Queen Branch, with properties at Bisbee and Douglas, Arizona, the company has its own Hospital and Medical Department. Payroll deductions are made for employees, and medical care is given. There is a schedule of charges for members of families of employees. This company is also interested in the Old Dominion Company at Globe, Arizona. As that is a small property, payroll deductions are made and the company provides its own dispensary, but arranges for hospital care with a nearby independent hospital.

The secretary of the State Medical Society of Arizona writes that in practically all mining camps of the state there is a hospital system for the men employed. They pay a certain sum each month which entitles them to treatment and, if necessary, hospitalization. The physicians are on salary.

THE SYSTEM IN THE NEW MEXICO, UTAH AND COLORADO MINING INDUSTRY

The chief copper producer in New Mexico is the Nevada Consolidated Copper Company. In 1929 the output of this com-

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

pany amounted to approximately 85 per cent of the total copper production of the State.⁴ The Company's medical service program in New Mexico is similar to that carried on at its Arizona and Nevada mines, described in preceding sections.

Another copper mining company in New Mexico writes that its medical plan is self-supporting. A physician has contracted with the company to treat all industrial accidents and cases of sickness of employees (with the usual exceptions of venereal disease and intoxication) for a payroll deduction of \$1.50 per month from each employee. Families of employees are not included. A hospital is provided by the company, and operated by the doctor, who pays all expenses including nurses, medicine, consultation, etc.

The leading metal mining companies operating in Utah are the following: Utah Copper Company (producing more than 90 per cent of all the copper produced in the State in 1929); Tintic Standard Mining, Silver King Coalition, Park-Utah Consolidated, Chief Consolidated, North Lily, New Quincy, Utah-Apex, United States Smelting, Refining and Mining.⁵

The mining companies listed above operate their own smelters and refineries. The International Smelting Company (a subsidiary of the Anaconda) operates a "custom" smelter, treating purchased ores. Employees of metallurgical plants participate in company medical programs.

As far as available information indicates, no mining company in Utah operates its own general hospital. Employers contract with independently owned nearby hospitals to provide hospitalization in the event of injury or sickness.

Utah Copper Company. This company employs a corps of physicians to provide medical service to employees at its various mines and plants throughout the state. Each employee contributes \$1 per month from wages toward the cost of this service, and

⁴ *Outline of the Mineral Resources of New Mexico*, by E. H. Wells, New Mexico School of Mines, Socorro, N. M., September 1, 1930.

⁵ *Gold, Silver, Copper, Lead and Zinc in Utah in 1929*. U. S. Department of Commerce, Washington, 1931.

ROCKY MOUNTAIN METAL MINING INDUSTRY

the company makes up the difference. No payroll deduction is made from employees working less than 3 days in a month; for 3 to 10 days, 50 cents is taken; for ten days or over, \$1 is deducted. The company maintains emergency or first-aid hospitals at its mines and mills, but contracts with an independently owned hospital to provide general hospitalization.

The notice to employees posted at the various mines and plants of the company gives more detailed information regarding this service. It specifically sets forth that "no deduction will be made from the wages of the employees for the compensation and other benefits provided for" in the Workmen's Compensation Act of the State of Utah. The company agrees to furnish the employees certain medical and hospital services not required by the Workmen's Compensation Act, including (1) medical and surgical treatment, or nurse or hospital services, in addition to requirements of the Act, as may reasonably be required at the time of injury and thereafter during disability, not to exceed two years. (2) Medical or surgical treatment or nurse or hospital service, including services of eye, ear or nose specialist, for not to exceed one year, to cure or relieve an illness or disability developed during employment; expressly excluding chronic illness, or disability existing prior to employment, illness due to venereal disease, tuberculosis, contagious diseases, quarrels. (3) The medical or hospital services will be furnished by physicians or surgeons selected and paid by the company; expenses incurred by employees with other physicians or hospitals will not be paid by the company. The notice designates two physicians in Salt Lake City, and local physicians employed by them, to provide medical service. Hospital ward care is given those employees who need it, in a certain hospital in Salt Lake City, also designated by the company.

United States Smelting, Refining and Mining Company. The system in operation at the mines, quarries and plants of this company is combined with the employees' mutual benefit associations. An official of the company writes that medical and hospital services at the several properties of the company are so

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

closely related to the benefit associations that it is difficult to explain them separately. The mutual benefit associations in the Intermountain Department of the company, though similar in many respects, differ in detail, for the reason that they were organized at different times and under different conditions.

At the Midvale smelter the membership dues (deducted from wages) are \$1.25 per month; 75 cents of this entitles the employee to medical and hospital care when required on account of illness or non-industrial accidents. The doctors and surgeons are paid fixed monthly salaries by the company for services rendered all employees for illness, as well as for industrial accidents. The difference between the expense involved (which includes doctors' and surgeons' salaries, hospital bills, drugs, etc.) and the amount paid in by employees, is absorbed in the company profit and loss account. The remaining 50 cents of each employee's contribution entitles him to the cash benefits paid by the mutual benefit association.

At the United States Niagara Mines at Bingham, and at the Lark Mine, the dues are \$1 per month. This entitles the employee to medical and hospital service for illness and non-industrial accidents, and membership in the welfare association. The doctors at these mines are paid an amount equivalent to \$1.35 per month for each employee, 60 cents of which is absorbed in the profit and loss account of the company, to cover expenses incurred in connection with industrial accidents. The Welfare Fund, created by the contribution of 25 cents per month by each employee, is used for cash sick benefits, etc., disbursed by a committee elected by employees.

It will be noted that this company, like the Utah Copper Company, does not own a general hospital, but contracts with independent institutions to provide care, in case hospitalization is needed.

The Anaconda Copper Company operates mines at North Lily, in the Tintic District, and a smelter at Park City. The medical program of this company for its Utah employees follows principles similar to those governing the plans in operation in

ROCKY MOUNTAIN METAL MINING INDUSTRY

Montana, already described in the section dealing with Montana.

The Park-Utah Consolidated Mines Company writes that for the charge of 50 cents per month per employee the Park City Miners Hospital, Park City, gives medical care to its employees in case of sickness.

Letters received from other metal mining companies in Utah indicate that medical and surgical care, whether arising out of industrial injury or sickness, are provided employees through contract arrangements with independent clinics and hospitals, similar to those described.

Tintic District Miners Union No. 151, International Union of Mine, Mill and Smelter Workers, informs us that it is the common practice for the metal mining companies in the Tintic District to provide medical and surgical care to employees through employed physicians, but that dependent members of employees' families are not entitled to free service.

The medical service program in operation at the coal, silver, lead and zinc mines and smelters of the American Smelting and Refining Company in the State of Colorado follows similar lines to the plan of that company described in the section of this chapter devoted to Idaho.

In Colorado one instance has been found of a hospital owned and operated by a miners' union and providing contract service. This is the Silverton Miners Union Hospital, owned by the Silverton Miners Union No. 26, affiliated with the International Union of Mine, Mill and Smelter Workers. Each member of the Silverton Miners Union pays \$1.50 to the Hospital through an authorized deduction from his wages. To this amount the mining company adds 75 cents. The amount paid by the company guarantees medical, surgical and hospital care to employees injured in the course of their employment and entitled to compensation and medical aid under the Workmen's Compensation Act of Colorado. The \$1.50 per month contributed by the employee out of his wages guarantees him medical, surgical and hospital care

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

in case he is disabled by a non-industrial injury or ordinary sickness.

THE IDAHO LUMBER INDUSTRY

Idaho is the only one of the eight Rocky Mountain states in which the lumber industry is important.⁶ How the hospital contract system operates in this industry is described in a letter from the head of a hospital in the northern part of Idaho. This physician writes that the local industry in that part of the state is lumbering, including logging, booming, transportation of logs by river and lake, and the manufacture of lumber and lumber products. Licensed hospital organizations, physicians, or combinations of physicians are allowed to make contracts with employers for the care of sick and injured employees. These contracts must first be submitted to the State Industrial Accident Board for approval, and penal bond must be furnished to insure proper performance of the contract.

At this particular hospital, the plan works out in general as follows: The hospital agrees to furnish physicians' and surgeons' treatment, hospital care, medicines, etc., for all injuries arising out of and in connection with employment; this includes the service of specialists when needed. The hospital also agrees to furnish the same service in all accident cases, whether occurring in pursuance of duty or otherwise, except when due to intoxication, fights, or illegal actions. This provides 24-hour protection for accidents. The hospital further agrees to care for all cases of sickness (except venereal disease, and conditions existing previous to employment), furnishing physicians' and surgeons' treatment and hospital care; and in addition to the usual and ordinary care such as is given to private patients in the same condition; the hospital agrees under the contract to furnish the services of specialists when needed.

In return for the coverage as outlined, the employer agrees to deduct \$1 a month from each employee, to add 50 per cent

⁶ The Census of 1930 shows 6,018 gainful workers in "forestry and fishing," 5,936 in "lumber and furniture" industries.

ROCKY MOUNTAIN METAL MINING INDUSTRY

of such deductions on his own account, and to pay the total amount to the hospital on each pay day. This arrangement has been in operation for the past ten years. Previous to that time the employer did not contribute on his own account, but the contract was carried out on a \$1 per capita basis, instead of \$1.50 as at present.

Another physician, operating a private hospital in the lumber region of Idaho, writes that the system of hospital contracts is common in both the mining and lumber industries of the state. His hospital contracts with employers to provide "medical, some surgical, and hospital care," for employees, for non-compensable injuries and sickness. Families of employees are not included. The contract also includes care of industrial accidents, the payment made by the employer being "in part compensated for by a reduction in the premium on his industrial accident insurance."

This physician points out that industrial surgery is a specialized type of work, and that men and hospitals specializing in this field of medical service are better equipped for the work than those handling such cases only occasionally. He states that by turning all revenue from contract practice in to maintenance and equipment, he has been able to maintain a hospital in his small community which can compete on a fair basis with the larger city institutions, to the benefit, he believes, of the community in general.

CHAPTER V

FIXED PAYMENT MEDICAL SERVICE IN THE COAL MINING INDUSTRY OF THE ROCKY MOUNTAIN STATES

THE United States Coal Commission defines the separate coal fields of the Mountain States as shown below. The number of mines operating and the total production for 1929 in the different fields are also given.

State	General Name of Field	Number of Operating Mines, 1929	Total Pro- duction (Net Tons) 1929
Colorado	Colorado Domestic	143	4,243,000
	Trinidad	31	2,544,000
	Northern Colorado	40	3,134,000
Montana	Montana	76	3,408,000
New Mexico	Gallup	15	1,100,000
	Cerrillos & Carthage	10	213,000
	Raton	13	1,285,000
	Monero	4	25,000
Utah	Utah	42	5,161,000
Wyoming	Wyoming	54	6,705,000
Total		428	27,818,000

The Census of 1930 reported the numbers of persons employed in coal mining in the various Rocky Mountain states as follows:

Colorado	11,612
Montana	2,428
New Mexico	3,383
Utah	3,283
Wyoming	5,062
Total	25,768

ROCKY MOUNTAIN COAL MINING INDUSTRY

The Rocky Mountain coal mining industry is characterized by a relatively large proportion of companies producing less than 50,000 tons per annum. Out of 504 companies that together produced 29.7 million tons of coal in 1929,¹ 408 produced less than 50,000 tons apiece. The total production of these 408 companies in 1929 represented only 6.9 per cent of the total. With few exceptions, these companies operated but one mine. The average number of days worked by them is smaller than the average of the larger companies, indicating a relatively intermittent rate of operations.²

In all but the smaller companies it is customary for the employee to receive medical and hospital service in return for a regular payroll deduction, or under the same sort of arrangement as has already been described in the preceding chapter for the metal mining region of the Rocky Mountain states.

WYOMING COAL INDUSTRY

In the Wyoming coal field, the system of providing medical care is unique, in that it is jointly operated by employers and employees, as an element in the annual wage agreement. The following information is taken from the agreement covering the southern field, dated October 11, 1928. Mr. James Morgan, Secretary-Treasurer of District No. 22, United Mine Workers of America, states that a similar arrangement exists in the northern coal field, and that approximately 5,000 employees and members of their families participate in this system.

The agreement provides that a Hospital Commission shall be formed at each camp, with full power to transact the affairs of

¹ *Coal in 1929*. U. S. Department of Commerce, Washington, 1931. The total given above includes small outlying fields of Arizona, Nevada, California, North and South Dakota.

² Among the coal mining companies in the states mentioned that produced over 200,000 tons in 1929 are the following: Colorado Fuel & Iron Co.; American Smelting & Refining Co.; Moffat Coal Co.; National Fuel Co.; Rocky Mountain Fuel Co.; Victor-American Fuel Co.; Colorado & Utah Coal Co.; Utah Fuel Co.; Boulder Valley Coal Co.; Calumet Fuel Co.; Northwestern Improvement Co. (Montana); Phelps-Dodge Corporation (New Mexico); U. S. Smelting, Refining and Mining Co. Most of these concerns have supplied information about the system of employee medical service.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

the Hospital Association; it also has power to employ and remove surgeons or other employees of the Association. A majority vote of the Commission controls in all matters coming before it. This Commission consists of three members, one representing the Company and employees not members of the U. M. W. of A., and two elected by the Local Union in such manner as suits their convenience and approval.

The companies agree to make the necessary per capita deductions from wages as agreed upon by the Hospital Commission, and turn the money over. When questions relative to the expenditure of funds contributed by the employer are involved, the employer and the representatives of the employees constituting the local Hospital Commission have equal voice subject to appeal by either party to the joint committee in the manner provided for in the handling of grievances. In all other matters the majority vote of the local Hospital Commission governs.

In the event of dissatisfaction arising over the service rendered by any surgeon, the aggrieved party must make his complaint in writing and give it to the Hospital Commission, and the defendant must be furnished a copy. If in the judgment of the Commission, the charges warrant such action, after both plaintiff and defendant have been heard, a meeting of those who pay into the hospital fund is called to act on the matter. Should this meeting decide that the charges against any surgeon are of such a character as to justify further action, an election is held, and if a majority of those who pay into the hospital fund decide to discharge the surgeon, he must be discharged. Should any member of the Commission be unable to attend a meeting he must have a representative present. Each Commission must designate a regular date of meeting. The treasurer of each local Commission is bonded in amount agreed upon by the president of District 22, and the president of the operators. No local hospital fund is permitted to accumulate more than \$5,000, unless mutually agreed to between the president of the operators and the president of District 22, U. M. W. of A. Surgeons are required to make reports to the company and to the Hospital Commission.

ROCKY MOUNTAIN COAL MINING INDUSTRY

When the doctor regularly representing the Hospital Commission, together with two other accredited doctors, one of whom shall be selected by the local union and one by the employer, decide that the services of a specialist is necessary to the welfare of any employee injured in the course of his employment, the employer agrees to pay the cost of such special treatment, up to \$150 in any one case; such payment is made by the employer to the local hospital fund. The services of two doctors called in consultation are paid for from the funds of the local Commission.

OPERATORS' CONTRIBUTIONS

The operators pay into the local Hospital Commission, organized in their camps, one-half cent per ton on each month's production of coal. This payment is made monthly, and is in lieu of any payment for hospital charges in mine injury cases from the compensation fund.

Certain interpretations of the agreement as it stands have been agreed upon between the union and the operators. These are: (1) the Hospital Commission can enter into contract with the doctor; (2) the contract with the doctor shall not be for a longer period than the general agreement, nor extend beyond the time of expiration of the general agreement; (3) when any new doctor is employed as per agreement, he does not become an employee of the Hospital Association until a contract is agreed to between the doctor and the Commission; (4) when any doctor's contract expires, he automatically ceases to be an employee of the Association until a new contract is agreed to by the Commission; (5) a majority vote of the Commission is required to make or renew contracts with doctors.

Mr. Morgan explains in his letter that while in general all local Hospital Associations must follow the agreement, there are certain local differences among the various camps. Most locals, he says, collect both a doctor and a hospital fee; where the latter is collected it covers hospital care for all sickness or injury of the employee, whether incurred on or off duty. Many locals

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

also provide hospital care for dependents, though a few do not. Two of the largest locals collect \$3 and \$3.45 per month and provide full medical, surgical and hospital care (including operations) for the men and their families.

Ownership and control of hospitals also vary. At Hanna, Gebo, and Superior, hospitals were built by the companies, and are used by the Hospital Associations. At Hanna and Gebo all cases of sickness and injury are cared for at these company hospitals, by the terms of the contracts with the doctors. At Superior, the hospital is for emergencies, where patients are cared for until they can be moved to the State Hospital at Rock Springs. With this State Hospital, all the local Hospital Commissions in Sweetwater County (the largest coal-producing county in Wyoming) make arrangements to care for their members.

At Kemmerer, in the Lincoln County coal field, a large hospital has been built by the miners and citizens of Kemmerer. By arrangement, all the local Hospital Associations send their hospital cases to this institution. The company provides at each mine an emergency room or small local hospital for temporary care.

Mr. Morgan summarizes the system as it operates, briefly as follows: "Under contract and payment of certain fixed sums monthly, all members of our organization and their families receive medical attention and medicines. All men injured in mines receive hospitalization through the same arrangements, and in most cases also for sickness. Many mining towns also arrange hospital care for members' families, and in two of the largest, arrangements cover not only hospital care and medical attention for men and families, but also cover operations necessary of any kind for all. Where coal companies have built hospitals, they are turned over to local Hospital Associations and run by them. In some instances companies charge nominal rentals for building, lights, etc. In others they furnish the above items to the Commission. In every case monthly fees are charged as agreed on locally, and these are deducted by the company

ROCKY MOUNTAIN COAL MINING INDUSTRY

and turned over to the local Commissions or direct to the doctor, depending on the contract in effect at each camp."

EMPLOYEE MEDICAL SERVICE IN THE COLORADO COAL INDUSTRY

The Colorado Fuel and Iron Company operates coal and iron mines in various counties of Colorado, and steel works at Pueblo. In 1929 the total production of coal by this company in Colorado amounted to 2,425,736 tons, or one-fourth of the production of the state. A letter from Dr. William Senger, Chief Surgeon of the company, dated March 24, 1931, and published articles, have supplied information as to the medical service program of the Colorado Fuel and Iron Company.

Full-time physicians are in attendance at all coal and iron mines. Hospitalization is carried on entirely through hospitals and dispensaries owned by the company. No person is employed until after he has passed a physical examination and has had his record card properly filled out and signed.

The physical examination is made by the company physician at a charge of \$1 per applicant, if accepted for employment. This money is paid directly to the clerk at the time the application is made, or if preferred, may be collected by payroll deduction. All such fees are credited to the hospital fund. At Denver, where no company physician is employed, the regular charge is \$2 per applicant.

Any one who leaves the employ of the company and is dropped from the payroll is no longer entitled to the hospital service. Should any individual seek reemployment, he is required to pass a physical examination as a new employee.

The medical department is maintained and its activities are directed to protect employees from sickness and disease and to cure them when preventive measures fail, as well as to relieve them and to assist their recovery in case of injury. The expenses of the medical department are paid from a fund made up of contributions by the company, dues (payroll deductions) of employees, and hospital fees from patients other than employees.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

The company charges no rent or interest on the medical department properties which it owns, and pays the cost of treatment of cases which come under the workmen's compensation act, to the extent required by that act.

Each employee who works or lives in a community where the medical department maintains a local physician, is charged for medical dues as follows: \$1.50 per month at the steel works and at the mines and quarries, deducted from the earnings each month, and entitling the employee to medical and surgical treatment and to hospital care and service in case of sickness or injury. Employees who work at places where the medical department does not maintain a local physician are not charged the medical department dues unless they choose to pay the dues for hospital privilege only (\$1 per month), in which case they must pay their own expenses to and from the hospital.

At Pueblo, where the Corwin Hospital, owned by the company, is located, employees are entitled to the necessary medical or surgical treatment by the local company physicians and surgeons, either at the hospital, the dispensary, or at their homes, provided they live within the city of Pueblo or within two miles of the hospital or dispensary.

At the mines and quarries, employees and their dependents are entitled to medical and surgical treatment by the local company physicians at the physician's office, or at their homes if they live within two miles of either the physician's office or the mine office; and at the physician's office only, if they live beyond the two-mile limit.

Employees only are entitled to hospital service in case of sickness or injury; their expenses to and from the hospital are paid by the medical department. Dependents of employees are charged at the rate of \$2.50 a day for a bed in a semi-private room, or \$3.50 for a private room. Medical and surgical service are furnished to dependents at reduced rates.

All cases of injury which come under the workmen's compensation act are treated as required by the act.

Employees are not entitled to treatment under their medical

ROCKY MOUNTAIN COAL MINING INDUSTRY

department dues, either by the local physician or at the hospital, in cases of disability which existed at or before the time they were employed; in dental cases; in cases of insanity, venereal or chronic diseases; in cases resulting from the use of intoxicants, stimulants or narcotics, or from vicious habits, fights, brawls or violations of laws or ordinances. Company physicians may charge reasonable fees for the treatment of such cases.

For normal cases of childbirth, a fee of \$35 may be charged by the company physician; no higher fee may be charged in any case without the approval of the chief surgeon and the manager of the department in which the employee is working. In case of a child born to an employee at the hospital, the fees collected go to the hospital fund.

Cases of insanity are referred to the county and state authorities for care and treatment.

Hospital treatment does not extend beyond the time in which benefit may reasonably be expected from hospital treatment, and in no case beyond the period when benefit may reasonably be expected from medical or surgical treatment.

Company employees and their dependents who come to the hospital for strictly dental troubles are charged for treatment; X-ray dental films for strictly dental troubles are charged for at regular rates. The dental department at the hospital was primarily established for the necessary treatment of patients already in the hospital, and not for general dental work among employees.

OTHER COAL MINING COMPANY PLANS

Four other Colorado coal companies have supplied information as to their medical service plans. These four companies provided in 1929 a total of 1,827,133 tons.

All of these concerns have company doctors who take care of all injuries and sickness among the employees and their families. Three of them employ the physicians on a salary basis, and the employees contributed to the cost of the service through a payroll deduction; the fourth company has a contract with the physician;

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

the collections from the payroll are turned over to the physician by the company, and constitute payment for service for any illness not connected with employment. None of the four companies owns a hospital. Three have contracts with independent hospitals for care of employees injured during employment; these arrangements do not include cases of non-compensable disability, nor are dependents of employees supplied with hospital care. The fourth company contributes, with other industrial concerns in the vicinity, to the support of an independent local hospital; none of the amount deducted from the employee's wages goes to the hospital, and employees needing hospital care for non-industrial illness make their own arrangements.

Many of the coal mining companies operating in Colorado are small enterprises, employing less than twenty persons apiece. Mr. James Dalrymple, Chief Inspector of Coal Mines of Colorado, informs us that "many of the small coal companies employing from one to ten men, and located in the outlying districts of the state, have no arrangements that I know of to take care of their employees."

Further information as to the practice in the coal fields of the northern part of Colorado is contained in a letter from an official of the United Mine Workers of America, who writes that the general practice in this field, is for the miners to pay \$1.50 per month to the coal company physician, who takes care of them and their dependents, including the dispensing of a limited amount of medicine. Single men pay \$1.00 per month for the same service. On the whole, says this official, the system is fairly satisfactory, yet capable of improvement "by the simple working out of a method whereby the men could have the choice of doctors, instead of being compelled to have the company doctor and no other." Regarding hospitalization, there is no plan of any kind for this service, either with the coal companies or through the local union of the United Mine Workers of America.

The criticism voiced in the foregoing letter was formally made in 1917 in a list of grievances presented to the Industrial Commission of Colorado by District No. 15, United Mine Work-

ROCKY MOUNTAIN COAL MINING INDUSTRY

ers of America, against the Colorado Fuel and Iron Company.⁸ The fifteenth item on the list reads: "Choice of doctors should be absolutely at the discretion of the men without any interference from any one or any source, which is not now the case."

The Commission's award was to the effect that physicians in the coal company camps were selected by the company, which maintained a system of emergency hospitals with a general hospital at Pueblo. The plan of selection was approved by the employees by the adoption of the company's "Industrial Plan." Medical and hospital service were furnished at \$1 per month for each employee and his family. The testimony, according to the award, did not present a serious complaint, the whole subject being covered by the statement of one of the signers of the nineteen grievances who testified, "one doctor cannot suit everybody," and by another witness who stated, "some like him and some don't, would be the same with any other doctor." Any other system, the Commission stated, would present all the disadvantages and lack many of the advantages of the existing one. No complaint had been made that the medical plan of the company did not fully comply with all of the requirements of the workmen's compensation act.

UTAH COAL MINING INDUSTRY

The Utah Fuel Company maintains physicians at all its coal mining camps, who give home and emergency hospital care to all employees; emergency hospitals are maintained at all camps. Hospital care other than emergency is arranged for by the company through contracts with independently owned hospitals. To the cost of this service the employees contribute \$1.50 per month by payroll deduction. An employee desiring his family to receive benefit of the medical plan contributes an additional \$1 per month for medical care in the home; hospitalization for families is not included.

⁸ Industrial Commission of Colorado, *Findings and Awards; the United Mine Workers of America, District No. 15, Employees of the Colorado Fuel & Iron Company, vs. the Colorado Fuel & Iron Company, October 20, 1917.*

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

General information indicating the prevalence of contract medical service in the mining and transportation industries of Utah is contained in a letter from the secretary of the medical society in one of the most important industrial counties of Utah. The letter states that the larger metal and coal mines and railroads all engage physicians to care for sickness among their employees. Some of these physicians are also expected to take care of the whole family, excepting for maternity cases, venereal disease and certain major operations. The monthly contributions vary from \$1 to \$2.50 per family. Usually, however, medical care for the family is practiced only in isolated mining communities. Many of the mines have large medical corps consisting of physicians living at the mines, and city physicians to take care of hospital cases. Hospitalization is guaranteed the employee, but not his family. One instance is mentioned of a medical corporation (for profit), organized to provide service to the employees of a group of small coal mining companies. It is operated by a layman, who employs physicians, furnishes medicines and provides hospital care.

A concern called the Welfare Medical Association, replying to our inquiry, states that it serves the employees of seven coal companies and their immediate dependent families, in industrial and non-industrial accidents and sickness. Employees are furnished all medical and surgical treatment, hospital care, transportation, etc., in connection with industrial injuries or non-industrial injuries or sickness, arising out of or during employment. (Chronic diseases, tuberculosis, dentistry, not included.) Dependent members of employees' families, while residing in the various mining camps, are furnished medical services and medicines. Charges are made for surgical services to dependents; in general, these charges approximate the medical fee schedule published by the Industrial Commission of Utah. The cost of care for industrial accident cases is paid by the employing company. The cost of the non-industrial service exceeds the income from payroll deductions of \$1.50 per man per month; this deficit is annually taken up by the seven coal companies on

ROCKY MOUNTAIN COAL MINING INDUSTRY

the basis of service rendered their respective employees. The Association maintains three hospitals, employs three doctors and several nurses, operates an X-ray machine, and maintains an ambulance, a mine rescue truck and mine rescue station, with instructors in first-aid.

At the coal properties of the United States Smelting, Refining & Mining Company in Utah, each employee pays \$1.50 per month for medical and hospital service for himself and his family, for illness and non-industrial injury. The coal properties are somewhat remote from other communities, which makes it necessary to retain doctors continuously at the mines. These doctors are paid straight salaries, plus certain allowances for medicines, etc. There is a hospital of five-bed capacity, in charge of a graduate nurse, located at the most central point. The chief surgeon, connected with a firm of other specialized doctors and surgeons in Salt Lake City, is also paid a straight salary. He has charge of the doctors and nurse at the mines, and treats major cases, when necessary, in Salt Lake City.

MONTANA COAL MINING INDUSTRY

Specific information as to contract medical service in the bituminous coal mining industry of Montana was received from only one concern. That company operates coal mines where, according to a letter received from the company, 240 men were employed in March, 1931. At this place all employees secure medical, surgical and hospital care in return for a fixed regular deduction of \$2 per month from wages. Ordinary medical service is included for dependent members of miners' families. Hospital care in case of non-industrial injury or ordinary sickness is provided employees in a local hospital with which the coal mining company has a contract. Dependents of employees requiring hospital care are received in the hospital as ordinary paying patients.

CHAPTER VI

FIXED PAYMENT MEDICAL SERVICE IN THE COAL AND METAL MINING INDUSTRIES OF THE CENTRAL STATES

THE INTERIOR COAL PROVINCE

A MAP of the coal fields of the United States shows four fairly distinct coal regions making up what is called the "Interior Province," as follows: 1. Northern region: Michigan; 2. Eastern region: Illinois, Indiana and Western Kentucky; 3. Western region: Iowa, Missouri and Kansas; 4. Southern region: Arkansas and Oklahoma. The 1930 Census shows the following numbers of persons gainfully employed in the coal mining industry in the above states.

Michigan	1,336 ^a
Illinois	59,639
Indiana	17,210
Iowa	7,759
Kansas	5,548
Missouri	6,360 _b
Oklahoma	5,997
Arkansas	3,751
Total	<u>107,600</u>

^a Number employed in 1929. (*Coal in 1929*. U. S. Department of Commerce, Washington, 1931.)

^b *Forty-third Annual Report, Missouri Bureau of Mines*. The State of Missouri contains two areas in which the mining of lead and zinc ores is extensively carried on. Lead and zinc mining is also carried on in Oklahoma. Arkansas is the principal American source of bauxite, the ore from which aluminum is manufactured. The system of employee group medical service in return for a payroll deduction is rarely found in the lead and zinc mining industry in these states. For convenience, the system of employee group medical service in operation in the bauxite mining industry of Arkansas will be described in conjunction with the account of the system in operation in the coal mining industry of that state.

CENTRAL STATES MINING INDUSTRY

For convenience, the northern and eastern coal regions of the interior province (Michigan, Illinois and Indiana) will be considered separately from the southwestern coal field (Iowa, Kansas, Missouri, Oklahoma, and Arkansas).

Michigan. Information received from medical societies in this state shows that it is not customary for the coal mining company to provide medical or hospital care to an employee in case of ordinary sickness or accidental injury.

Illinois. Information received from several of the largest coal producers of Illinois indicates clearly that it is not customary for coal companies to provide medical care or hospitalization for non-industrial injuries in return for a payroll deduction. Where surgeons are employed by coal mining companies, they are to provide first-aid for industrial accidents only. In some districts of the Illinois coal field local unions have undertaken to provide medical care to members. A hospital in the Williamson coal field writes as follows:

"Two local unions in the county have included in their by-laws that they will pay to any member of their local or member of his family \$100 for a needed operation and will pay \$3 per day for a maximum of fourteen days' stay in the hospital. Three other local unions will pay a maximum of \$100 for an operation on any member or family dependent, but make no arrangements for hospital bills. According to the wording of the by-laws, this money should be paid to the member himself; however, it is usually given to the doctor or the hospital concerned. None of the local unions designate any doctor or any hospital that the man must patronize. There are some 18 or 20 local unions in Williamson county, but these five are the only ones that have these regulations in their by-laws.

"It is sometimes possible for a man by applying to his local union to get permission to pass a paper among the other members soliciting help for such an emergency. The amount he collects varies greatly. The money in any case is checked off from the men by the coal company and paid to the local union

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

involved. They in turn check it out to the hospital or doctor to whom it is due.

"I believe that there are in the extreme eastern part of the county one or two local unions that have an arrangement with a hospital in Harrisburg, in Saline county. Just what the arrangement is I don't know. Franklin County has a different arrangement, a much more extensive one, although it does not include all the local unions in Franklin county. So far as Williamson county is concerned this arrangement takes care of a very small number of patients brought to this hospital, which is the only hospital in Williamson county."

An official of the United Mine Workers of America, Springfield, Illinois, writes:

"Some of our local unions have arrangements to provide hospital services for their members, which is handled in the same way as their sick benefits. In West Frankfort, the heart of the coal fields of southern Illinois, there is located a miners' hospital, owned by the miners and paid for by them through assessments that are levied on the membership. Doctors and nurses are employed at so much per month, and paid for by the miners through the means of assessments levied by their local unions. In some cases injured and sick miners are taken into privately owned hospitals, and their hospital bills are taken care of by assessments levied on the membership of the local unions.

"These are all voluntary arrangements made by the miners themselves, and the coal companies have no jurisdiction—except to collect the assessments through the medium of the check-off system which is invoked through the contract between the miners and operators, and which applies to the collection of all dues and assessments. The hospital at West Frankfort is quite an institution, and many miners are treated at that hospital."

Indiana. According to reliable information, the system of medical service in consideration of an authorized payroll deduction does not exist in the Indiana coal field. In response to an inquiry, a leading physician of Terre Haute, Indiana, writes, under date of March 17, 1931, as follows:

CENTRAL STATES MINING INDUSTRY

"In the Indiana coal fields the custom of contract service does not prevail, nor has it at any time since I started practicing in 1904, at Linton, Indiana, which place at that time was the leading field in the state. No doubt there have been some isolated cases, but none of any consequence. Years ago, some of the local unions would check off the men fifty cents a month, for one of the two hospitals in this City, the hospital agreeing to provide accommodations for a given period; this practice was rather isolated and did not last very long, and at the present time does not exist. It has always been the practice for the miner to call whomever he wanted and for such services he himself was responsible."

Another leading physician of Terre Haute, with a considerable industrial practice, confirms the foregoing statement in the following words (letter of March 13, 1931):

"Concerning medical and hospital service for the employees of mining companies in this region, I wish to state that I know of no example of such service that is paid for entirely or in part by any company, or by regular monthly contributions or deductions from the pay of employees. Aside from the workings of the Workmen's Compensation Act, all medical services are rendered by private physicians on an individual basis, as are all hospital services. I know of no groups of individuals who are cared for, when sick, except on the basis of private patients of individual physicians. Of course we have provisions for the care of the indigent sick, but the services of private physicians are easily accessible to all in this region, and fees are made within the reach of their pocketbooks."

The attitude of the Indiana State Medical Association is indicated in a letter from the Secretary (January 3, 1931), stating that so far as can be found out there is no contract practice among ethical physicians and clinics. The Secretary's letter quotes a statement of one of the large industrial clinics in Indianapolis, as follows:

"It has been the policy of this clinic at all times not to have

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

any contract form whatsoever relative to industrial accidents, nor do we operate upon any schedule of fees.

"The only work which we do which might be called contract is the examination of prospective employees, and this is done upon a fixed fee depending upon the type of examination required by the employer.

"It is our opinion that any contract work is upon the wrong basis, not only from the viewpoint of the doctor himself but that of the employer and employee as well. It is our opinion that the best type of work done is that in which there is no contract basis, unless it be perhaps where some physician or surgeon is a full-time employee of an organization."

The Secretary of the Medical Society adds that the Society believes that this is the general attitude toward contract practice of the Indiana profession as a whole.

Iowa. The Iowa Industrial Commissioner (workmen's compensation service) writes that "there is no tendency in this state on the part of employers to provide medical, surgical and hospital treatment in any combined arrangements, taking care of non-compensable as well as compensable cases. . . . I know of no employers who provide such service in their own hospitals."

Kansas. Information received from coal mining companies in Kansas is to the effect that a deduction from the employees' wages is made only when the employee specifically requests it in behalf of a physician selected by himself.

In all of the states mentioned above (excepting the state of Arkansas, which has no workmen's compensation law) the employer makes his own arrangements for the provision of hospital care necessitated by an industrial injury, and leaves to the employee the provision of hospital care arising out of ordinary sickness, or non-industrial injury.

CONTRACT SERVICE IN SOUTHWESTERN COAL FIELD

In the southwestern coal field, groups of employees contract with hospital associations (operating on a profit basis) to provide

CENTRAL STATES MINING INDUSTRY

members of the group and their dependents with medical and hospital care at a fixed amount per employee per month.

Employee group medical service is found to a limited extent in the southwestern coal field. The system is described in a letter from Mr. W. L. A. Johnson, Commissioner of the Southwestern Interstate Coal Operators Association, reading as follows:

"Formerly, in the mining industry of the southwest, covering Kansas, Missouri, Arkansas, and Oklahoma, a company-doctor check-off at about \$1 per month was quite prevalent among all company 'camps.' This appeared necessary to induce some doctor to locate within the coal camp and take care of the health situation. As a rule such subscriptions were voluntary, but it became necessary to require positive signature for check-off in order to secure definitely the location of a doctor, frequently called the Company Doctor.

"It is true that perhaps many abuses grew out of this plan of operation, and in later years the United Mine Workers organization objected to the system and it was agreed to entirely eliminate the same, so far as the company's check-off was concerned, unless by special request and solicitation of the individual miners themselves. Even this practice has now practically gone out of existence in these four states, and in the place of same various efforts have been made by physicians to organize what is called 'Miners Hospitals' in which they undertake to induce the miners to sign a subscription of \$1 per month, which gives the miner the guarantee of all medical attention necessary, also to cover his entire family, even to the extent of hospitalization in severe cases. The coal operators have been unwilling to become a party to this plan, other than as each individual company complies with petitions from the miners to deduct from wages the amount for such hospital association. In the last two or three years such associations have practically dwindled down to a small following."

From one of the "Miners Hospital Associations" mentioned by Mr. Johnson, the following information as to the present

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

system of providing medical care in the southwestern coal field was received:

"It is the common practice for the coal companies to carry a check-off list for their employees when requested by the men themselves. This money is paid over to a physician who takes care of sick employees and their families in their homes. None of the coal companies own hospitals. They make arrangements with local hospitals for the care of workmen's compensation cases only. Hospital care for non-industrial illness is provided by the Hospital Association. This is a private enterprise for group service eliciting the coöperation of employers and employees. Collections are made by the coal company on the payroll from all the men who sign contracts for this service. The full amount of such deductions, less 5 per cent for collecting, is paid over to the Hospital Association by the company. The deduction is \$1 per month, the membership dues being \$5. The service consists of surgical and medical treatment in the hospital, including board, ward, bed, nurse, medicines, dressings, operations, laboratory examinations, and X-ray. The member, his wife and all children under sixteen receive the service when needed, without charge. The Association owns no hospitals, but gives the service at local hospitals. The patient is free to choose his own doctor; the Association cultivates the friendliest relation with the family physician, and coöperates with him in everything for the good of the patient and supplies a need he is unprepared to meet—Hospital Service."

Another of these medical service associations, in a letter dated March 31, 1931, states that it has something over 8,000 members, including employees in practically all the coal mines in Arkansas and eastern Oklahoma. About 98 per cent of the operators coöperate with the Association in the way of collecting dues through the company office. Dependent members of subscribers' families are included in the service. In this case, the contract for medical service is between the certificate holder and the medical staff in the hospital which provides treatment.

"A large per cent of our membership is obtained by sollicita-

CENTRAL STATES MINING INDUSTRY

tion. We find it no trouble to have the employee carry our protection when the employer coöperates with us and encourages the men to take it. The coal officials endorse it very readily, as we take care of the accidents and injuries, so far as the medical and surgical and hospitalization are concerned. . . . We have a local general practice contract with the local physicians in each community and coal mining town that takes care of the accidents and injuries so far as first-aid is concerned, and also gives their families general practice.

“You wanted to know if we had any arrangements with the miners of the United Mine Workers of America. You will note the United Mine Workers of America is not functioning in Arkansas and Oklahoma. We once had contracts with all the local Unions in Arkansas and Oklahoma where the secretaries of the local Union collected dues for us instead of the Coal Companies. But since the organization has gone down we have our dues collected through the coal company office. We have no compensation law in Arkansas but do have one in Oklahoma.”

SCOPE OF MEDICAL SERVICE CONTRACT

The certificate of membership issued by this Association provides as follows:

The holder, his wife and minor children are entitled to medical and surgical treatment, advice and consultation, as often and as long as required, such service to be provided by a designated local hospital, and its staff of physicians and surgeons. The service is subject to certain limitations, i.e., in confinement cases, physicians' services, but not hospital service, are furnished only after the certificate has been in force twelve months; diseases existing prior to issuance of certificate are not covered by the contract; ordinary examinations, consultations, prescriptions, and vaccinations are furnished at the discretion of surgeon in charge; treatment by eye, ear, nose and throat specialists are furnished on order of the Chief Surgeon, in cases of accident requiring special attention; physicians and operations, but not hospital service, are

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

furnished in incurable diseases, such as cancer, etc.; excluded altogether are insanity, attempted suicide, alcoholism, pulmonary tuberculosis, venereal disease, contagious disease.

The membership fees and dues are: \$5 for the first month and \$2 per month thereafter; this covers, as stated, the holder, his wife and minor children. Physical examinations for membership are not required. The member may select as his physician any member of the staff or the associate chief of the designated hospital to attend him. The staff doctors will make residence calls, but the regular charge is made for these. The Employees' Group Plan enables an employee to purchase a membership through his employer by authorizing the deduction of the monthly dues from his wages.

The "local general practice contract" referred to above is issued under the name "General Practice Association." The service described in the certificates may be summarized as follows: Medical treatment, advice, and consultation, as often and as long as required, is provided by a designated physician, whose name appears on the certificate; to the holder, his wife and dependents, subject to the following limitation: In confinement cases, an extra charge of \$15 must be paid; medicines, serums and anti-toxins are extra; house calls are made only when patient is "wholly unable" to go to the doctor's office, and no house calls, except emergency, are made between 10 P.M. and 6 A.M.; treatment of insanity, tuberculosis, cancer or any incurable disease is excluded.

ARKANSAS BAUXITE INDUSTRY

This state ranks first in the United States in the production of bauxite ore. The Federal Census of 1930 shows 1,579 gainfully employed persons in mines and quarries other than coal mines and oil and gas wells. The chief producer of bauxite ore has kindly furnished the following information:

"We maintain a hospital in connection with our mining operations in Arkansas, and we maintain a company physician. The company owns the land and the hospital building and pays

CENTRAL STATES MINING INDUSTRY

all of the costs pertaining to the running of said hospital, although as partial reimbursement we deduct \$1.50 per month from the pay envelopes of married men and \$1 per month from single men for which our mining organization gets ordinary medical treatment without further cost. We pay our company doctor a regular salary, and he is permitted to obtain fees from private patients in the district who are not connected with our organization. Our hospital is well equipped and our doctor is an excellent surgeon, and where patients in the hospital, either employees or non-employees, can afford to pay board we charge them \$1 per day for meals. In the case of operations, either employees or non-employees, if the patient can afford it, we charge \$10 for the anesthetic and \$10 for the operating room, plus modest fees for surgical work. Our medical and hospital expenses are substantially higher than the total of our collections, but for this difference we are independent of hospital and medical aid from the neighboring towns."

Arkansas does not have a workmen's compensation law.

LAKE SUPERIOR IRON MINING INDUSTRY

Eighty-four per cent of all the iron ore mined in the United States in 1929 came from the so-called iron range of Lake Superior (Michigan and Minnesota). In that same year, Michigan supplied 9.3 per cent of the total copper produced in the United States. The number of persons gainfully employed in extraction of minerals in these two states, according to the Census of 1930, was 40,895. In both these states it is customary for the iron mining and copper mining companies to provide medical care to the employee for non-occupational injury and ordinary sickness in consideration of a fixed deduction from wages.

The following account summarizes information supplied by several of the leading iron mining corporations of Minnesota and Michigan, as to the system of employee group medical service in operation in the Lake Superior iron ore region. The usual deduction from wages is \$1.25 per employee per month. For this con-

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

tribution, medical care is guaranteed the employee and dependent members of his family. If hospitalization is necessary, a charge is made for an operation and for board, but reduced rates are in effect for contributing employees and their dependents. Medical service is provided from "base" hospitals, located at strategic points on the iron range. Several of these hospitals are owned by mining companies, some are owned by private concerns. However, most of those owned by mining companies are turned over to surgeons for operation under a contract. The total payroll deduction is turned over by the employer to the contracting surgeon, who is expected to provide all necessary service.¹ Physicians employed by the chief surgeon give treatment either at the hospital (out-patient service) or at the patient's home. It should be clearly understood that the deduction from the employee's wages covers only medical service arising out of a non-compensable injury, or ordinary sickness. For industrial injuries, the mining company contracts with the chief surgeon operating the hospital, to provide all necessary surgical and hospital treatment required by the workmen's compensation act. The consideration for this service is a fixed payment per employee per month. Each iron mining company maintains its own staff of surgeons to give necessary first-aid in case of an industrial injury.

The following extract from a letter received from a leading independent iron ore producer in the Lake Superior region will help the reader better to visualize the system in operation.

"In Minnesota our plan is the general plan followed by the iron ore mining companies in the Lake Superior district. Our mining companies carry their own compensation risk, and contract with a doctor in the community to furnish all medical services for their employees, both that required under the Workmen's Compensation Law, and also medical services for their employees and their families. The doctor receives through monthly payroll deductions \$1.25 from the man, which provides for medical attention for himself and family. In addition to this,

¹ Section 3444, *Minnesota General Statutes, 1923*, permits employer to maintain own hospitals, or to contract with independent hospitals or physicians under Commissioner of Labor and Industry and Commissioner of Insurance.

CENTRAL STATES MINING INDUSTRY

the contract also provides for certain fixed extra charges for surgical or special medical attention furnished employees or their families. The mining company pays the same doctor 50 cents per month per man, which provides for the medical, surgical and hospital treatment required under the Compensation Law.

"At one of our iron ore mining properties, the payroll deduction provides hospital, as well as medical treatment to employees and members of their families. In a few districts, instead of contracting with a doctor, the mining company owns and operates its own hospital, with the doctors on a salary basis."

SELF-INSURING MINING COMPANIES

It will be noted that the iron mining company quoted above carries its own compensation risk. In other words, it elects, under the Minnesota Workmen's Compensation Act, to "self-insure" its liability to pay compensation and provide medical aid to employees injured in the course of their employment. This authorization by the Minnesota act to employers to "self-insure" constitutes the key element in the existing system of contributory medical service for non-compensation cases in that state. The Industrial Commission of Minnesota, in its report for the year ending June 30, 1930, states that "while the number of self-insurers is small compared to the number carrying insurance, it is probable that the payroll of this class is a very large proportion of the total payroll of the state." The report also states that "such employers are generally provided with an efficient agency for furnishing medical and surgical treatment." Out of a total of \$2,253,525 expended during the year ending June 30, 1930, for medical and hospital benefits for the cure and relief of persons injured in industry, "approximately \$552,494 was for services rendered under what is known as the 'contract medical plan.' Owing to the fact that it is impossible to analyze the 'contract medical' expense, no attempt has been made to show percentages for this item of cost." None of this expense is for medical or

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

hospital care for injuries sustained outside of employment, or for ordinary disease.

MEDICAL PLANS LICENSED BY STATE

In Minnesota, employer-maintained plans for providing non-compensation medical or hospital care, or for paying cash benefits outside the field of workmen's compensation are brought under the supervision of the state authorities by Section 3444 of the General Statutes of 1923. In response to an inquiry, the Industrial Commission of Minnesota supplies the following information, shedding further light on the legal basis and present extent of plans for providing medical and hospital service to employees in the event of sickness or non-industrial injury, in return for a fixed, regular deduction from the employee's wages.

"You are advised that Section 3444, G.S. 1923, of this state, provides that 'no employer shall, by agreement with his employees or otherwise, make deductions from their wages for the purpose of furnishing them with medical or hospital care, accident, sickness, or old age insurance or benefits, either directly or through a mutual association, unless he has first received from the commissioner of insurance of this state, a license for the benefit plan he operates or proposes to operate. Such license shall be granted by the commissioner of insurance only when he is satisfied that the benefits given are commensurate with the charges made, and that the said charges are sufficient to keep the fund solvent. All such licenses shall be for the period of one year, and it shall be proper for the commissioner to require a statement of the operation of the fund, on a form to be prescribed by him before granting a renewal. The fee for any license granted under this act shall be \$1, and the fee for filing the annual statement \$1. Provided, that in any case before granting a license the commissioner of insurance shall submit the proposed plan to the commissioner of labor and industries in order that he may determine whether the benefits are in conjunction with benefits under the workmen's compensation act.'

CENTRAL STATES MINING INDUSTRY

"Our records show that at the present time there are 115 employers in this state who have taken advantage of this section of the law, and are now deducting a certain amount of money per month from the employees' wages for the purpose of providing additional benefits to the injured employees other than those prescribed in the Compensation Law. Different employers have different plans of operating their benefit fund. The Oliver Iron Mining Company (subsidiary of United States Steel Corporation) of Duluth, Minnesota, operates under what is known as the Mesaba plan. This same plan is being used by practically all iron mining companies in this state. The Northwestern Bell Telephone Company and the International Harvester Company, and many others too numerous to mention, all have their own plan of operation. The Oliver Iron Mining Company have their own doctors and hospitals, as do many other iron mining companies."

Inquiry of the Insurance Division of the Department of Commerce of the State of Minnesota brings out that licenses have been issued to 84 corporations, classified as follows: iron mining corporations, 30; manufacturing corporations, 16; public utilities, 4; other corporations, 34. The employer's application for a license sets forth that "no part of the sums collected from employees, as herein stated, has been used to pay for or defray any of the cost of said employer for medical, surgical or hospital services incurred on account or by reason of any accident for which said employer would have been liable under the provisions of section 23-a, general statutes, 1923, otherwise known as the Minnesota Workmen's Compensation Law." The report accompanying the application for license sets forth the number of non-compensation accident cases, and the number of cases other than accident, cared for during the period covered; also the amount paid out by the benefit fund for cases other than accidents. The report further separates the amount of benefits paid out to employees in case of industrial accident from the amount paid out by the benefit fund for medical and hospital service, outside the field of compensation.

The Insurance Division further states that "the iron mining corporations usually furnish their employees, and in some in-

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

stances members of the employee's family, with medical, surgical and hospital services, and to cover such expense, deduct stipulated sums from the monthly wages of each employee. A number of logging camps (listed under 'other corporations') also supply their employees, but not members of their families, with medical and surgical aid as above, and to the payroll deductions of employees, usually contribute a sum equal to or in excess of the per capita payment by employees." ²

MICHIGAN COPPER MINING INDUSTRY

The leading producer of copper in the state is the Calumet and Hecla Consolidated Copper Company. In 1929 this company produced close to 50 per cent of the entire production of the state.³ This company writes that physicians and nurses are provided by the company, for which the employee contributes \$1.50 per month. This payment also entitles members of the employee's family to medicines and medical attendance. If confined to a hospital, there is a charge for hospital board. Examination of the Michigan workmen's compensation law fails to show any special provision relating to plans by which "self-insuring" employers undertake, in agreement with their employees, to provide medical or hospital care for non-compensation injuries and sickness, in return for an authorized payroll deduction. No information is available as to the extent of medical service in other copper companies operating in the state of Michigan.⁴

² The other benefit associations reported by the Insurance Division of Minnesota are, as far as can be judged by the information submitted, typical "establishment mutual benefit associations," like those described in Chapter XII. These associations pay cash benefit in the event of disability, but do not (except in a few instances) provide medical or hospital care.

³ *Copper in 1929*. U. S. Department of Commerce, Washington, 1931.

⁴ Personal inquiry by the author of this report in the chief industrial cities of Michigan satisfies him that outside of the iron ore and copper mining industries, it is not customary for the employer to provide medical care. The medical staff maintained by leading industrial corporations in connection with safety and accident-prevention programs are usually available for consultation by employees. The industrial health service does not, however, follow the employee into his home. The Wayne County Medical Society (Detroit and vicinity) informs us that it does not know of any company in which payroll deductions are made to cover the cost of medical care.

CHAPTER VII

FIXED PAYMENT MEDICAL SERVICE IN THE COAL MINING INDUSTRY OF THE APPALACHIAN STATES

THE states of Pennsylvania, Maryland, Ohio, West Virginia, Virginia, Kentucky, Tennessee and Alabama comprise within their boundaries the most important coal mining region in the United States. The anthracite mining industry of the country is found almost entirely within the northeastern counties of Pennsylvania. In this industry, however, no deduction from miners' wages to cover medical or hospital service is made. The anthracite industry may therefore be eliminated from further consideration.¹

Seventy per cent of all the bituminous coal produced in the United States in 1929 came from the Appalachian region. The average total number of persons employed in the eight Appalachian bituminous coal mining states in 1929 was approximately 368,933.² The numbers reported for the various states were as follows:

<i>State</i>	<i>Number Employed</i>
Alabama	25,208
Kentucky	58,649
Maryland	3,289
Ohio	25,399
Pennsylvania	131,774
Tennessee	7,619
Virginia	12,053
West Virginia	104,942
Total	368,933

¹ In 1929 approximately 151,501 persons were employed in anthracite coal mining in Pennsylvania. (*Coal in 1929*, United States Department of Commerce, Washington, D. C., 1931.)

² *Coal in 1929*, United States Department of Commerce, Washington, D. C., 1931.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

The large majority of these coal mining employees, together with dependent members of their families, are entitled to medical service from a company doctor, in return for a fixed periodic payment, deducted from wages by the employer.³

The United States Coal Commission defines 49 fairly distinct fields within this region. Inasmuch as the system by which employees secure medical and hospital care is not uniform in the different fields, it may be well to identify them. The following figures give the total number of operating mines and total production from the various fields of the Appalachian region in 1929.⁴

U. S. Coal Commission Field No.	State	General Name of Field	1929	
			Number of mines	Production (net tons)
1	Pennsylvania	Pittsburgh	225	33,414,000
2	do	Connellsville	140	36,647,000
3	do	Westmoreland-Ligonier	79	11,600,000
4a, b	do	Freeport (thick and thin).....	85	9,860,000
5	do	Butler-Mercer	64	1,760,000
6	do	Blossburg	12	178,000
7	do	Broad Top	39	1,218,000
8	do	Somerset	109	6,350,000
9a	do	Central Pennsylvania, western ..	65	2,959,000
9b	do	Central Pennsylvania, middle ..	126	9,632,000
9c	do	Central Pennsylvania, eastern ..	501	29,899,000
10	Maryland-West Virginia	Maryland-Potomac	103	4,371,000
11	West Virginia	Fairmont	136	23,739,000
12	Ohio-West Virginia	Panhandle-Pittsburgh #8	168	18,769,000
13	do	Pomeroy	26	687,000
14	West Virginia	Putnam County	3	444,000
15	Kentucky-W. Virginia	Kenova	17	3,111,000
16	do	Thacker	46	8,909,000
17	West Virginia	Tug River	54	8,441,000
18	Virginia-W. Virginia	Pocahontas	81	22,738,000
19	West Virginia	Winding Gulf	59	11,593,000
20	do	New River	101	13,602,000
21	do	Kanawha	110	17,331,000
22	do	Coal River	11	2,276,000

³ The reader is referred to the note by Mr. Hugh Frayne, voicing his objection in principle to the payroll deduction method of paying for medical care to industrial employees and their dependents. (See foot of page 3.)

⁴ *Coal in 1929*. United States Department of Commerce, Washington, D. C., 1931.

APPALACHIAN COAL MINING INDUSTRY

U. S. Coal Commission Field No.	State	General Name of Field	1929	
			Number of mines	Production (net tons)
23	West Virginia	Logan	72	18,581,000
24a	do	Coal and Coke	7	860,000
24b	do	Preston County	29	1,638,000
24c	do	Taylor County, Junior, Phillippi, and Gauley	76	4,536,000
25	Virginia	Southwestern Virginia	62	8,302,000
26	do	Clinch Valley	17	2,462,000
27	do	Virginia "anthracite"	8	269,000
28	do	Richmond Basin
29	Ohio	Massillon-Palmyra-Lisbon	90	1,487,000
30	do	Coshocton-Goshen	145	2,096,000
31	do	Cambridge	45	2,310,000
32	do	Crooksville	54	528,000
33	do	Hocking	97	3,803,000
34	do	Jackson and Ironton	52	397,000
36	Kentucky	Northeast Kentucky	115	13,669,000
37	do	Hazard	73	7,424,000
38	do	Harlan	57	14,340,000
39	Kentucky-Tennessee	Southern Appalachian	102	6,821,000
40	do	Jellico	23	709,000
41	Kentucky	Western Kentucky	144	14,437,000
42	Tennessee	Rockwood-Soddy	35	2,121,000
43	do	Fentress	7	673,000
44	Alabama	Big Seam Group	50	6,031,000
45	Alabama-Georgia	Cahaba Group	85	5,325,000
46	Alabama	Pratt Group	68	6,632,000

The following summarizes the situation as to employee group medical service in the various states of the Appalachian region.

PENNSYLVANIA

One important coal producing section of the Central Pennsylvania bituminous field, namely, Clearfield County, reports the gradual disappearance of the system of group medical service because of the steady decline in coal production. In Clearfield County, production declined from 4,359,264 tons in 1927 to 3,344,170 tons in 1928; the number of operating mines declined from 163 to 122, and the average number of persons employed

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

fell from 8,004 in 1927 to 6,535 in 1928. The secretary of the County Medical Society states: "It formerly was the practice among some of the soft coal companies to secure a physician at their mining towns and deduct an amount each payday from their employees. There never has been any similar arrangement to provide hospital care. Since we are in the heart of a bituminous coal mining district in which the industry has been demoralized for the past three years, I would say that this accounts for the elimination of the above type of service. As a result, many small towns have no mines working and no physician for miles. The clay industry, fire brick and refractories, seem never to have adopted the above type of contract practice. I presume this is because their plants are located to better advantage where medical and hospital care are more available."

With the exception of certain districts of the Connellsville and the Westmoreland-Ligonier fields, and the relatively unimportant Broadtop and Blossburg fields, it is the custom in the Pennsylvania bituminous field for the coal mining company to make a fixed regular deduction from the employee's wages to cover the expense of medical care to the employee and dependent members of his family. The service ordinarily includes such treatment as the company doctor can give in his office or in the patient's home. For special care, including obstetrical work, it is the custom for the company physician to charge a fixed amount.

Hospital service, however, except for industrial injury coming under the workmen's compensation law, is rarely included in the fixed payment payroll deduction plan in the Pennsylvania bituminous field. Speaking generally, the coal mining employee who requires hospital service arranges for it at the customary rates prevailing in his community.

TWO EXAMPLES OF HOSPITAL PLANS

Two instances of company plans that include hospital care as well as treatment by the company physician have been found in the Central Pennsylvania field. One of these companies owns and

APPALACHIAN COAL MINING INDUSTRY

operates a hospital. The other contracts with a nearby community hospital to provide service. The company providing service in its own hospital is the Berwind-White Coal Mining Company. In 1928 this company employed an average of approximately 3,000 persons in its mines in Somerset, Clearfield and Cambria Counties. The hospital (located at Windber, Pennsylvania) is an 80-bed, Class A institution. One dollar per month is deducted from the wages of each employee as his contribution toward the cost of service for himself and his dependents. The staff of the hospital is for the most part employed on a full-time basis, though there are a few consultants who are paid salaries for part-time service. The hospital is not open to other physicians and surgeons.

An official of the company states that a steadily increasing amount of service is being given to employees and members of their families by the hospital. In July, 1931, the contributions of the employees represented about 42 per cent of the total net operating cost of the hospital, the company paying the remainder of the cost. The official who supplied the above information states that the medical service provided by his company is justified by increased efficiency on the part of employees, but that obviously this is a question which each company must decide for itself. Conceivably there may be a point at which competitive conditions in a given coal field may deter a company from increasing medical and hospital service to employees over and above the quantity and quality of service approximately covered by the contribution of the employees.

The hospital also receives outside paying patients, and a considerable proportion of its service is to this class of patients.

The second company describes its plan as follows: "Our company employs a chief surgeon and five assistants. This corps of surgeons or physicians takes care of our accident compensation work, and also renders medical and surgical services to all of our employees and their families. For the latter work (not compensation) the employees contribute at the rate of \$1.75 per month in the case of a married man, and \$1.25 per month in the

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

case of a single man. The medical and surgical service rendered includes the furnishing of necessary drugs and medicines.

"Hospitalization for all our employees, as well as their families, is provided at three different institutions. One of these takes care of the major portion of our employees under a contract between the hospital and our corporation; the consideration involved in that contract being a \$25,000 contribution made by the corporation to the hospital. Our employees, either married or single, pay 50 cents a month to the hospital, which entitles the employee and his family to hospitalization (ward service) without any additional cost, or if a patient paying this 50 cent rate and known as a subscription patient, wishes to pay for a private room, he is assigned such at a discount of \$5 per week.

"In a general way, it may be stated that our chief surgeon ranks among the foremost general surgeons of the State, is a member of the American College of Surgeons, and in addition to general surgery has specialized along various lines. His several assistants are able practitioners of good repute. The hospital which takes care of the greater number of our employees as above set forth, was within the last eighteen months enlarged from a 40- to a 120-bed institution and was adequately equipped at a cost of about a quarter of a million dollars. It is recognized by the American College of Surgeons as a Class 'A' institution."

This company employed approximately 1,400 men in 1928.

OHIO

In the southeastern section of Ohio (West Virginia-Ohio field), the payroll deduction apparently covers only company doctor service. An official of the United Mine Workers of America writes that most of the mines in Ohio are working on a non-union basis at the present time, and he understands that several of the coal companies have put into practice the same system of payroll deductions for medical service as prevails in West Virginia and other non-union states. This trade union official expresses the opinion that the monthly deduction from wages,

APPALACHIAN COAL MINING INDUSTRY

averaging \$24 per year, is in excess of what medical service would cost the miner if he arranged with the doctor himself.

Relatively few replies were received from Ohio coal mining companies in answer to an inquiry about employee group medical service. One of the few which includes hospital service in the payroll deduction, describes its plan as follows:

"We operate two companies in Eastern Ohio. Between the two companies we operate five mines and have four locations or villages at the five mines, part of our men living in these villages and the balance of them living in the neighborhood and driving to the mines.

"We have set up in each one of these four locations what we call a 'Medical, Hospital and Burial Fund Association' to handle all cases of illness of our employees and their families other than industrial accidents which are handled entirely by the state in accordance with the workmen's compensation law of Ohio.

"Each mine has a separate fund, with one exception, where two mines at the same point pay into the same fund. We check-off from the employees \$3 a month for a married man and \$1.50 a month for a single man. This money is deposited to the credit of the Association at that particular point and the affairs of the Association are administered by a standing committee composed of the Superintendent at that mine, the Safety Director of the company, who is a member of each one of the Associations, and four miners elected each year by the members of the Association.

"1. Each pay period (we pay twice a month) 45 per cent of the collection is turned over to the doctor who takes care of the employees and their families at that point.

"You will see from this that the doctors' incomes vary with the size of the mines. The local doctor also gets 90 per cent or more of the industrial work at these points which adds to his income, and, of course, he is at liberty to take care of the outside work he may have or get except that his first duty is to the Association.

"2. As stated above, this not only takes care of the employees but in the case of one paying as a married man, takes care of all

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

members of his family of kin cousin or nearer, living with the employee and dependent on him.

"3. We do not have any hospitals of our own, but have arrangements with hospitals in the vicinity, Martins Ferry, Bellaire, Steubenville and Wheeling, so that our patients can be taken care of in these hospitals. We pay the regular hospital rates but get some consideration from the staff surgeons and doctors due to the fact that the pay is prompt and there is considerable of it. The bills for such work are sent to the association, the standing committees investigate them, find out whether the patients have been properly referred to the hospital by the local doctor, and if everything is in order, pay the bills.

"Many people have received exceptionally good care when it was needed through this system, which they would have been unable to get had we not had the system working, and the doctors, hospitals and men connected with the system seem to be satisfied with the way it is working."

WEST VIRGINIA

It is the almost universal custom in the coal mining industry of West Virginia for the employer to deduct a fixed amount from the employees' wages, as remuneration to the company doctor for medical treatment rendered by him to employees and dependent members of their families, for sickness and injury not coming under the workmen's compensation law. Something over 100,000 coal mining employees are covered in this way.

In the Panhandle and Fairmont coal fields (northern West Virginia), inquiry on the ground by the author shows that coal mining employees who require hospital service for non-industrial injuries or for ordinary sickness or disease, make their own arrangements with local community hospitals. In some instances, the coal mining company will, if specially requested to do so, make a periodic deduction from the employee's wages in order to discharge the bills of the hospital and the attending surgeons.

In the coal fields of southern West Virginia, according to

APPALACHIAN COAL MINING INDUSTRY

information received from coal operators' associations, owners of private hospitals, the West Virginia Medical Society, and individual coal companies, there are usually two deductions from the employee's wages, one for company doctor service, the other for hospital service.

A letter from the executive secretary of the Kanawha Coal Operators' Association, Charleston, West Virginia, dated March 5, 1931, states: "Practically all mines in southern West Virginia not located close to towns or large communities have arrangements with doctors to stay in the mining camps to give medical attention to the employees and their families and surrounding territory. These rates, agreed upon with the employees, run from 75 cents to \$1 for single men and \$1.50 to \$2 for married men. This includes all medical attention, and practically all medicine is furnished free of charge. In addition to the above, hospitalization is arranged with hospitals in Charleston, Montgomery, Beckley, Logan, Bluefield and other cities for which a charge is made from \$1 to \$1.35 per month which includes hospitalization, operations and care of the employees and their families for both occupational and non-occupational accidents and sickness of all kinds. It would be impossible for the isolated mining camp in southern West Virginia to secure the services of an efficient doctor unless arrangements of this kind were made, and by all employees paying into this fund to make it a small monthly fee for the services of the physician, who furnishes his own medicines."

A letter, dated March 10, 1931, from the New River Coal Operators' Association, Mount Hope, West Virginia, says: "It is the practice for the coal mining companies in this field to have a company physician who gives medical attention to miners and their families in return for a monthly deduction of \$1 to \$1.50. This is regardless of the size of the family or amount of medical attention necessary. In regard to hospitalization, the coal companies provide an arrangement for the men through the payment of \$1 or \$1.25, according to the hospital, whereby hospitalization is given to themselves and their families. Operations are per-

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

formed where necessary without additional compensation by such hospitals. Service is thereby rendered not only from a medical standpoint, but hospitalization standpoint as well, which would entail many times the cost if rendered to individuals."

The hospital contract system, as it operates in the southern West Virginia field is discussed in the next chapter.

VIRGINIA

Practically all of the 10¼ million tons of coal produced in Virginia comes from Wise, Tazewell, Russell, Lee and Dickenson Counties in the southwestern corner of the state. Seven coal companies together produced 71 per cent of the total. The large majority of the other operators produce less than 100,000 tons apiece annually. The 1930 Census reported the number of persons employed in coal mining in Virginia as approximately 13,846.

A letter received from the Virginia Coal Operators' Association, March 6, 1931, states that "Every mining company of any consequence in the Virginia field employs a physician either on the basis of the amount of fees collected from employees, or on a salary basis. These physicians give ordinary medical care to miners and their families, but as a rule their employment does not encompass the treatment of serious injuries which come under the Virginia Compensation Act. There is no uniformity of fees collected, that feature depending largely upon the situation of the physician employed, accessibility to the plant and facilities afforded for properly taking care of the practice. The fees range from 50 cents to \$1 per single man, and from \$1 to \$1.50 per married man."

Hospitalization. Employees of three of the largest coal mining companies in the Virginia field are hospitalized in company-owned hospitals. These are as follows:

<i>County</i>	<i>City</i>	<i>Number of Beds</i>	<i>Owned by</i>
Wise	Toms Creek	20	Virginia Iron, Coal & Coke Co.
Wise	Stonega	20	Stonega Coal & Coke Co.
Russell	Dante	25	Clinchfield Coal & Coke Co.

APPALACHIAN COAL MINING INDUSTRY

Dr. C. B. Bowyer, physician in charge of the Stonega Hospital, informs us that all of the large companies put up the requisite bond with the Industrial Commission of Virginia, and thereby receive authorization to "self-insure" their liability under the Virginia compensation law. The total amount collected from employees through payroll deductions for medical service is applied on the operating cost of the company hospitals.

A general idea of how the service functions in a company operating its own hospital is given in the following extract from a letter from Dr. Bowyer describing the service provided under his direction by the Stonega Coal & Coke Company.

"1. Medical Care: The Stonega Coke & Coal Company maintains a medical staff of eight men under my supervision, one located at each colliery to look after the health and welfare of employees and their families living at the colliery. In return for this service the company collects \$1.80 for married men and 90 cents for single men, per month. These deductions pay approximately 70 per cent of the cost of maintaining the medical department.

"2. Hospitalization: The company owns and operates a small hospital for the care and treatment of employees only. The hospital is a 16-bed hospital with X-ray and laboratory equipment; with a staff of two doctors, three nurses, orderly, maids, etc. Under the compensation laws, of course, all injured parties are admitted to the hospital free of charge. The three rules of our hospital which govern the admittance of patients to the hospital and which were put into effect January 1, 1930, are as follows: First: All employees injured while on duty, but under no other circumstances, will be admitted to the Stonega Hospital and treated free of charge, provided that in the judgment of the attending physician the injury is of such a nature as to require hospital treatment. Second: Any employee or member of the family of an employee under the care of the medical department of the company at the time, will be admitted to the Stonega Hospital for an operation, provided he or she is willing to pay, in advance, a hospital fee of not less than \$5 and not more than

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

\$30. Third: Any employee or member of the family of an employee under the care of the medical department of the company at the time, if the circumstances are sufficiently critical as to warrant it, in the judgment of the physician in charge, and the conditions in the hospital are such as to permit it, will be admitted to the Stonega Hospital for medical treatment provided the case is neither contagious, malignant, nor tubercular, and also provided the patient will pay, in advance, a hospital fee of \$10 per week. No other charges will be made. (It will be noted from Dr. Bowyer's statement that no deduction is made from employees' wages for hospital insurance.)

"It is our plan to take care of all emergency surgery of any employee or member of his family under the medical department. We also take a limited number of medical cases which are covered by Rule No. 3. Having a limited number of beds, we limit the medical cases and in fact it is an exception rather than a rule to handle medical cases in the hospital. The fees mentioned above, giving payroll deductions, entitle the employee or his family to be admitted to the hospital under the rules and regulations noted above. Records show that there are about 3,000 employees of the Stonega Coke and Coal Company; about 90 per cent are married. We figure that each family will average three persons. I would say the number of employees are 3,000 and the dependents nearly 6,000."

PRACTICE IN SMALLER VIRGINIA COAL COMPANIES

As pointed out above, the large majority of the companies mining coal in the Virginia field produce less than 100,000 tons a year. These companies do not self-insure their compensation liability, but insure in carriers approved by the Industrial Commission. These insurance companies usually make contracts with independent hospitals in the Virginia coal field to provide necessary care arising out of injuries sustained by employees of their coal company policy-holders.

Employees of these "non-self-insuring" coal companies make

APPALACHIAN COAL MINING INDUSTRY

their own private arrangements for hospital care in case they are disabled by non-industrial injury or disease.

The privately owned hospitals which serve the population of the Virginia coal field are as follows:

<i>County</i>	<i>City</i>	<i>Name of Hospital</i>	<i>Number of Beds</i>
Wise	Appalachia	Masonic Hospital	15
Wise	Norton	Norton Hospital	30
Tazewell	Richlands	Mattie Williams Hospital	30
Dickenson	Clintwood	Dickenson County Hospital	30
Dickenson	Clintwood	Sutherland Hospital	12
Lee	Pennington Gap	Lee General Hospital	?

KENTUCKY

As shown in the table at the beginning of this chapter, there are several fairly distinct coal fields in the state of Kentucky. The most important region is that in the eastern part of the state, with a production in 1929 of 35,433,000 tons, as against 14,437,000 tons for the western Kentucky field. In all of the coal fields of Kentucky, it is customary for the employer to deduct a fixed amount from the employee's wages to cover the cost of medical service provided by the company doctor. Hospital service is usually included in the eastern Kentucky field, but is only exceptionally provided in the western Kentucky field.

An official of District No. 23, United Mine Workers of America, Central City, Kentucky (western field), writes: "This is a non-union coal field. In most instances the coal company employs a doctor and checks from \$1 to \$2 per month per man to maintain the doctor. In obstetrical cases the miners are checked \$25 extra. In addition to these monthly charges whether the miner uses the doctor or not, the doctor visits the sick when called and writes prescriptions for the medicine and the miner buys the medicine. There are only two or three places where hospitalization is carried on by the company, and in these instances the miners are charged a monthly rate by the company to maintain the hospital."

Two of the largest companies operating in the eastern Ken-

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

tucky field are the United States Coal and Coke Company (a subsidiary of the United States Steel Corporation), and the Consolidation Coal Company. Each of these owns and operates a Class A hospital; the former at Lynch, the latter at Jenkins. The periodic deduction from employees' wages entitles dependent members of employees' families to hospital as well as medical care.

CONSOLIDATION COAL COMPANY'S HEALTH PROGRAM

Although the Consolidation Coal Company is a large employer in Somerset County, Pennsylvania; in Garrett and Alleghany Counties, Maryland; in the Fairmont field of northern West Virginia; and in the Elkhorn and Miller's Creek fields of eastern Kentucky, it provides hospital service to employees only at its Kentucky mines. Because of the scope of this company's health program for employees, the following brief summary, as supplied by Dr. D. J. Kindel, Medical Director, is given.

Before the present program was instituted, the company employed physicians on a contract basis, each employee contributing a stated amount which was withheld from his wages and paid to a designated physician. Obstetrical surgery and venereal disease were charged extra; a wide variety of such fees existed. The physicians were chosen by mine superintendents, other officials, or the people themselves. One physician usually served several communities of the same company, and frequently those of other companies. He would necessarily "sublet" some of his work, which the company found had undesirable features. In 1927 there were approximately 35 physicians employed by the company on this basis, each independent of the others, without coordination or cooperation. No definite plan of work existed; methods and equipment were not standardized; and a great deal of the practice of medicine was on a pill-dispensing basis. Records were inadequate, and an organized health program was lacking. Nurses administered to the sick and injured in the homes, assisted with household duties, and filled in wherever they could.

Executives of the company, realizing the possibilities of an

APPALACHIAN COAL MINING INDUSTRY

organized medical department, made a survey of medical, hospital, nursing and sanitation problems of all company properties in 1926-1927, and the present program was started in 1927. The fundamental object of the company's medical program is to provide medical and nursing service to 10,000 employees and their families in four states—Kentucky, West Virginia, Pennsylvania and Maryland.

Scattered locations make it difficult to carry on the program. This has resulted in the establishment of areas or "medical units" based on locations and number of employees, each in charge of a physician and a public health nurse. Sometimes two physicians are required in one area. In October 1928, there were thirteen units, where employees received all usual medical attention, including minor surgery.

For medical service married employees contribute \$1.50 per month and single employees \$1 per month. A fee of \$20 is allowed the physician in obstetrical cases, also a small fee in venereal disease cases.

The staff and personnel consist of 18 full time physicians in charge of 13 medical units; one chief hospital surgeon with one assistant; one full time laboratory physician; six dentists; one supervisor of public health nurses; 11 full time public health nurses; 8 hospital nurses.

With the exception of the Elkhorn Division, Kentucky, hospital service is procured by employees in private or state institutions. No deduction is made outside the Elkhorn Division for hospitalization. Sometimes, when requested by an employee who has incurred expense for hospital care, the company will deduct a fixed amount each pay day and remit to the hospital.

The medical program comprises: *Care of injured and ill employees and their families*; (a) visits in homes; (b) consultations and treatment in a medical unit. One of the greatest problems, Dr. Kindel states, is to make patients come to the doctor's office; some feel that monthly dues entitle them to call a doctor to their homes for any cause. This is the only objection to the plan of monthly contributions. Long established precedent in the coal

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

field is believed to be responsible for this, and the medical department is gradually overcoming it by an educational campaign. All community units are practically the same, with standardized equipment, instruments, drugs and supplies. An attempt is made to impress employees with the fact that they can be better taken care of at the unit than at home. "Progress is slow, but there is gradual improvement."

Dispensing of drugs. Employees attended by company physician are provided with drugs, medicines, dressings and supplies without further charge.

Clinics are conducted by company nurses. During the first 8 months of 1928, a total of 7,000 individuals, mostly children, were examined by doctors and dentists at these clinics.

Immunization. This service is confined to locations where contagious diseases are most prevalent.

Daily medical reports. Each physician must make daily reports covering cases seen each day, primarily as a record of the prevalence and character of diseases in the communities. Diagnosis is made if possible. A record is kept of new and return cases, and occupational injury. Reports are checked and summarized monthly.

The people use the clinic service freely, because there are no fees to pay; hence, while many minor ailments are treated, incipient serious disease is also frequently uncovered and checked.

A quantitative summary of daily medical reports for the first five months of 1928 showed as follows:

Total calls	52,046
House calls	14,277
Office calls	37,378
House and office calls	391
Colored	6,787
White	45,259
Males	29,092
Females	22,954
Average calls per day.....	2,496
Number of physicians reporting.....	16

APPALACHIAN COAL MINING INDUSTRY

Compensation injuries. Another phase of the medical program is care and treatment of compensable injuries, requiring 1,100 to 1,300 services per month. The employee must receive a "Return to Work" certificate before he may resume his regular occupation after accident or long illness; the purpose is to decrease absenteeism, avoid risk of relapse, regulate compensation, and obtain data as to time lost.

Dental service. The company has agreements with six dentists, the company providing location and making collections over payroll for services in accordance with a standard list of charges. Maintenance work is provided for children under 15 at half price. Each child is given a dental examination once a year.

Tonsillectomies are usually performed by company doctors, at a charge of \$20; some are done free of charge.

Special clinics. Eye, orthopedic, and other special clinics are conducted similarly to dental clinics.

Public health nursing service. The medical department program includes bedside, maternity, and visiting nurse service; prenatal and infant care; pre-school child welfare service; school nurse service, including social service and educational work; nursing care for tuberculosis and communicable disease. Other features of the company health program include housing and sanitation, water supply, etc.; these departments work in close coöperation with the medical department.

Hospital service. Hospitalization is provided in the Elkhorn field in the company-owned hospital at Jenkins. In return for a contribution of 50 cents per month from married employees and 40 cents per month from single employees, care arising out of non-industrial injury and ordinary sickness is assured employees and their dependents. If private room service is desired, a charge of \$1.50 per day is made. Surgical and medical services are charged for, but according to the coal company, the fees are 25 per cent lower than for corresponding services elsewhere in the region.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

TENNESSEE

The principal coal fields of Tennessee are situated in the eastern half of the state, within reach of Chattanooga and Knoxville.

A claim agent for a number of Tennessee coal companies writes that "in practically every coal mining village in the state, medical attention is rendered the employees and their families, covering sickness and non-occupational injuries, by a physician who has been elected by the miners and for whose services the miners pay a stipulated sum per month, commonly referred to as medical cuts. In some localities medical cuts are compulsory, and in other localities are voluntary on the part of the miners. Medical attention and hospitalization in connection with occupational injuries are paid for by the company." The "medical cuts," or payroll deductions, range from \$1 to \$1.50 per month per employee. Information received from several Tennessee coal companies indicates that hospitalization for non-industrial injury is provided employees and dependent members of their families under contracts between coal mining companies and independent hospitals.

ALABAMA

The bulk of the coal produced in Alabama comes from six counties with the city of Birmingham at the approximate center.

The prevailing custom in the coal mining industry of this state is for the company to provide hospital care, as well as company doctor service, in consideration of a fixed deduction from wages. Information as to the scope of the service, and the relation of the employer to the medical personnel, was obtained by personal interviews and correspondence with company officials.

Approximately 25,000 coal mining employees in this state are covered by the company doctor system.

One company, which employed an average of 375 men in 1930, employs a full-time physician on a fixed salary. There is no contract, and no outside practice by the physician is per-

APPALACHIAN COAL MINING INDUSTRY

mitted; his entire attention is given to the employees and their families. Medical and surgical treatment in accident or sickness, medicines, and attendant nursing care in the home, are part of the service. The doctor is permitted to charge a fee of \$15 in obstetrical cases, and a small fee in venereal and genito-urinary cases. In caring for venereal disease, he works in coöperation with the state, which furnishes the drugs for treatment. The company gives the physician a free hand in the ordering of medicines, serums, etc. For this company doctor service the employees contribute, by means of monthly payroll deductions, 90 cents for single men, \$1.35 for married men. Hospitalization, both for accident and sickness, is given in a local hospital in Birmingham, and includes treatment by a hospital staff physician. The company's contract for this service is with the staff physician, not with the hospital. It provides that the company's employees shall receive hospital care, and medical or surgical treatment while in the hospital. To the cost of this service the employees contribute by an additional monthly payroll deduction of 50 cents for single men, \$1 for married men. These contributions are carried by the company in a special fund, and are paid over in full to the hospital physician with whom the contract is made. Dental care is not included in the plan, but is secured for employees at reduced rates, by an informal arrangement between the company and a dentist. The president of the company states that the two contributions made by the employees do not cover the cost of the medical and hospital service. The company makes up the difference, which amounts to about one-third of the total cost. An approximate total of 1,250 persons, employees and dependents, was covered (May 1931) by the service.

Two other coal companies (controlled by one corporation) which in May 1931 employed about 400 men, at three mines located a few miles from Birmingham, had two full-time physicians to care for the employees and their families. An emergency receiving room and a dispensary are maintained, and care is given in the homes when needed. For this service the payroll deduction is 75 cents per month for single men, \$1 for married men. Con-

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

tracts between the doctors and the controlling coal corporation provide that the doctors shall devote their entire time to the care of the mine employees and their families; in return for this service, the total amount collected through payroll deductions is turned over by the company to the doctors. Though there is no stipulation in the contract to this effect, the coal companies state that in "short times" they supplement the amount of the payroll deduction, to bring the doctors' remuneration up to a fair average amount.

Hospitalization for non-industrial injury or disease, including medical and surgical treatment by the hospital staff physicians, is provided in a Birmingham hospital, under a contract between the company and the hospital. The acceptance of this service is optional on the part of the employee, and the payroll deduction is voluntary. About 75 per cent of the employees avail themselves of this protection, and authorize a deduction of \$1 per month, which includes their dependents.

In the case of industrial injuries, care is given by the company doctors, and by the hospital if needed, all under the above mentioned contracts. If further treatment should be required which could not be furnished by these agencies, the company would consider itself liable for the expense to the amount of \$100, the sum set by the Alabama Workmen's Compensation Law as the limit of the employer's liability for the cost of medical, surgical and hospital service for an industrial injury.

This coal corporation, when it first opened its mines about thirty years ago, owned and operated a hospital. It was found impossible to furnish first-class care within the financial limits set by the size of the company's operations, and the contract plan was substituted. About 2,000 persons, employees and dependents, were covered by the present plan of service in May 1931.

Another Alabama coal mining company operating several mines and employing approximately 1,700 men, owns a hospital at the mines, and arranges with a group of six physicians to operate it. All payroll deductions are turned over by the company to the physicians' group. There is no contract, but an informal

APPALACHIAN COAL MINING INDUSTRY

"agreement" between the company and the doctors, who are permitted to engage in outside practice. The service includes medical and surgical treatment and hospital care. Home visits are made when necessary. Two deductions are made, one for medical, and one for hospital service. The former is 75 cents and \$1.25 per month for single and married men respectively; the latter, 50 cents and \$1 per month. The total number of persons covered by the service in May 1931 was approximately 6,000.

One other coal company, which in 1929 employed a total average of 650 men, states in a letter that all employees and dependent members of their families are given medical and surgical treatment and hospital care under the contract system, in return for a monthly "cut" or payroll deduction.

GROUP MEDICAL SERVICE IN ALABAMA MANUFACTURING INDUSTRIES

Tennessee Coal, Iron & Railroad Company. This company, a subsidiary of the United States Steel Corporation, is the largest industrial employer in Alabama. In addition to operating coal and iron mines in Jefferson County, it has iron and steel works in the vicinity of Birmingham. This company had approximately 20,000 employees in May 1931, of whom about 4,000 were coal miners. Seventy-three per cent of the employees are colored. These employees and their families constitute a group of about 90,000 persons.

The medical and hospital service program of this company was described in the *Journal of Industrial Hygiene* for February 1926, by Dr. Lloyd Noland, M.D., Superintendent, Department of Health, and Chief Surgeon of the company. The following is in part a summary of that article, supplemented by information received from Dr. Noland by letter, and from personal investigation on the ground by the authors.

The company owns and operates a 320-bed fully equipped general hospital at Fairfield, Alabama, just outside Birmingham. This base hospital is the clearing house and center of all the work of the company's department of health. In addition, there

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

are twenty dispensaries and emergency hospitals at the various plants and villages. The hospital staff and the district physicians number seventy-three doctors, all on full-time salary, no outside private practice being permitted. The hospital staff of physicians covers the various specialties. Out-patient clinics are maintained at the base hospital, to which cases are referred by the district physicians, the clinics acting as the basis of consultation work. In addition to their medical work, the district physicians act as local health officers in the company towns.

The medical division has as its function the handling of emergency accident cases occurring in line of duty, as well as the general medical care of all employees, and of the dependent families of those who reside within a radius of 2½ miles of any dispensary; treatment is given either in the homes or at the dispensaries.

The expense of the medical division is borne partly by the company and partly by the employees, through a system of voluntary contributions. Any employee living within a 2½ mile radius of a dispensary, and whose wages or salary are less than \$250 per month, may request that he be placed on the "medical list," and that \$1.25 per month be deducted from his wages in payment. This entitles him and his dependents to treatment for any possible ailment, either at the dispensaries or at his home, and to professional service at the base hospital. Employees whose salary is \$250 or more per month may not be on the "medical list," but may receive service as private patients. Practically all of the employees who are eligible avail themselves of the "medical list" service.

Hospital care when needed is provided at the base hospital, and is furnished at the rate of \$1.25 per day (one-third of actual cost) for ward service. Private or semi-private rooms may be had at higher rates. Employees on the "medical list" who receive hospital care may on request have deductions made from their wages to pay their bills. Workmen's compensation cases, except for the necessary emergency first-aid care at the scene of accident, are

APPALACHIAN COAL MINING INDUSTRY

cared for at the hospital; the company is billed by the hospital at the actual cost.

The company employs fifteen dentists on full-time salary. No outside work is permitted. Dental clinics (one traveling) are maintained, and all classes of work are performed. Employees are charged at a low rate covering actual cost only.

The payroll deductions and the hospital charges (\$1.25 per day, ward rate) meet about 55 per cent of the cost of maintaining the health department; the company makes up the remainder. The payroll deductions are distributed, 40 per cent to the hospital, 60 per cent retained at works to pay the district physicians and the sanitary force, and for sanitation operations.

ANOTHER MANUFACTURING COMPANY PLAN

Another manufacturing company in Alabama, which employed 1,200 men in May 1931, maintains a medical service plan, partly financed through payroll deductions. Dependent members of employees' families are not entitled to free service. There is a dispensary building at the plant fully equipped for emergencies, examinations, medical and minor surgical treatment, and dental treatment. Two full-time physicians are employed on salary (no contracts), a part-time dentist on salary, and a nurse. The physicians give care and treatment in the home when necessary. For operations or special treatment beyond the scope of the company physicians or dispensary facilities, the company pays fees up to \$25 for minor, \$50 for major operations. Dental work is also done, no charges being made except for gold fillings and bridge work, for which reduced charges are paid by the employee through the company office, by payroll deduction if requested by the employee.

When hospital care is recommended by the company doctors it is given at a local community (non-profit) hospital. The company has a contract with this hospital to care for its employees, including ward care and the services of the hospital staff physicians and surgeons, at the rate of \$25 per week. A limit is set on

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

non-compensation cases of six consecutive weeks in hospital for any one sickness, or twelve weeks in any calendar year.

All of the foregoing service is paid for out of a fund created in part by deductions of 25¢ per week from the wages of each employee. Hospital treatment and care for the families of employees is provided by means of a voluntary payroll deduction of 50 cents a month for ward service, or \$1 if private room service is desired, including treatment by hospital staff physicians and surgeons. The company has a separate contract with the same local hospital covering this service. The deductions are carried by the company in a special hospital fund, out of which the hospital is paid for services rendered the families of employees under the contract. Ninety-eight per cent of the married employees avail themselves of this hospital service for their families.

MEDICAL SERVICE IN AN EMPLOYEE-OWNED CONCERN

The American Cast Iron Pipe Company, Birmingham, is owned and operated by the employees on a profit-sharing basis. The medical service for employees and their families is one of many coöperative welfare activities carried on by the employee-owners. There is a medical building, with emergency beds, out-patient clinic, laboratory, X-ray, sun-lamp, dental rooms, etc., and a staff of physicians, surgeons, dentists, nurses and technicians, all on salary. In addition, a staff of specialists is retained for consultation purposes, including a diagnostician, a pediatrician, and an ear, nose and throat specialist. These consultants are paid retaining fees. The services of an optician are provided at nominal fees. Home visits are made by the company doctors and nurses. Medicines must be paid for, except such stock medicines as may be given by the doctors at the dispensary. Dental work is done free of charge, except for gold fillings, bridge work, etc. When other than emergency hospital care is needed, local community hospitals are used; there are no contract arrangements. The cost of such care is not as-

APPALACHIAN COAL MINING INDUSTRY

sessed on the medical department, but is a benefit of the employees' mutual benefit association.

No payroll deductions are taken for any of these services. The cost of all the various welfare services is borne by the company, which in this instance is also the employees. In May, 1931, there were approximately 1,000 employees on the payroll, representing with their families about 5,000 persons entitled to receive the medical service described.

SUMMARY

The foregoing survey shows that the large number of bituminous coal mining companies in the Appalachian states fall into the following three classes, so far as medical and hospital service to employees for non-industrial injury and sickness is concerned: (a) Coal companies which make no deduction from wages of employees to cover the cost of medical or hospital service; (b) Coal companies which deduct a fixed amount regularly from the wages of their employees to cover the cost of service by the company doctor, but which do not undertake to provide the employee with hospital service, excepting in the case of an injury covered by the compensation law; (c) Coal companies which not only make a regular deduction from the employee's wages for company doctor service, but which also deduct a fixed amount regularly to cover the cost of hospital care. Companies which make no deduction whatever constitute a small minority of the Appalachian coal mining companies, and are found only in the western Maryland coal field, and in certain districts of the central Pennsylvania and Ohio fields. Companies which make a deduction from employees' wages for the company doctor constitute the great majority of all the mining concerns operating in the Appalachian states. Companies which make deductions from wages for hospital as well as medical care are numerous in the southern West Virginia field, but rare in the northern West Virginia, Ohio, and Pennsylvania fields.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

Of the coal mining companies making a deduction from employees' wages to cover hospital service, eleven provide care in their own hospitals. One of these is in the central Pennsylvania field; four are in the eastern Kentucky field; three in the Virginia field; and three in Alabama. The others contract with some independent hospital at a fixed rate per employee per month. The contract covers care to employees for both compensable injury and sickness, and to dependents for sickness. The amount collected by the employer at regular intervals from the wages of the employees is turned over to the contracting hospital, together with a list of all contributing employees and dependents entitled to hospital care.

No information is available showing how much is paid to contract hospitals by employers to cover the cost of care necessitated by compensable injury; or how much is collected by coal companies from employees and turned over to the contract hospitals to cover the cost of care arising out of injury or disease not due to the employment. In the southern West Virginia coal field, where the hospital contract system is practically universal, the complaint is made that the result is to saddle on the employee the expense of hospital care which the workmen's compensation law intended should be borne by the employer. No similar charge has been heard in the coal fields of Virginia, Kentucky, Tennessee and Alabama, where the hospital contract system is found to a limited extent. The next chapter will be devoted to detailed consideration of the hospital contract system in the southern West Virginia coal field.

CHAPTER VIII

THE HOSPITAL CONTRACT SYSTEM IN THE SOUTHERN WEST VIRGINIA COAL FIELD

THE hospital contract system as extensively found in the southern West Virginia coal field illustrates how the principle of insurance is being utilized to secure hospital care for a large industrial population living in small scattered communities.¹ However, complaint against the system as it operates in the coal field of southern West Virginia also shows the importance of administering such a plan so that the fixed periodic payment by the employee is exclusively applied to the purchase of treatment not coming under the workmen's compensation law. Where the same hospital handles both compensable injury cases and cases of disease not covered by the compensation law, it is obviously necessary for it to show that the full cost of medical care which the compensation law intends the employer to provide at his own expense is duly collected from the employer.

At the 1931 session of the West Virginia Legislature the hospital contract system was investigated and amendments to the compensation law were introduced. These amendments would have eliminated all uncertainty as to the legal responsibility of the coal mining company to pay for medical care arising out of a compensable injury, notwithstanding the existence of a contract between it and an independent hospital covering the provision of treatment to employees and their dependents in return for a

¹The southern West Virginia coal field comprises five fairly distinct districts, known as New River, Pocahontas, Kanawha, Logan and Mingo. The chief producing counties are McDowell, Logan, Raleigh, Fayette, Kanawha, Mingo, Mercer, Boone, Wyoming, Greenbrier, and Clay. The average total number of persons employed in the five southern coal districts in 1928 was 77,000 (Report of West Virginia Department of Mines, Charleston).

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

fixed, periodic deduction from wages. The attempt to amend the law was unsuccessful. The fact that similar complaint is not found in those sections of Virginia, Kentucky, Tennessee or Alabama where hospital contract practice is found, may be due to the clear, categorical language of the compensation laws of those four states, in respect to payroll deductions for medical and hospital benefits. They make it a misdemeanor for the employer to apply a payroll deduction towards the payment of any part of his insurance premium.

Before entering into a more detailed discussion of the hospital contract system, however, it may be well to consider why the contract system is almost universal in the southern West Virginia coal field, but is non-existent in the northern West Virginia-Ohio-Pennsylvania field.

The answer to this question is found in the different stages of community development which had been reached by the towns of the northern and the southern coal fields respectively when the workmen's compensation laws became operative. (Ohio passed its compensation law in 1911; West Virginia in 1913; Maryland in 1914; Pennsylvania in 1915; Kentucky in 1916; Virginia in 1918; and Tennessee and Alabama in 1919.) Enactment of the new legislation found the cities of the central and western Pennsylvania, Ohio and northern West Virginia coal fields reasonably well equipped with hospitals in which the coal mining employer could discharge his new legal responsibility to provide medical care in case of industrial injury. By the time the Tennessee and Alabama laws were passed, hospital facilities available for meeting the requirements of workmen's compensation in the coal fields of those states were also reasonably adequate.

The southern West Virginia-Virginia-eastern Kentucky coal field, however, is much younger industrially than the northern field, and when workmen's compensation entered into force in West Virginia, Virginia and Kentucky, this region was but meagerly equipped with hospitals.² The hospital resources of the

²The growth of the southern West Virginia-Virginia-eastern Kentucky coal region during the past twenty years has been at the expense of the northern Appalachian and Tennessee and Alabama fields. In 1913 the bituminous coal fields of

WEST VIRGINIA HOSPITAL CONTRACT SYSTEM

northern and the southern coal fields respectively when the state compensation laws went into force are shown by information taken from the Hospital Register of the American Medical Association.

Pennsylvania. The following table shows the geographical distribution of the 41 non-governmental general medical and surgical hospitals serving the central and western Pennsylvania bituminous coal field the year the Pennsylvania compensation law was passed (1915).

<i>County</i>	<i>City</i>	<i>Hospitals</i>
Allegheny	Pittsburgh	13
	Bellevue	1
	Braddock	1
	Homestead	1
	McKeesport	1
	McKees Rocks	1
	Sewickley	1
	Tarentum	1
	Wilkinsburg	1
Armstrong	Kittanning	1
Butler	Butler	1
Cambria	Johnstown	4
	Spangler	1
Clearfield	Clearfield	1
	Dubois	1
Fayette	Connellsville	1
	Uniontown	1
Greene	Indiana	1
Somerset	Windber	1
Washington	Canonsburg	1
	Washington	2
Westmoreland	Greensburg	1
	Latrobe	1
	Mt. Pleasant	1
	New Kensington	1

Pennsylvania, Maryland, Ohio, and northern West Virginia (Panhandle, Fairmont, Preston-Barbour, Elk Garden, Mason and Putnam Districts) produced 71 per cent of all the bituminous coal produced in the Appalachian coal mining states. By 1929, however, the relative proportion produced by the northern Appalachian field had not only fallen to 52 per cent of the total, but the absolute production of this area had declined from 233,621,782 tons in 1913, to 208,152,949 tons in 1929. During the same 16-year period, the production in the fields comprising the southern counties of West Virginia, the western corner of Virginia, and the eastern section of Kentucky, had increased from 71,054,881 tons to 166,083,612. In Tennessee, production declined from 6,860,184 tons in 1913 to 5,405,464 tons in 1929; during the same period, production in Alabama remained practically stationary, 17,678,522 tons in 1913, 17,943,923 tons in 1929.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

In addition to these non-governmental hospitals, there were two state miners' hospitals, one at Connellsville (Fayette County) and one at Blossburg (Tioga County).⁸

Northern West Virginia. The two chief coal districts in northern West Virginia are Fairmont (comprising Harrison, Marion and Monongalia Counties), and Panhandle (comprising Brooke, Hancock, Ohio and Marshall Counties). In 1912 the former had five non-governmental and one state miners' hospitals, with a total of approximately 365 beds. In case of necessity, moreover, the Fairmont district could make use of hospitals in Uniontown, Pa., to the north. The Panhandle field could call upon four hospitals in Wheeling and one in Glendale, with a total of approximately 300 beds, for service. In addition, the needs of this region could be met by utilizing hospitals in nearby Steubenville, Ohio, Washington and Pittsburgh, Pa.

Southern West Virginia. Although in 1912 the southern West Virginia coal field had 18 hospitals, or 7 more than the Panhandle and Fairmont districts together, the number of beds was about the same. However, these beds had to meet the needs of a region over three and a half times as large as the combined distribution of these hospitals in the southern West Virginia field in 1912 was as follows: Beckley (Raleigh County), 1; Bluefield (Mercer County), 3; Rock (Mercer County), 1; Charleston (Kanawha County), 2; Hansford (Kanawha County), 1; Fayetteville (Fayette County), 1; Oak Hill (Fayette County), 1; Hinton (Summers County), 2; Logan (Logan County), 1; Marlinton (Pocahontas County), 1; Matewan (Mingo County),

⁸ The extent of the reliance in Pennsylvania upon voluntarily organized, non-profit community hospitals is shown by the recommendation by Governor Fisher in his message to the General Assembly, January 1, 1929, that the 10 miners' hospitals (8 in the anthracite region) be turned over to properly incorporated and responsible local bodies under state aid. (*Fifth Biennial Report*, Secretary of Welfare, Dept. of Welfare, 1929-1930, Harrisburg, Pa.) It should be noted that it is the policy of the State of Pennsylvania to make grants in aid of non-profit hospitals serving the community. According to the report just cited, 161 of the hospitals in Pennsylvania in 1929 received state aid. This is in accordance with the policy enunciated by the State Department of Welfare (*Bulletin 31, A Ten-Year Building Program for State Institutions*, Dept. of Welfare, Harrisburg, 1927, p. 81) that "while the care of mental patients is a recognized responsibility of the State, care of the sick and injured in general hospitals is recognized as the obligation of local communities, looking to the state for state-aid."

WEST VIRGINIA HOSPITAL CONTRACT SYSTEM

1; Welch (McDowell County), 1 (State Miners' Hospital); McKendree (Fayette County), 1 (State Miners' Hospital).⁴

Hospitals have come into existence in the Appalachian coal field in four ways: 1. By the initiative of government; 2. by the initiative of employers; 3. by the initiative of local communities acting voluntarily; 4. by the initiative of private parties desirous of making a profit. Governmental hospitals have played a relatively unimportant part in meeting the needs of the population in the Appalachian coal mining states. So have coal company-owned hospitals, of which there are less than a dozen in the Appalachian mining region. While voluntary community effort has brought into being some of the largest hospitals serving the Pennsylvania, Ohio, and northern West Virginia coal fields, this force has been practically inoperative in the southern West Virginia field. This is doubtless due to the small size of the mining communities. The Census of 1910 (to take the one nearest to the year when workmen's compensation went into force in West Virginia) throws light on this point. The total area of the seven counties comprising the Panhandle and Fairmont fields is 1,678 square miles. The total population in 1910 was 227,032. The eleven coal producing counties which comprise the southern West Virginia field had 334,916 inhabitants in 1910, or approximately 50 per cent more than the Fairmont and Panhandle districts, but they were distributed over 6,268 square miles, or more than three and one-half times the area of the two chief northern coal districts. The relatively more densely settled northern coal fields had in 1910 the following cities with over 9,000

⁴ The three "State Miners' Hospitals" of West Virginia (now called Emergency Hospitals) were established twelve years before the compensation law was passed. Their purpose was to provide free hospitalization to miners injured while at work. At the present time they are operated under the usual policies of general medical, and surgical hospitals, and are open to the entire population of the communities they serve. They receive a biennial appropriation from the state which covers only part of the operating expenses. Payment is demanded from all patients, but non-paying, i.e., "charity" patients, are accepted. For workmen's compensation cases, the hospitals bill the state compensation fund in accordance with the Workmen's Compensation Medical Fee Schedule. The medical staffs are closed, and the physicians are on salaries.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

ORIGINS OF WEST VIRGINIA CONTRACT PRACTICE

Light on the origins and early development of the contract system in the southern West Virginia coal field is contained in the presidential address delivered by Dr. Albert H. Hoge, at the 1932 meeting of the West Virginia State Medical Association, at Parkersburg. In the course of a discussion of industrial medicine in West Virginia, Dr. Hoge said: "In the earlier industrial development of our State, many corporations, in order to insure proper medical care of their employees, imported physicians and deducted a certain amount each month from the employee to pay them. This method assured medical and surgical care of the employee and also served as a protection to the employer. This form of practice still prevails in most of the mining sections. . . . During the year 1899, George W. Peterkin, the first Episcopal Bishop of West Virginia and a man beloved by all who knew him, started a movement in this State destined to cause a great deal of controversy. Because there were no hospitals to care for the miners between Beckley and Charleston and realizing the great suffering resulting from this condition, he organized and built on the banks of the Kanawha River what was known as 'Sheltering Arms Hospital.' It was supported by miners, operators, pay patients, churches and private contributions. Each miner paid fifteen cents per month. This assured him and his family, whether sick or injured, the privilege of hospital wards. Some of the great surgeons of our State are products of this hospital. The building still stands, although closed about 1920, because it could no longer be supported under changed conditions.

"A short time afterwards the State built three hospitals for the care of miners, located at Welch, McKendrie and Fairmont. These were known as Miners' Hospitals, Nos. 1, 2 and 3. They assured adequate care of miners and their families in the southern, central and northern fields. Later, many private hospitals were built throughout these areas to meet the ever increasing industrial development and increased growth in population; also

WEST VIRGINIA HOSPITAL CONTRACT SYSTEM

because the State Legislature had passed a Workmen's Compensation Law that would compel the various industries to care for their injured employees. The passage of this law and the fact that sufficient private hospitals were now in existence to handle this work should have made it unnecessary for the State to longer operate its hospitals. They are, however, still in existence, operating in open competition to the private ones and running on the same basis, except that the tax-payers are compelled to contribute huge sums each year to make up their deficit.

"From these great humane movements there has developed in the southern part of the State what is known as a contract hospital system. Under this plan individual hospitals agree to care for the employees and members of their families for a fixed amount each month."

SCOPE OF HOSPITAL CONTRACT SERVICE

Information as to the nature and scope of hospital contract service in the southern Appalachian coal region has been supplied by superintendents of hospitals, by physicians in private practice, by coal companies, and others. The following information will serve to give the reader a general idea of the service to which the coal mining employee and his dependents are entitled in return for the fixed, periodic deduction from wages.

One of the largest coal companies operating in West Virginia writes: "We have a regular payroll deduction of \$1.50 per month for doctor covering medical services to the employees and dependent members of his family. As to hospitalization, the employee pays \$1 per month, which entitles him to hospitalization for himself and dependent members of his family. This covers any kind of hospital care except communicable diseases. The arrangement we have is with the . . . Hospital at . . . which is of a high order and has been productive of excellent results and has been satisfactory to our employees as well as to the company and also the hospital management. Under this arrangement the employee is entitled to a ward bed in the hospital, and

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

if a private room is desired the patient is allowed a credit of \$18 per week on the price of the room which amounts to \$30 or \$35 per week. At present we have about 700 men on this list, which does not include all of our employees."

The nature of the service which is guaranteed to employees and dependent members of their families under the contract plan of hospitalization is indicated in more detail by a hospital notice posted by the Houston Collieries Company, a subsidiary of the Koppers Coal Company, which states that the Houston Collieries Company has entered into an arrangement with the Bluefield Sanitarium, owners of the new Stevens Clinic Hospital, at Welch, in order to provide adequate hospital facilities for their employees. The coal company agrees to collect over the payroll, the sum of \$1.50 from every married employee, and \$1 from each unmarried employee, and pay the entire amount over to the hospital. In return, the hospital agrees to furnish the necessary care and treatment for any sickness or injury which requires hospital facilities, this service to include a ward bed, proper food, drugs and dressings, nursing care, and medical and surgical treatment. Any patient may occupy a private room by paying a sum representing the difference between the regular ward room rates and private room rates. The services will not include contagious diseases; drunkenness or any injury sustained on account of same; insanity, ordinary obstetric cases, venereal diseases, or typhoid fever. In the case of typhoid fever, where there are no home facilities, the patient will be admitted at a ward rate of \$3.50 per day, with no other charges. The notice further declares that the employee's continuance in the employment of the company after receipt of this notice will be considered as constituting an agreement on his part to the deduction of the amounts mentioned, for the purpose outlined.

This company, under date of March 24, 1931, supplies further information on the subject of its arrangements for medical and hospital service for employees and dependent members of their families: "The physician is not paid by the company, although the employment of doctors and their supervision rests with this

WEST VIRGINIA HOSPITAL CONTRACT SYSTEM

department. They are paid by the payroll deductions on the part of the men, which vary in the different coal fields, the range being from \$1.50 to \$2 for married men and \$1 to \$1.50 for single men. The money so collected is paid over to the doctors without any commission or deductions whatever by the Accounting Department of the coal company. This is a generally followed practice in West Virginia and the same arrangement applies as to hospital payments. Hospital activities are supervised by this department and a contract is entered into between the company and the hospital whereby the hospital agrees to furnish necessary medical attention to employees and members of their families in accordance with the terms of the contract."

Various hospitals in the mining districts of southern West Virginia have supplied information which may be summarized as follows:

Hospital A (Privately owned). "Practically all hospitals in (southern) West Virginia take the industrial patients and their families, giving any hospital care needed for a sum of from \$1.00 to \$2 per month per family. This is separate and apart from the doctor at the 'Plant' which is usually \$1.75 for married and \$1 for single workmen, all deducted from workmen's earnings by employer. This is how it is worked practically all over the state. Bluefield, Welch, Huntington, Logan, Beckley, Charleston, have several hospitals all doing contract work."

Hospital B (A non-profit institution). "This hospital at the present time is providing care for about 8,000 mining employees on the basis of a contract with the employer. This contract provides that the employer shall collect \$1.30 per month per man from each employee; for this consideration, the hospital renders all necessary hospital treatment to said employees and their dependents."

Hospital C (Privately owned). "This hospital provides hospitalization for fifteen coal companies with an estimated number of employees of 3,000. The employees, of course, are the usual ratio of married and single. We provide this service under an agreement whereby the company deducts a certain sum from

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

each employee, which is paid to the hospital. This is exclusive of the medical service which the employee receives from his company physician, for which a separate deduction is made from his wages."

HOSPITAL CONTRACT SERVICE IN DETAIL

The Bluefield Sanitarium, Bluefield (controlling also the Stevens Clinic at Welch), has kindly submitted the following detailed account of its contract service to coal mining employees.

"The Bluefield Sanitarium is a general hospital and serves in part the city of Bluefield and surrounding community. The community is largely dependent on the coal industry. The institution is privately owned and privately operated. The parent hospital also owns and operates the Stevens Clinic Hospital at Welch. The latter hospital was opened April 1, 1930. It is located 40 miles west of Bluefield and the community served is similar, except that the population is almost entirely industrial. The two hospitals operate on both a contract basis (insurance principle) and the old system of rate charges and fees. Approximately 60 per cent of the work done is on the contract basis. The capacity of the parent institution is 100 beds and that of the Stevens Clinic 75 beds. The group idea obtains in the professional care of patients and the two hospitals employ 13 full-time and 3 part-time doctors, exclusive of internes. The Bluefield Sanitarium is accredited by the American College of Surgeons.

"The scheme of providing medical and surgical treatment and hospital service on the basis of a monthly assessment plan is not original with us and has been in vogue in southern West Virginia for a number of years. The plan had its inception at the Bluefield Sanitarium on September 1, 1927, when a large coal producing company of the section employing approximately 4,000 people entered into a contract with this institution for hospitalization of its sick and injured employees and their dependents. Numerous smaller producers followed this lead, so that at the present time something like 20 different employers of labor

WEST VIRGINIA HOSPITAL CONTRACT SYSTEM

have this arrangement with the parent hospital or its unit at Welch.

"In the month of December, 1930, the two hospitals were providing service for approximately 11,500 employees. Including dependents, a population of between 40,000 and 50,000 was served.

"The plan is defined in the contract between employer and the hospital. For certain hospital service provided, the employer collects for the hospital \$1 per month for each single employee and \$1.50 for each married employee or any person who provides for a family. Dependent is construed to mean any person living in the household of an employee and dependent upon him for support (usually a wife and minor children, occasionally a widowed mother or an invalid father).

"In consideration of the monthly assessment the hospital undertakes to furnish service to such sick and injured employees and their dependents who ordinarily would require hospital facilities for their care. The service includes a ward bed, food, drugs and dressings, ordinary nursing care, the benefit of diagnostic methods, and adequate medical and surgical treatment. Any patient may elect to occupy a private room by paying the difference between the private room rate and the ward rate of \$3.50 per day. Except that the usual contagious diseases are excluded and that pulmonary tuberculosis and incurable cases are admitted for diagnosis only, there are no hard and fast rules as to what constitutes a hospital case. Even in the case of contagious diseases, these patients may be admitted when certain complications (obstruction in laryngeal diphtheria and middle ears and mastoids in measles and scarlet fever) make hospitalization a necessity. Only complicated obstetric cases are received. The plan is simplified by the fact that family doctors are provided on much the same principle as hospital service is provided. There is no financial competition, and the local doctor is free to refer any patient where he thinks hospitalization is necessary. The hospital, with its clinical and X-ray laboratories and other diagnostic facil-

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

ities, coöperates freely with the family doctor in any of his problems.

“Our scheme, representing as it does an insurance principle of dividing risks into charges that are fixed and regularly paid, has, we believe, gone a long way in solving hospital difficulties and in providing a means of the public’s escape from the serious financial penalties of illness.

“The cost to the individual in our plan appears on first sight to be extremely small and inadequate. The merit of the plan must stand on the quantity and quality of work done and if it pays its way. The hospital must do its full job, or else the scheme is thoroughly unworkable. We have kept accurate statistics, which permit of every conceivable analysis, and we are satisfied that the arrangement does pay its way and that the public has a good insurance investment.

“On the arrangement in operation at the Bluefield Sanitarium and the Stevens Clinic both in the year 1930 (the Stevens Clinic operating from April 1, 1930) the average number of employees paying assessment was approximately 10,500 (representing a population of not less than 40,000). In the year period, 5,879 patients were referred to the hospital. These represent original references, and patients coming in subsequently for observation or the continuation of some special treatment already instituted are not included in the total. Of these, 3,437 were out-patients and 2,442 were admitted to the hospital. The work in connection with out-patients is similar to that in any well-organized out-patient department. The hospital patients included the general run of hospital work and was similar to that done on patients paying their way on the regular system of rate charges and fees. The total hospital days for the contract patients numbered 17,573. The daily average was 48 patients and the average stay of a patient in hospital was 7.2 days.

ANALYSIS OF HOSPITAL COSTS

“For the purpose of an accurate idea as to how well the scheme paid its way, skeleton charges were made for various

WEST VIRGINIA HOSPITAL CONTRACT SYSTEM

services rendered all patients referred on contract. In the case of mine injury patients the schedule of fees and charges allowed by the Compensation Commissioner of this state was adhered to strictly. In instances of sickness, where the compensation schedule did not apply throughout, minimum current charges were used. On this basis the actual money collected on the assessment plan represented 59 cents on each dollar of skeleton charges made. The Stevens Clinic was operating in the period largely on new contracts and the volume of work necessarily was larger than it would be after a year. At the Bluefield Sanitarium, for instance, where contracts have been in force for a considerable length of time, collections represented $66\frac{2}{3}$ cents on the dollar of skeleton charges. After the first year of a contract, we have looked upon 65 cents on the dollar as a normal return.

“The question arises at once if this 65 cents on the dollar for service rendered is adequate. In the ordinary arrangement of rate charges and fees, the best collecting we have ever been able to make was 75 cents on the dollar. There was along with such work a considerable amount of charity and courtesy work for which no charge was made. If these were included, with usual charges made, we are rather inclined to the belief that the contract patient, paying on an insurance principle, was more profitable.

“As a protection against the hazards of sickness—a simple illness at home or a major surgical operation entailing a stay in hospital—the married employee in the Pocahontas coal field pays \$3.50 (\$2 to his family doctor and \$1.50 to his hospital), or \$42 a year. For this amount, hardly the equivalent of the cost of his automobile insurance, every legitimate illness is covered except that of childbirth. Charity is eliminated entirely.”

The following analysis of statistical records kept by the Bluefield Sanitarium and the Stevens Clinic is of value: “The average number of employees on contract at the Bluefield Sanitarium (based on full year period) was nearly 8,000. At the Stevens Clinic (based on nine months period) the average number of employees was a little over 3,500.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

"The total number of patients referred to the Bluefield Sanitarium was 3,750 (original references counted only and the patients returning for subsequent observation or continuation of treatment already instituted are not included). The total number referred to the Stevens Clinic (nine months period) was 2,129. Total for both places 5,779.

"Of the 3,750 patients referred to the Bluefield Sanitarium, approximately 60 per cent were handled as out-patients. The handling of out-patients was that typical of any out-patient department and included various cases of minor surgery, limited examinations, and complete examinations. A large amount of out-patient work was taken up in the eye, ear, nose and throat department and in the departments of urology and X-ray and clinical laboratories. 1,224 of the 2,129 patients referred to the Stevens Clinic (approximately 60 per cent and same as Bluefield Sanitarium) were handled as out-patients.

"Of the 3,750 patients referred to the Bluefield Sanitarium, 1,537 were admitted to the hospital. These patients were hospitalized for various diagnostic procedures, for the treatment of various medical conditions requiring hospital facilities, and for surgery varying from a simple removal of tonsils to major operations. 905 of the 2,129 patients referred to the Stevens Clinic (approximately 40 per cent) were admitted to hospital.

"The total number of hospital days at the Bluefield Sanitarium was 12,149 (year period). The total number of hospital days at the Stevens Clinic was 5,424 (9 months period). Total hospital days both places numbered 17,573. The daily average of patients in the Bluefield Sanitarium was 34. The daily average at the Stevens Clinic was approximately 20. The average stay of a patient at the Bluefield Sanitarium was approximately 8 days. The average stay at the Stevens Clinic was approximately 6 days. The average number of patients in hospital at the Bluefield Sanitarium per 1000 employees was 4.25. At the Stevens Clinic the average was 5.17 per 1,000 employees. Mine injury cases constituted 20 per cent of the work at both places, with no material variation in percentage at the two places."

WEST VIRGINIA HOSPITAL CONTRACT SYSTEM

DIFFERENCES OF MEDICAL OPINION AS TO HOSPITAL CONTRACT SERVICE

Opinions differ in the medical profession of West Virginia as to the desirability of this form of hospital insurance. The head of a large hospital in the northern part of the state declares that under hospital contract practice, "the patient is hurried in and out of the hospital without the proper treatment."

The medical superintendent of a large hospital in West Virginia, a former president of the state Hospital Association, has the following to say about the system: "The deduction from employees is commonly called 'list practice'; this may be divided into two types:

"Type I. In which the deduction is made for the care of the employee and his dependent family for all hospital requirements with the following exceptions: normal obstetrics, venereal diseases, accidents received in line of duty, and accidents due to lawlessness. The deduction in these cases is usually \$1 per month for both single and married men. The company physician fills out a blank making a tentative diagnosis and the superintendent approves the blank stating that the patient is paying into the relief and thereby has a right to the hospital care. Speaking as one who does this work I can frankly say that the hospital can give excellent care and treatment to the individual patient where there is a full-time conscientious staff, without financial loss, provided the hospital does not undertake a greater 'list practice' than it has beds or man power to take care of. In West Virginia the amount of this work is very limited for several reasons: 1. Most hospitals are privately owned with no state endowment and consequently must realize a gain on their investment. 2. Many hospitals are inadequately equipped and cannot give proper care. 3. The corporations themselves are not in the main interested in the welfare of the individuals and refuse to coöperate. 4. The corporations make little or no pretense at investigating institutions or the personnel attached to them. 5. Because it is the other man's dollar, political affiliation permits inferior medicine. In brief, this type of health insurance in the state of West Virginia

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

should and could be most satisfactory, entailing neither financial loss nor gain if properly carried out.

"Type II. The same as type I except: In this class a small additional charge is made against the employee (20 to 50 cents) giving him all the above as enumerated in type I, but without his knowledge including accident in line of duty. This is a most pernicious system and the one most prevalent in the state. Because by including accidents in line of duty the employer is relieved of all compensation charges incident to the care of the injured. Thus a man injured loses his right to choose his hospital or surgeon and is practically forced into the contract hospital. He does not know that he himself has been charged off in the past for injuries he might receive. Consequently the competitive field which promotes better medical and better hospitalization is removed. The scientific ambitions of the individual are somewhat bent when he is guaranteed an income that does not depend on his ability. The employee is robbed of his personal liberty and all profit is at his expense.

"Some time ago a member of our compensation department made the statement 'that more than 70 per cent of the bad results came from the list practice hospitals.' There are some of us in the state who have made an effort to keep out of this work, but because of lack of endowment to carry on first class work, and the lack of state aid to take care of the indigent and the inability to obtain coöperation from employers through any other means than assisting their net incomes, we are being forced into this work."

On the other hand the following opinion, generally favorable to the hospital contract system, is expressed by the medical director of a large coal company which does not have such contracts: "Contracts between coal companies and hospitals are usually based on an additional deduction of \$1.50 per month from the employee, which provides complete hospitalization for himself and his family and includes the care of compensable, occupational injuries. Briefly and frankly it has been found to the advantage of the employee, the company and the hospital, to have a hospital contract arrangement, and under the circumstances it is possible

WEST VIRGINIA HOSPITAL CONTRACT SYSTEM

to obtain complete medical and hospitalization care for the sum of \$36 per year for a married man and his family and \$24 for a single man. Many thousands of employees in southern West Virginia are affected by this contract system. There is only one real and logical objection to the plan, which is promptly eliminated if the various companies and employee groups are represented by proper medical supervision of hospital cases, and this is the inclination on the part of some hospitals to give inadequate care and discharge patients earlier than ordinarily would be the case."

A DETAILED MEDICAL CRITICISM

The following criticism of the hospital "list" system as it operates in the southern West Virginia coal field was voiced by Dr. Harry M. Hall, M.D., in the February, 1931, number of the *West Virginia Medical Journal*.⁶ "It (hospital contract practice) introduces a commercial element. Hospitals enter into competitive bargaining for it pretty much as packing houses bid for cattle. It creates a bad feeling which, I suspect, would never exist if the ordinary course of hospitalization were pursued. This is denied on the surface; but an observer going into a locality will learn, rather sooner than later, that there is an element of antagonism which can be directly traced to its operation. It lowers the general impression of people not connected with it in their opinion of hospitals. It has a tendency to cheapen the outlook. If faithfully followed with the conscience possessed by the average human being, it has its elements of danger, financial and otherwise. For instance, we may have 500 miners and each one of them pays in one dollar per week, which usually covers the family as well. This is \$2,000 per month. Say in the aggregate families and all the number represented there would be four times 500, or 2,000 people. Let us hypothesize long enough to say that 25 of them needed intensive laboratory work, which is decidedly expensive for a hospital, not only in material but also in the time used by

⁶ *West Virginia Medical Journal*, Vol. XXVII, No. 2, pp. 54-55.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

the technical workers in doing it. Let us imagine that 25 more had to have gastroenterological X-ray pictures involving the whole alimentary tract. Fifteen had to have chest plates. Ten more were involved in physiotherapy. Where, may we ask, would the \$2,000 go, and how much of it would be left? It is customary, in some places, to have this also include casualty. This, it seems to me, would carry the matter into the red figures. It is sometimes a matter of extra charge for operating rooms and delivery rooms. In any case it would not be much.

“Departing from this, let us say an epidemic involved these two thousand. Here again would be disaster. The only way to insure a profit would be to cut in on the quality of the service given. As this is not included in our analysis at all, it seems to us as if the hazards in the list practice far outweigh its probable gains if it is carried out faithfully, honestly and adequately. What is the remedy? First, a form of health insurance bought like an automobile is purchased in the open market at a cost of no more than is paid in at the mine. If that is not sufficient, raise it. But give to the worker a chance to choose his doctor and his hospital like any one else. If necessary (although it is debatable), give him a special rate in laboratory and X-ray departments. But let all hospitals do alike. Second, all hospitals should meet together and every one of them voluntarily give the matter up. It will take courage, but if all do it, the matter will end at once.”

That the hospital contract system has the effect of bringing about lack of balance in regional hospital facilities, i.e., excessive facilities in some regions; insufficient facilities in others; is suggested by one of the leaders in the West Virginia medical profession, who practices in the Pocahontas and Tug River coal fields (McDowell County). This physician reminds us that when the Stevens Clinic was opened on April 1, 1930, two hospitals, namely, State Miners' Hospital No. 1, with 115 beds, and Grace Hospital, with 70 beds, were already in operation. He insists that these two hospitals adequately met the needs of the region. As shown earlier, the Stevens Clinic is owned by the Bluefield Sanitarium.

WEST VIRGINIA HOSPITAL CONTRACT SYSTEM

HOSPITAL CONTRACT SERVICE AND WORKMEN'S COMPENSATION

The criticism that under the hospital contract system as found in the southern West Virginia coal field the injured employee pays for hospital care which the compensation law intended the employer should pay must now be taken up. On this point the head of a hospital writes: "Our hospital has a contract with a large number of coal companies and other industrial corporations to provide hospital care in the case of sickness, non-industrial accidents, and industrial accidents. The cost is met by deductions from the wages of the employee. This is distinctly different from the medical service which the employee receives from the company physician. It is my impression that all of the hospitals in southern West Virginia have this arrangement. I believe you are laboring under the impression that this contract does not care for the industrial injury, that the employer arranges for this work through the Compensation Department. Unfortunately, this is not the case. The employee pays for hospitalization in industrial accidents by the arrangement referred to above."

The head of another hospital in the southern West Virginia coal field says: "You evidently misunderstand just what is going on in southern West Virginia in the coal field practice. It is true that all coal operators employ a company physician who renders first-aid to the employees and their dependents. The employer has entered into a contract with certain hospitals located in this section that, for an additional sum of \$1.50 and \$2 per month, they take care of all mine accident cases without any additional charge. You see by this means the employer has shifted the burden of paying in to the Workmen's Compensation Commission any funds for surgical, medical and hospital attention."

This contention was also made in an address delivered before the Mercer County Bar Association on December 31, 1930, by Russell S. Ritz, the Association's President. In the course of that address, Mr. Ritz said: "Under the pretense of authority of Section 9 of Article 2 of the Code, permitting employers of 'sufficient financial responsibility' to elect to pay compensation and expenses

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

directly to injured employees, large numbers of employers have made contracts for medical and surgical treatment for their employees for both sickness and injury, by which contracts they agree with a doctor or a hospital of their own choosing that they will deduct from the wages of their employees certain sums each month which they agree to turn over to such doctor or hospital, in consideration of which the doctor or hospital thus chosen and selected by the employer agrees to furnish medical and surgical treatment to the employee for sickness and injury.

“Under this plan the employer pays nothing for medical or surgical treatment of his employees, but the entire burden is placed upon the employee, and the extent of the employee’s disability is determined by a doctor or hospital of the employer’s choosing, and the employer pays compensation direct to the employee, based upon the finding of such physician or hospital. By this method it can clearly be seen that instead of the industry bearing the burden of the injured employee’s disability, the employer by such a contract is relieving the industry and placing the burden upon the injured employee himself. This is directly in violation of the spirit and purpose of every compensation law that has ever been enacted, and if it violates the intent and purpose of the law it violates the law itself. Under the present West Virginia law it is my view that such practice is unauthorized and that those employers who have seen fit to adopt this plan cannot claim protection of the law itself. If, however, it can be claimed that the law authorizes such a plan, then, as heretofore observed, it is violative of all the basic principles upon which compensation laws are founded. If the employer desiring to pay compensation and expenses direct to his own injured employees would treat them as the law provides that the Compensation Commissioner shall treat them, then he should pay for the medical, surgical and hospital treatment as may be reasonably required, not to exceed the sum of \$800 in each case. The hospital and doctor list practice plan does not contemplate that the employer shall pay any part of the expense of medical, surgical or hospital treatment for the injured employees, but on the contrary, places the entire

WEST VIRGINIA HOSPITAL CONTRACT SYSTEM

burden of these expenses upon the injured employee. The worst vice of it all, however, consists in having the extent of the injured employee's injuries determined by a doctor or hospital in the employ of the employer. Assuming such doctor or hospital organization to be entirely honest and conscientious, there is present every incentive for the minimizing of the injured employee's disability; for by so doing the doctor saves money to his employer. By this method the employer, in effect, says to his employee, I will pay you compensation for your injury, but you shall submit yourself to treatment and examination by doctors of my choosing and employment who are paid for by you, and if the doctors so selected by me and paid for by you find any disability I will pay in accordance with such finding. This is what is known as list practice. So long as it is limited to the treatment of employees and their families for sickness, it is entirely proper and should be paid for by the employee—but the employer would only be remotely interested in this character of practice. What many of the employers are actually doing under the guise of this law is employing doctors at the expense of the injured employee to treat him for his injuries, thereby saving to themselves thousands of dollars which they otherwise, under the law, would be required to pay out for such medical and surgical treatment.”⁷

It will be recalled that the Kanawha Coal Operators' Association stated that the deduction from wages covers hospitalization “for both occupational and non-occupational accidents, and sickness of all kinds.” (page 147)

From a leading member of the West Virginia medical profession comes the following criticism of the hospital contract system: “One must believe that originally most of these hospital owners believed that they were rendering good service for an amount within reach of all. The amount originally charged each employee was sufficient to justify competent service, but during the past decade many abuses have developed in this line. Hospitals

⁷ “West Virginia's Workmen's Compensation Law.” An address by Russell S. Ritz, President of the Mercer County Bar Association. Delivered before the 27th Annual Meeting of the Association December 31, 1930. Printed and distributed by Mercer County Bar Association, Bluefield, W. Va.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

have been built in the area mentioned for no other reason than to bid for this kind of work. There has developed such a competition that each man or group has formulated its own rules of conduct, resulting in one group deliberately underbidding another in the cutting of prices, and in some cases the employing of solicitors for additional business. These institutions have necessarily become highly commercialized. Most of these contracts are drawn between the hospital and the company officials. Seldom does the employee, who is paying the entire bill, have a voice in selecting the hospital.

“Our compensation laws provide that \$800 may be spent for medical, surgical and hospital care of the injured employee; also that \$600 additional may be spent for rehabilitating an individual. Under the present contract hospital plan not one dollar of the amount is available for him. The corporation is entirely relieved of the duty of furnishing hospital or surgical care to any injured employee.

“Members of our profession and hospitals adjacent to such territory are denied the opportunity to treat those injured because they must go to a designated hospital, regardless of their wishes. The contract hospital, doing this work, receives no compensation for treating any injured employee except the monthly check from the payroll. Each day spent in that hospital by an injured employee is a complete loss to the institution. It is no wonder that some are sent home before it is safe to go, while others receive no hospital care when in need of it.

“Another very serious objection to this form of practice is that the injured employee has no appeal, nor assistance from the Compensation Department in selecting another hospital or surgeon because of improper attention. If he goes to another in order to save his life or limb, he must personally bear all his expenses.

“The very basic principles for which the compensation laws were passed are rendered null and void by such contracts. The injured man is denied the choice of physician or hospital. The corporation is relieved of the burden of caring for the injured, this expense being borne by the employee. Physicians and hos-

WEST VIRGINIA HOSPITAL CONTRACT SYSTEM

pitals are denied the opportunity to collect fees that are justly and legally due them.

“One could continue indefinitely outlining the abuses of this system. Suffice it to say that it has developed into a commercial form of practice that is not for the best interests of the sick nor for our profession.”

INVESTIGATION BY WEST VIRGINIA LEGISLATURE

During 1931 the question of hospital contract practice in West Virginia was investigated by the State Legislature, and discontinuance of the system was recommended “insofar as it relates to industrial accidents.” From the report of the Legislative Committee the following is taken:⁸

“Mr. Farrell, from the Spécial Committee, appointed under authority of a resolution adopted by the House on January 23, 1931, to make inquiry into the administration of the Workmen’s Compensation Fund and the defects, if any, of the workmen’s compensation law, and any other phases of the said workmen’s compensation fund and the workmen’s compensation law which they may deem proper, substituted the following report, which was received: *The List Hospital Contract Practice*. Your Committee inquired into this particular phase of the administration of the workmen’s compensation law, and heard the testimony of a large number of physicians, doctors and others, among whom were Dr. Benjamin I. Golden, of Elkins, West Virginia; Dr. T. E. Vass, Dr. R. H. Walker, Dr. James McClung, and other doctors as well, also, as Dr. R. O. Rogers, Dr. R. A. Salton, Dr. W. H. St. Clair, Dr. C. W. Stallard, and others who appeared as proponents of the list hospital contract service. Your Committee found among those who propose the continuation of the list hospital contract service, without exception, that all of these proponents were realizing vast sums of money from such service; and in a number of instances found that the hospital received as

⁸ *Journal of the House of Delegates, Charleston, West Virginia. Proceedings, March 11, 1931.*

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

much as \$5,000 per patient per year for hospitalization in wards alone where the ward services could have been rendered at an average cost of approximately \$1,000 per year. Your Committee has found that there is no question relative to the legality of such contracts, but that in almost every instance the employers designate the hospital for the employees, although the amount is deducted from the employee's pay envelope, and that he, the employee, has no voice in the selection of the hospital. Your Committee found one hospital where the deductions were made from the employee's envelope for the hospital service, but where this service is only provided him in cases of injuries arising from industrial accidents alone, which of necessity means that the employee is required to pay a part of the compensation premium. Your Committee's attention has also been directed to the fact that in almost every instance the list hospital engaged in this work does not have the adequate capacity to take care of all the people that might be entitled to the service; in several instances your Committee found that a hospital having a capacity of seventy-five patients would be required to render services to a potentiality of fifty or sixty thousand cases; in no instance has a potentiality been under five thousand cases, and some of these list hospitals have had as low as thirty beds with which to care for this vast number of potential cases. Your Committee has found that, in a number of instances, the hospital contract service yields adequate hospital service and performs its work in proper fashion, but your Committee has further found, from the evidence adduced before it, that for the treatment of industrial accident cases, it would be far wiser to abolish entirely this practice and only permit it for economical reasons in cases of sickness or other diseases that may arise to those who desire to become subscribers to such contract. We therefore respectfully recommend . . . (2) that the contract hospital service be discontinued insofar as it relates to industrial accidents and affects the employees whose employers are subscribing to the compensation fund."⁹

⁹ West Virginia is one of the states having a monopolistic workmen's compensation insurance fund. All employers subject to the Act pay premiums into this fund to cover their liability in case of injury to an employee. Compensation due

WEST VIRGINIA HOSPITAL CONTRACT SYSTEM

COMPENSATION LAWS OF VIRGINIA, KENTUCKY, TENNESSEE AND ALABAMA

As already stated, the system of medical service contracts between coal companies and hospitals exists to some extent in the coal industry of Virginia, Kentucky, Tennessee and Alabama, without provoking the complaint that the expense of hospital care for compensable injury is thereby shifted from the employer to the employee.

Without going into a detailed analysis of the workmen's compensation laws of the Southern Appalachian states, as they relate to medical and hospital insurance systems, attention may be directed to the unequivocal language of the compensation acts of Virginia, Kentucky, Tennessee and Alabama, as contrasted to the often vague, indefinite wording of the West Virginia act. The latter leaves room for different interpretations as to the employer's responsibility for medical expense due to an industrial injury, where the employee participates in a hospital service plan. The laws of the other states leave no room for doubt as to the intention of the law. For example, substitute systems of compensation, based on mutual agreements between employers and employees, are permitted by all five states. However, the laws of all of the states excepting West Virginia expressly stipulate that if the substitute system requires contributions from employees, it must confer *additional* benefits commensurate with the amount deducted from wages. The laws of Virginia, Kentucky, Tennessee and Alabama make it a punishable offense for the employer to apply a payroll deduction on the payment of any portion of his own insurance premium. This applies equally to employers who secure authorization to pay compensation and provide medical care direct to employees. The West Virginia law is silent on this point.

injured employees of employers insuring in the State fund, and bills for medical and hospital care are ordinarily paid out of this fund upon order of the Compensation Commissioner. Employers authorized to "self-insure" are apparently permitted to insure their risk with a private insurance carrier.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

UNSUCCESSFUL ATTEMPT TO AMEND WEST VIRGINIA LAW

If amendments to the West Virginia compensation law proposed at the Legislative session of 1931 had been enacted, all doubt as to the responsibility of the employer to pay for hospital care necessitated by an industrial injury would have been removed. House Bill No. 165, introduced January 30, provided for the modification of the existing law by adding the following words to article 9, section 2: "The expense of medical, surgical, dental, and hospital treatment of injured employees shall be paid by the employer, either to the injured employee or to the person, firm or corporation rendering such service, for such amount as will compensate for the actual service rendered, not to exceed the sum of eight hundred dollars, *and any contract providing differently for the payment of such medical, surgical, dental and hospital treatment shall be null and void.*¹⁰ The character and extent of the injured employee's injuries shall be ascertained and determined by physicians and surgeons who are not under contract with or in the employ of the employer, and who are not connected with any hospital that may be under contract with the employer to furnish treatment to its injured employees. The protection of this act shall at the election of the employee be denied to any employer who violates this provision."

Although the attempt to amend the West Virginia law failed, it is evident that there is a wide-spread belief in that state that legislation is needed to safeguard the rights of the many thousands of coal mining employees who are covered by hospital insurance contracts.

¹⁰ Italics ours.

CHAPTER IX

FIXED PAYMENT MEDICAL SERVICE FOR RAILROAD EMPLOYEES

EMPLOYEES of a number of trunk-line railroad systems in the United States normally secure medical, surgical and hospital care arising out of injury or sickness by virtue of their membership in employee hospital associations.¹

In all, twenty-seven separate hospital associations have been found. In some instances, because of consolidations, one railroad system may have more than one hospital association; in others the hospital association may cover employees of only a part of the system. Twenty of the hospital associations found in the course of this investigation are connected with railroads operating out of Chicago and west of the Mississippi River, and seven with systems operating in states east of that river.

The funds out of which the cost of the service provided by these railroad hospital associations is met are derived chiefly from dues collected by the railroad companies from employees through a deduction from wages, and turned over to the hospital associations. Most associations receive some financial support from the railroad company, in payment of the expense of hospital care necessitated by injuries sustained "in line of duty." In some hospital associations, such payment is on a case-by-case basis; in others, a periodic lump sum payment by the railroad company discharges its responsibility for medical care arising out of "duty" accidents.

As pointed out in Chapter I, there is no Federal Workmen's Compensation Act applying to employees engaged in interstate commerce, but only a Federal Employers' Liability Law, liberal-

¹ Figures given in this chapter have been compiled from *Statistics of Railways in the United States, 1929*, Interstate Commerce Commission, Washington, 1930, and periodical statistical releases. A Class I railroad is one having annual revenue over \$1,000,000. Class I railroads operated 92.2 per cent of the steam railroad mileage at the close of 1929; they had on their payrolls 98 per cent of the total steam railroad employees.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

izing the conditions of recovery of damages from the employer by the employee engaged in interstate commerce.² The present system under which American railroads in practically all cases pay for medical, surgical and hospital care to employees disabled by a "duty" injury, as well as compensate the employee for loss of earning power, is the result of mutual understandings between the railroad management and the employees.

MEMBERSHIP AUTOMATIC

In most of the railroad employee hospital associations, membership is automatic; all officers and employees of the company from the president down belong to the association. Strictly speaking, membership in the hospital association ceases when employment ceases, or when the employee ceases to pay his dues. Usually, however, there is a provision for continuance of membership in the hospital association during a period of "lay-off". Dependent members of families of employees are not entitled to free hospital service by virtue of the breadwinner's membership in the association, but it is customary to allow them reduced rates.³

COMPANY-OWNED AND "DESIGNATED" HOSPITALS

Of the 27 associations, 17 directly operate a total of 33 hospitals, located at strategic points along the lines of their respective railroads and ranging in size from 20 to 300 beds, and representing a total bed capacity of 3,129.⁴ Title to these hospitals is generally held by the railroad company. Hospital associations not directly operating hospitals arrange with independent institutions in cities and towns along the line of the road, to provide

²In 1911-12 a Federal Commission made an extensive study of compensation for injured railroad employees, reporting a Workmen's Compensation Bill which passed both Houses of Congress, but with amendments that were not agreed upon when Congress adjourned. Since 1912 bills have been introduced in Congress, but have never been reported out of committee.

³According to figures published by the Interstate Commerce Commission (Statement No. M-300, February, 1932) the total number of employees on Class I steam railroads in the middle of February 1932, was 1,093,215, a decline of 567,635 from the average total of 1,660,850 for the year 1929. Presumably there was a corresponding decline in the number of employees entitled to medical care from the railroad hospital associations.

⁴Figures compiled from American Medical Association Hospital Census for 1930. All of the 33 hospitals are registered by the American Medical Association.

RAILROAD EMPLOYEE MEDICAL SERVICE

hospitalization to members disabled by a "non-duty" injury or sickness. These are known as "designated" hospitals. The hospital association pays the hospital for service rendered, either on a case basis, or under a definite contract arrangement. Where the designated independent hospital provides care arising out of an injury sustained in the course of duty, payment is usually paid directly to the hospital by the railroad company.

Practically all American trunk-line railroads maintain a staff of employed physicians and surgeons to render first-aid to employees and passengers injured in connection with the operation of the railroad. Where there is a hospital association, the physicians on the medical staff of the association are usually the company physicians and surgeons. Various methods are employed of adjusting their remuneration for services rendered, between the company and the association. Only one of the 27 associations definitely states that the company has a separate staff of surgeons to care for employees injured on duty; in the event that the association takes care of such patients, the company reimburses it for any expense incurred. Another association states that the company "appoints the Association physicians as Company Surgeons." Otherwise all information available indicates that association physicians are also the company medical staff; in fact, in many cases they are referred to as "company surgeons". On the smaller roads only the chief surgeon, the district surgeons, and the head of the hospital are full-time salaried officers, others being employed on a part-time basis, or on a fee basis. The associations operating large hospitals employ full staffs, some on full-time, some on part-time basis. Specialists are usually on a fee basis, sometimes "fixed" fees, according to a regular schedule of rates. Consultants on the staffs are paid for their services either by a regular salary, a retaining fee, or for services as rendered.

CASH BENEFIT PAID BY TWO ASSOCIATIONS

Only two out of 27 hospital associations studied provide any monetary benefit to the members covering the loss of regular earnings during the period of disability.⁵

⁵ As will be shown in detail in Chapter XIII (Trade Union Sick Benefit Plans),

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

On railroads which do not have employee hospital associations, employees make their own private arrangements for medical, surgical and hospital care arising out of a "non-duty" injury or illness. On such roads, surgical and hospital care necessitated by a "duty" injury are usually provided at company expense by the railroad's own staff of surgeons, in independent hospitals designated by the railroad company.

The following table shows the total owned mileage and average total number of employees in 1929 of all Class I railroads in the United States (classified by railroad "regions") that have

Districts and Regions	All Class I Steam Railroads		Railroads Reporting Hospital Associations		Per Cent of Total	
	Mileage Owned	Employees	Mileage Owned	Employees	Mileage Owned	Employees
<i>Eastern and Southern Districts</i>	68,850	1,029,739	15,949	146,847	23.2	14.3
<i>Western District:—</i>						
North Western Region	44,300	197,285	20,887	54,266 ^a	48.0	27.5
Central Western Region	37,956	281,344	27,158	224,630	71.6	79.8
South Western Region	24,724	152,482	23,590	145,662	95.4	95.5
Totals	175,830	1,660,850	87,584	571,405 ^b	49.8	34.4 ^c

^a Includes only the 10,439 employees of the Chicago, Milwaukee, St. Paul and Pacific Railway on the lines west of Mobridge, So. Dakota; the remaining 37,456 employees of this Railway System, on lines east of Mobridge, do not participate in the Hospital Association.

^b To make the figures comparable with estimated total number of employees in the mining and lumber industries who receive medical service from the employer, the percentage figure shown in the last column (34.4) has been applied to the total number of employees of Class I steam railroads reported to the Interstate Commerce Commission for April 15, 1930,—the month during which the Federal Census was taken. This figure was 1,572,566.

^c Railroads not heard from accounted for 8.2 per cent of the total employees. In the Eastern and Southern Districts, the proportion was 11.1 per cent; in the Northwestern Region, 1.6 per cent; in the Southwestern Region, 4.9 per cent. It does not seem likely that reports from these railroads would increase the number entitled to hospital care as members of hospital associations.

national railroad brotherhoods and their local lodges, as well as many of the local unions affiliated with the shop craft national unions, provide cash disability benefits to members temporarily deprived of regular earnings through sickness or accident.

RAILROAD EMPLOYEE MEDICAL SERVICE

hospital associations, and the per cent of such mileage and number of employees to the total mileage and number of employees for the entire country.

Following is a list of Class I railroads in the various "regions" which have employee hospital associations. The total owned mileage, total average number of employees and the states served by them are also given. In general, the employees who are entitled to medical service as members of railroad hospital associations would be residents of the states mentioned.

CLASS I STEAM RAILROADS HAVING HOSPITAL ASSOCIATIONS PROVIDING MEDICAL, SURGICAL AND HOSPITAL CARE AS A MEMBERSHIP BENEFIT

EASTERN AND SOUTHERN DISTRICTS

(Comprising New England, Great Lakes, Central Eastern, Pocohontas, and Southern Regions)

Railroad	Miles Owned 1929	Number of Employees 1929	States Served
Atlantic Coast Line Railroad Co.	4,844	25,753	Virginia, N. Carolina, S. Carolina, Georgia, Florida, Alabama
Illinois Central System, including Illinois Central Railroad Co., Gulf & Ship Island R.R. Co. and Yazoo & Mississippi Valley R.R.	3,836	55,856	Illinois, Indiana, Missouri, Kentucky, Tennessee, Alabama, Mississippi, Louisiana, Arkansas, Nebraska, Iowa, Wisconsin, Minnesota, S. Dakota
Central of Georgia Railway Co. ^a	1,477	8,011	Georgia, Alabama
Florida East Coast Railway Co.	857	3,505	Florida
Chesapeake & Ohio Railway Co.	2,260	32,740	Virginia, W. Virginia, Kentucky, Ohio, Illinois
Wabash Railway Company	1,953	18,099	Ohio, Indiana, Michigan, Illinois, Iowa, Nebraska, Missouri, Kansas (also operates in Ontario, Canada)
Missouri-Illinois R.R. Co. (Missouri-Pacific System) ²	136	564	Missouri, Illinois
Gulf, Mobile & Northern R.R. Co.	586	2,319	Alabama, Mississippi, Tennessee, Kentucky
Total for Eastern and Southern Districts	15,949	146,847	

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

CLASS I STEAM RAILROADS HAVING HOSPITAL ASSOCIATIONS PROVIDING
MEDICAL, SURGICAL AND HOSPITAL CARE AS A MEMBERSHIP BENEFIT
(Continued)

WESTERN DISTRICT
(North Western Region)

Railroad	Miles Owned 1929	Number of Employees 1929	States Served
Chicago, Milwaukee, St. Paul & Pacific Railroad ^b	10,180	10,439 ^b	Indiana, Illinois, Missouri, Wisconsin, Iowa, Minnesota, No. Dakota, Nebraska, Wyoming, Montana, Idaho, Washington
Northern Pacific Railway Co. ...	6,504	25,403	Illinois, Wisconsin, Minnesota, No. Dakota, Montana, Washington, Oregon
Chicago, St. Paul, Minneapolis & Omaha Railway Co. (Chicago & No. Western System)	1,674	8,087	Wisconsin, Minnesota, Iowa, Nebraska, So. Dakota
Oregon-Washington Railroad & Navigation Co. (Union Pacific System) ^{c,d}	2,034	7,988	Washington, Oregon
Spokane, Portland & Seattle Railway Company	495	2,349	Washington, Oregon
Total for North Western Region	20,887	54,266	

(Central Western Region)

Union Pacific Railroad Company (Union Pacific System) ^{d,e} including St. Joseph & Grand Island Railway Co.	4,012	27,817	Illinois, Iowa, Missouri, Nebraska, Kansas, Colorado, Wyoming, Montana, Idaho, Washington, Oregon
Oregon Short Line Railroad Co. (Union Pacific System) ^{d,e} ...	2,343	8,521	Oregon, Idaho, Wyoming
Los Angeles & Salt Lake R.R. Co. (Union Pacific System) ^{d,e} ..	1,078	6,376	Utah, Nevada, California
Southern Pacific Co. (Southern Pacific System) ^{f,g} including Northwestern Pacific R.R. Co.	1,752	67,349	Louisiana, Texas, New Mexico, Arizona, Utah, California, Nevada, Oregon, Washington
Western Pacific Railroad Co. ...	1,053	5,176	California, Nevada, Utah

RAILROAD EMPLOYEE MEDICAL SERVICE

**CLASS I STEAM RAILROADS HAVING HOSPITAL ASSOCIATIONS PROVIDING
MEDICAL, SURGICAL AND HOSPITAL CARE AS A MEMBERSHIP BENEFIT
(Continued)**

Railroad	Miles Owned 1929	Number of Em- ployees 1929	States Served
Atchison, Topeka & Santa Fe Railroad Co. (Santa Fe System) ^a including Panhandle & Santa Fe Railway Co.	7,273	57,540	Illinois, Iowa, Missouri, Kansas, Oklahoma, Louisiana, New Mexico, Colorado, Arizona, California, Texas
Chicago, Rock Island & Pacific Railway Co. (Rock Island System) ^b including Rock Island & Gulf Railroad Co.	5,942	38,109	Illinois, Iowa, Missouri, Nebraska, Kansas, Colorado, Oklahoma, Arkansas, Tennessee, Louisiana, Texas, New Mexico, Arizona, California
Denver & Rio Grande Western Railroad Co.	2,459	9,741	Colorado, New Mexico, Utah
Colorado & Southern Ry. Co. (Burlington Route)	860	2,785	Colorado
Denver & Salt Lake Ry. Co. (Burlington Route)	220	967	Colorado
Nevada Northern Railway Co...	166	249	Nevada
Total for Central Western Region	27,158	224,630	

(South Western Region)

Missouri Pacific Railroad Co. (Missouri Pacific System) ¹ ..	6,540	37,289	Missouri, Illinois, Kansas, Nebraska, Colorado, Arkansas, Oklahoma
Texas Pacific Railway Co. ² (Missouri-Pacific System) including: Int. Great Northern R.R. Co., St. Louis, Brownsville & Mexico Railway Co. and Missouri-Pacific Lines in Texas...	4,150	23,419	Louisiana, Texas
St. Louis-San Francisco Ry. Co. (Frisco Lines) ^b including: St. Louis-San Francisco & Texas Ry. Co., Fort Worth & Rio Grande Ry. Co.	5,469	23,494	Kansas, Missouri, Oklahoma, Arkansas, Texas, Louisiana, Tennessee, Mississippi, Alabama, Florida
Gulf, Colorado & Santa Fe Ry. Co (Santa Fe System) ^c ...	1,243	7,988	Texas

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

CLASS I STEAM RAILROADS HAVING HOSPITAL ASSOCIATIONS PROVIDING
MEDICAL, SURGICAL AND HOSPITAL CARE AS A MEMBERSHIP BENEFIT
(Continued)

Railroad	Miles Owned 1929	Number of Em- ployees 1929	States Served
Kansas City, Mexico & Orient Ry. Co. (Santa Fe System) ^a ²	259	976	Kansas, Oklahoma, Texas (also Mexico)
Kansas City, Mexico & Orient Ry. Co. of Texas (Santa Fe System) ^a ²	466	1,040	Texas
Kansas City Southern Railway Co. (Kansas City-Southern System) including: Texarkana & Ft. Smith Ry. Co.	606	5,225	Kansas, Missouri, Oklahoma, Arkansas, Texas, Louisiana
St. Louis-Southwestern Ry. Co. (St. Louis - Southwestern Lines) ² including: St. Louis-Southwestern Ry. Co. of Texas	1,384	7,745	Missouri, Arkansas, Tennessee, Louisiana, Texas
Missouri-Kansas-Texas R.R. Co. (M.-K.-T. Lines) ² including: Missouri-Kansas-Texas R.R. Co. of Texas	2,678	13,391	Missouri, Kansas, Oklahoma, Texas
Midland Valley Railroad Co....	338	1,054	Kansas, Oklahoma, Arkansas
Texas & New Orleans R.R. Co. (Southern Pacific System) ¹ ² ..	457	24,041	Texas, Louisiana
Total for South Western Region.	23,590	145,662	
Grand Total	87,584	571,405	

^a Subsidiary of Illinois Central System, but has own Hospital Department.
^b Hospital Association covers employees only on lines West of Moberly (So. Dakota). The Chief Surgeon, Lines West, states in letter (July 27, 1931) that in 1927 the number of contributing employees in the Hospital Association was 10,439. The total number of employees of the entire road, East and West, was 47,995 (Statistics of Railways in U. S., I. C. C., 1929). The mileage figure as given is that of the entire road, East and West, 1929.
^c This system also operates in Central Western Region.
^d The Hospital Department plan is uniform over entire Union Pacific system, but each subsidiary company organizes, administers, and operates its own Department.
^e This System also operates in North Western Region.
^f This System also operates in South Western Region.
^g The Hospital Association operates over the entire system.
^h The Hospital Association operates on lines in Tennessee, Louisiana, Oklahoma, Arkansas, Texas.
ⁱ This System also operates in Central Eastern Region.
^j The Texas Pacific is part of the Missouri Pacific System, but has its own Hospital Association, in which are included employees of International Great Northern and St. Louis, Brownsville & Mexico Railroads.

RAILROAD EMPLOYEE MEDICAL SERVICE

FORM OF ORGANIZATION

Analysis of by-laws, rules and regulations, annual reports, etc., relating to the 27 railroad hospital associations found by the National Bureau, indicates that while they vary considerably in detail, they are in the main sufficiently similar to permit of presentation in summary form of their general characteristics. They classify first into two main groups, "Hospital Associations" and "Hospital Departments". Hospital associations are usually organizations technically separate from the railroad company, frequently incorporated, and administered by a governing body on which both the company and the employees are represented. A hospital department, as its name indicates, is operated as a department of the company. On the larger roads operating hospital departments there is a governing or advisory board on which the contributing employees are represented.

Of the 27 organizations under consideration, 20 are associations; two of these are called "benefit" associations. Seven are departments, three being called hospital departments; two, medical departments; one, a hospital trust; and one a relief department.

The administration of hospital associations is usually entrusted to a board of managers, trustees, directors or governors. In most cases this body is representative of both the company and the contributing employees. For 14 of the 20 associations studied, information on this point is available. The proportion of company and employee representatives varies greatly. Two boards of directors are entirely elected by the members of the association (contributing employees); another association (one of the largest) is directed entirely by company officials. Between these two extremes are eleven associations whose governing boards are composed of appointees of the companies and elected representatives of the employees as shown in the table on the next page.

Of the seven organizations conducted as departments of the railroad companies, two of the largest are administered similarly to associations. In one, the department is in charge of a board

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

<i>Name of Governing Body</i>	<i>Total Number of Members</i>	<i>Appointed by Company</i>	<i>Elected by Employees</i>
Board of Governors	19	9	10
“ “ Managers	12	3	9
“ “ Managers	9	5	4
“ “ Trustees	12	6	6
“ “ Trustees	5	3	2
“ “ Managers	16	6	10
“ “ Trustees	9	2	7
“ “ Managers	8	4	4
“ “ Trustees	5	3	2
“ “ Trustees	6 ^a	3	3
“ “ Trustees	11	1	10

^a A seventh trustee may be elected by these six in case of failure to agree on any matter of importance; he must be a person not connected with the company in any capacity.

of nine members, five appointed by the company, four elected by employees; one of the company appointees is the chief surgeon, who is the executive officer of the department. In the other, the medical director, a company officer, has full charge, with the assistance of an advisory committee of twelve, six appointed by the company, six elected by the employees. A hospital department in one of the large railroads of the southwest is administered by the company as trustee; a general board of elected representatives of the employees inspects all operations, and all rules, regulations, policies, must be submitted for its approval. Three of the remaining four hospital departments, one of them being that of a large system in the central and northwestern regions, operate strictly as company departments, in charge of the chief surgeon, who is responsible to the general manager; in the fourth, the claim agent of the company administers the department, and appoints the chief surgeon.

GOVERNING BODIES

The duties of governing bodies are, in general, the supervision of all operations of the association,⁷ the holding of meet-

⁷ The term "hospital association" will be used hereafter as the general title for these railroad contributory medical service organizations, whether designated by their official titles as "associations," "departments," or otherwise.

RAILROAD EMPLOYEE MEDICAL SERVICE

ings at stated intervals, and at the call of the Chairman or President; the election of officers, and of an executive committee or officer, to whom is delegated the direct administration of the affairs of the association; the disbursement of the funds of the association, and accounting for same; amending or repealing by-laws, and issuing rules and regulations.

The executive head of the organization is in nearly all cases the chief surgeon. His duties are defined in terms similar to the following: he has immediate supervision and control of the hospital and all matters pertaining to the management of the association; he appoints and fixes the compensation of all physicians, surgeons, and other employees of the association; he makes rules and regulations governing the medical staff, the hospitals, the provision of the benefits, etc.; and certifies to the correctness of all bills and accounts.

The method of selecting the chief surgeon varies. Where the service is operated as a company department, he is naturally a company official. In eleven of the associations he is appointed by the company, in nine, elected by the governing board (on which the employees are represented). In one large association the president of the board is the executive officer, and the chief surgeon, a company appointee, is responsible to him.

MEMBERSHIP CONDITIONS

In two of the organizations studied, the by-laws seem to leave with the employee the option of joining the association. In these two instances information is to the effect that practically all eligible employees are members. In the other 25 associations, membership is compulsory, as usually stated, "on all officers and employees" while in the service of the company. Certain exceptions are made; for instance, employees working "off the line of road" are usually ineligible, also temporary employees, and those receiving less than a specified wage. Employees of the hospital association are included as mem-

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

bers in a number of cases; in one, as non-contributing members. On at least one road, pensioned employees are compulsory members; information on this point is available for nine other associations, as follows: six permit pensioned employees to retain membership voluntarily, on payment of dues, usually based on amount of monthly pension; three permit pensioners to remain members without payment of dues, but in one instance no free hospital care is allowed this class of members; one association keeps as "honorary members" not paying dues, all superannuated and permanently disabled employees, and those who have been contributing members for 25 years; another has several classes of "non-contributing members," i.e., superannuated, pensioned and permanently disabled employees of the company, employees of the hospital association, and dependents of employee members (this last class receives surgical treatment only, at an association hospital). This last mentioned association is the only one which includes dependents as members, even of a special class; a few of the associations give certain limited medical service to dependents of members, which will be discussed later.

MEMBERSHIP DUES

Membership dues are in most cases based on the amount of pay received in a month, and vary in amount from a minimum of 25 cents on one road to a maximum of \$3.75 on another; sometimes the dues are reckoned at one per cent of the monthly wage, with a stated maximum. The range of the amounts of dues on different railroads may be indicated by some typical examples: 35 cents to 50 cents; 55 cents to \$1; 35 cents to \$1.25; 40 cents to \$1.75; 75 cents to \$3.75 (the highest minimum and maximum among the 27 associations). Seven associations have a flat rate of contribution, six of \$1, one of \$1.50 per month; for four of the associations, information is not at hand as to the amount of the monthly dues.

RAILROAD EMPLOYEE MEDICAL SERVICE

COMPANY CONTRIBUTIONS

Practice as to financial contributions by the railroad company to the hospital association varies greatly among the 27 associations. Many of the hospital associations now operating as independent institutions, particularly the older ones, were established by the railroad companies, and transferred to the associations, which had been especially organized to take them over, when they became self-sustaining. The property so transferred usually consisted of hospital buildings and grounds, and accumulated funds. Sometimes the company retains title to the hospital plant, permitting the association the use of it free of charge. A brief summary statement of the methods of a few of the more important associations is given here for convenience: company pays "operating expenses" (not salaries or maintenance), pays interest on monthly balances of association funds, and guarantees deficit, if any; company owns the hospital properties and pays for upkeep; company pays all expenses incident to care of employees injured on duty, including proportionate share of physicians' salaries; company owns hospital plant, pays part of operating expenses, and pays cost of care of employees injured on duty; company owns and pays for upkeep of hospital buildings and grounds; in three of the smaller associations the companies make up the deficit which exists each year; company contributes \$1,000 per month to the association; company contributes monthly a sum equal to 10 per cent of the employees' contributions, and appoints the association physicians as company surgeons, i.e., pays for their services to employees injured on duty; company reimburses association for expense of care of injuries incurred on duty, when these cases are handled by the association (this company maintains a separate medical staff); company pays a certain percentage of the operating expenses each month; company built and owns hospitals, and pays all expenses incident to care of injuries incurred on duty; company built and owns the hospitals; company pays for care of employees injured on duty, including pro rata share of physicians' salaries. For eight of the associations

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

studied, information at hand indicates no direct financial contribution by the company at the present time; for the remaining four, no information at all on this point is available. It is customary on most roads to furnish free transportation to sick and injured employees to and from the hospital, to members of the medical staff, and for hospital supplies and equipment. Free telegraph and telephone service is frequently mentioned as a company contribution, to "facilitate the care and transportation of sick and injured members of the hospital association."

SCOPE OF SERVICE

It may be stated in general terms that all railroad hospital associations offer medical and surgical treatment and hospital care to members disabled by any injury or by sickness, while they are in the employ of the railroad companies. The object of the association is usually stated in the by-laws to be "to provide medical and surgical attention to sick and injured employees of the railroad company." A description in summary form of the service offered by four associations in different sections of the country will perhaps give a sufficiently adequate picture of the medical, surgical and hospital service provided by railroad hospital associations.

1. *An Eastern Railroad System.* A Hospital Association in the eastern section has approximately 30,000 members, and operates two hospitals totalling 235 beds. Nine physicians, surgeons and specialists constitute the medical staffs of the two hospitals. The Association designates nine independent outside hospitals, and employs sixteen of the medical staff of these hospitals as association physicians. In addition it employs about 300 local physicians at various points along the railroad lines. Sick or injured members of the Association must be sent to an Association or designated hospital; the local Association doctors are not required to attend sick members, beyond facilitating their removal to the hospital; (if in an emergency another hospital must be used the patient must be moved as soon as possible to an Association

RAILROAD EMPLOYEE MEDICAL SERVICE

hospital); members entering an Association hospital "shall be provided with first-class medical and surgical attention, medicines, nursing and board, without charge"; the services of eye, ear, nose and throat specialists are supplied when authorized by the proper medical officer; dental work is done only when made necessary because of accident, or when specially recommended by the proper medical officer; medicines are furnished free, from the dispensaries at the two Association hospitals, upon prescription of any physician, when indorsed by a specified company official, or may be obtained elsewhere under authority of the Chief Surgeon; stretchers are kept at all principal stations; free ambulance service is furnished to convey badly injured or very sick members from train to hospital; members may send dependent relatives needing treatment to either of the two Association hospitals, where reduced rates are charged them for hospital care, including board, general nursing, and use of operating room, but not medical or surgical treatment. Members suffering from the effects of injuries or diseases contracted prior to their employment by the company may not be treated for these at the Association's expense; chronic, mental and venereal diseases are excluded from treatment at the expense of the Association, unless specially authorized by the Chief Surgeon. When a member dies in an Association or designated hospital, and his family is in straitened circumstances, a funeral allowance of \$50 may be made, on approval of the Association's finance committee.

2. *A Mississippi Valley Railroad System.* A railroad system serving the Mississippi and Missouri River valleys has a Hospital Association of approximately 50,000 members, operates three hospitals totalling 423 beds, and designates independent hospitals at all principal cities on its line of road. Including the staff men of these hospitals and local physicians at other points, the Association employs approximately 800 physicians. Sick and injured members receive medical and surgical treatment, at home or at the doctor's office, including medicines, dressings, and certain appliances, up to a period of one year continuously; further treatment must be approved by the Chief Surgeon. In case hospital care is needed

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

the patient is sent to one of the three Association hospitals or to a designated hospital, where he is "furnished with all necessary care and attention as determined by the surgeon in charge"; (this means regular ward service; special nursing and private room are furnished only when the physician in charge deems it necessary for the patient's welfare); hospital care is limited to a continuous period of six months, unless further care is authorized by the Chief Surgeon. As a matter of actual practice, (we are informed by the Chief Surgeon) these limitations are seldom adhered to; a patient receives care as long as he needs it, unless he is an incurable case, when other arrangements would naturally be made. The medical service at the hospital includes everything necessary for diagnosis and treatment, i.e., laboratory, X-ray, specialist treatment, surgery, medicines and appliances. In case of the death of a member, either at home or in the hospital, burial expense of \$30 may be allowed. The usual exclusions are made, i.e., no treatment is furnished for chronic diseases acquired before employment (unless the employee has been in continuous service for the preceding one year); venereal diseases, intemperance, vicious habits, injuries received in a fight or unlawful act; contagious diseases subject to quarantine are not treated, but home treatment is given in typhoid, diphtheria, scarlet fever, measles, and other contagious diseases not treated in general hospitals; trachoma, pellagra, and pulmonary tuberculosis are given treatment by local association physicians, but are not admitted to hospitals; mental diseases and epilepsy are not treated; dental service, and treatment for acute conditions due to pregnancy, are not furnished. Dependent families of members are not beneficiaries of the Association. The hospitals operated by the Association are open to the public, and any person may be taken as a private paying patient at regular hospital rates.

3. *A North Western Railroad System.* A Railroad Hospital Association in the northwest has a membership of approximately 10,000; owns and operates two hospitals totalling 55 beds, and has contracts with 21 independent hospitals along the lines of road. The annual report of the association for 1929 lists 141 "Associa-

RAILROAD EMPLOYEE MEDICAL SERVICE

tion surgeons," including oculists, 15 "consultants," and 21 "association dentists." The benefits consist of: hospital (ward) care under the direction of Association surgeons at hospitals operated or designated by the Association; (emergency cases may be treated temporarily at other hospitals at Association expense on order of district surgeon; ambulance and attendant are furnished when necessary in the transfer of patients); medical and surgical treatment by Association surgeons (a) at Association or designated hospitals, (b) at other hospitals in emergency, (c) at member's home or surgeon's office, in any place where an Association surgeon is located, (d) at other points on the line, temporarily, when authorized by Chief or District Surgeon, (e) by specialists, on authority of Chief or District Surgeon, (f) superannuated employees who have been members of Association for 25 years are given free office treatment by Association surgeons, but not medicines or hospital care. Medicines are furnished free on prescription of Association surgeons, by Association druggists; artificial limbs, eyes and surgical appliances are furnished, but not renewed. Eye examinations are given by Association oculists, and spectacles are provided to cost not more than \$5. Vaccination for smallpox is done on request; typhoid fever inoculations are given when that disease is prevalent; hay fever inoculations are given on order of an Association surgeon. On the death of a member, a burial allowance of \$75 may be made. Dental service provided consists of X-ray examinations in case of injury or for diagnostic purposes; extractions; and treatment for conditions due to injury. The usual restrictions are named, treatment not being allowed for conditions due to venereal disease, use of intoxicants or narcotics, unlawful acts, personal difficulties or assaults not connected with the company's business, or for conditions existing prior to employment; exceptions to this last restriction are made in the case of chronically infected tonsils for those who have been members of the Association for one year or more, and for rupture, nasal deformities and other chronic conditions, for members who have contributed continuously for three years or more. Quarantine diseases are excluded, but other contagious diseases.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

are given "necessary and practicable" care. Pulmonary tuberculosis is treated by Association physicians, but tuberculous patients are not given hospital care, except that in cases where the disease develops after the person has passed a physical examination for employment or has contributed continuously for two years or more, the Association allows \$2 per day, for a maximum of 90 days, for treatment in a sanatorium, on authority of the Chief Surgeon. The Association does not furnish care or treatment for mental conditions, for the aged or permanently disabled, for pregnancy or complications thereof. Chiropodist, Pasteur and "experimental types" of treatment are specifically excluded. Treatment in the hospital or by the Association line surgeons is continued as long as the surgeons consider it necessary, "but treatment of those incapacitated from work by accident or sickness will not exceed three months, except at discretion of the Chief Surgeon in cases where he considers there is reasonable hope of full recovery" by continuing the treatment. Treatment for incurable conditions is restricted to stated periods, depending on the length of time the patient has been contributing to the Association.

4. *A South Western Railroad System.* A Hospital Association of a large railroad in the central and southwestern regions serves approximately 38,000 employees, owns and operates two hospitals totalling 450 beds, and uses the facilities of an independent hospital in another city; in addition it has arrangements for emergency care of members with 50 independent hospitals along the line, and local surgeons and dispensaries at 293 additional points. The Association staff consists of 591 physicians, surgeons and specialists. Complete medical and surgical treatment and hospital care for all sickness and injury (with the usual exclusions) are given, including physiotherapy, dental treatment and work, X-rays, laboratory and specialist treatment. Members suffering from pulmonary tuberculosis are given care at the expense of the Association, under special arrangements with four tuberculosis sanatoria, for a maximum period of 14 months; totally disabled tuberculosis patients under treatment at home are

RAILROAD EMPLOYEE MEDICAL SERVICE

allowed \$30 per month for 36 months. Dependents of Association members are accepted as surgical patients in association hospitals, at reduced rates for both care and treatment.

RAILROAD "RELIEF DEPARTMENTS"

The reader will perhaps have remarked the absence from the list of railroads having hospital associations, of some of the largest railroad systems in the eastern and middle western sections of the United States. Among the Class I railroads not having employee hospital associations are the following: Boston and Maine; New York, New Haven and Hartford; New York Central; Pennsylvania; Baltimore and Ohio; Southern; Louisville and Nashville; Great Northern; Chicago and Northwestern; Burlington.

On several of these railroad systems, one finds well organized "relief" departments of long standing. The relief departments function as mutual benefit associations, providing cash benefit to cover loss of earnings caused by a disabling injury or sickness. As already pointed out, the railroad provides or pays for hospital care arising out of a "duty" injury, even when no hospital association exists. The following summary will give an outline picture of the organization, administrative methods and benefits of railroad relief departments.

1. *The Pennsylvania Railroad Voluntary Relief Department.*⁸

This organization states its object to be the establishment and management of a "Fund" for the payment of definite amounts to contributing members when they are disabled by accident or sickness, and death benefits to their beneficiaries. The relief fund is formed by voluntary contributions from members; appropriations, when necessary to make up deficits, from the company;

⁸ The following information was obtained from printed regulations, and from personal interview and correspondence with the Superintendent of the Relief Department, Mr. E. B. Hunt, to whom acknowledgment is made.

The railroads included in the Pennsylvania system in 1929 employed an average of 182,529 persons.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

income derived from investments; and such gifts or legacies as may be made. The company supplies the facilities for conducting the Department and pays all operating expenses, including the salaries of the medical staff; takes charge of the funds, and is responsible for their safekeeping. The Department is administered by an Advisory Committee, consisting of the vice-president in charge of personnel as *ex-officio* Chairman and Superintendent, 18 members chosen by contributing employees, and 18 chosen by the Boards of Directors of the railroad in the system.

For the treatment of accidental injuries and for other emergencies affecting both employees and the traveling public, medical examiners, under the supervision of the Relief Department, are stationed in cities along the lines of the road. These men are full-time salaried employees of the company; in July, 1931, there were 97 of them. They examine applicants for employment, and through periodic examinations keep check on the physical condition of the men actively engaged in the operation of trains. Connected with each medical examiner's office is a dispensary where employees may secure ambulatory treatment for both accidental injuries and sickness. At other points such as yards and shops, complete first-aid rooms are maintained. In addition to this service, local practicing physicians at convenient points are under contract to the company to answer emergency calls. Arrangements are also made with local hospitals at principal points to receive and care for injured persons, at the expense of the company.

Membership in the Relief Department is voluntary, but the Superintendent states that 95 per cent of the employees join, usually making their application at the time of the medical examination for entering employment.

Contributions are made monthly, are deducted from payroll, and range from 75 cents to \$3.75, based on wages or salary; supplementary contributions to cover an additional death benefit may be made if the member desires.

Benefits due by reason of these contributions consist of cash payments to members disabled by accident or sickness, ranging

RAILROAD EMPLOYEE MEDICAL SERVICE

from 50 cents to \$2.50 per day for a maximum period of 52 weeks, and at half these rates after 52 weeks, during the continuance of the disability; (for sickness benefits there is a waiting period of six days). Benefits from \$250 to \$1,250 are paid on the death of a member, to his designated beneficiary. Superannuation allowances are paid under certain conditions. In a few special instances, the relief department pays for medical, surgical or hospital care received by a member arising out of a non-duty injury or sickness.

Members suffering from disabilities due to intoxication, immoral practices, use of narcotics, voluntary self-injury, unlawful acts, may not receive benefits for these.

Periodic health examinations by the medical examiners are offered by the Relief Department, of which a large proportion of the employees voluntarily avail themselves.

2. *The Relief Department of the Baltimore and Ohio Railroad Company.*⁹ This Department had its inception in the establishment in 1884 of an employees' relief fund known as the "Invalid Fund." In 1879 officials of the company made first-hand studies abroad of the activities and scope of the English Friendly Societies and similar institutions on the Continent, which resulted in the organization of an Employees' Relief Association, later (1882) incorporated. This Association relinquished its charter in 1889, and the present relief feature was organized as a section of the Relief Department of the Company. The Department has two functions, the Relief Feature and the Savings Feature.

The company has general charge of the Department; furnishes office room and equipment; gives the services of its officers and employees, and the use of its facilities; is custodian of the funds, and guarantees "the true and faithful performance" of the officers and employees of the Department; and assumes the

⁹ The following information was obtained from printed regulations, and personal interview with Dr. E. V. Milholland, Superintendent and Medical Director, and Mr. W. H. Ball, Assistant Superintendent, of the Relief Department, to whom acknowledgment is made.

The B. & O. Railroad Company employed an average total of 63,921 persons in 1929.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

operating expenses of the Department, including "payment for the services of all necessary medical examiners and surgeons."

The senior vice-president of the company appoints the Superintendent, who is also the Medical Director, and certain other officers of the Department. An Advisory Committee elected by the contributing employees makes recommendation in reference to the business of the Department, and receives complaints of members. An Operating Committee representing both the company and the employees has charge of the operations of the Relief Feature.

Membership in the Relief Feature is voluntary; 90 per cent of the eligible employees belong. All must pass a medical examination, hence applications for membership are usually filed at the time of passing the examination for employment. Contributions range from 75 cents to \$5 per month according to wages or salary, and class of employment. Contributions are collected by payroll deduction, on order of the member; they may be paid directly by the member if he so prefers.

The cash benefits paid are in the same amounts, and for the same periods, as in the Pennsylvania Railroad Relief Department.

The medical service of the company is organized and supervised by the Relief Department, through the Medical Director. At each of three independent local hospitals at important cities on the lines, a "diagnostic unit" of physicians and specialists is maintained, and hospital care provided. There are 45 full-time salaried medical examiners stationed along the lines, and arrangements are had with local physicians for emergency service. At the three hospitals, disabled employees come or are brought in for whatever examination, diagnosis, medical, surgical, or specialist treatment, or hospital care they may need, at the company's expense. Technically this service is for injury incurred on duty, but the Medical Director states that the company has always "taken care" of sick employees whatever the cause of their disability.

A point of interest in connection with the operation of the

RAILROAD EMPLOYEE MEDICAL SERVICE

two railroad relief departments just described, is that while the benefits due the members by reason of their contributions do not include medical, surgical, or hospital care for any disability, the railroad companies give to the relief departments the duty of organizing and supervising the medical staff and facilities through which such service is provided to disabled employees at the expense of the companies.

One railroad relief department, that of the Atlantic Coast Line, has been classed in this study as a hospital association, for the reason that, in addition to paying cash benefits, it operates a hospital and conducts a medical service providing complete care to sick and injured members, as a membership benefit.

CHAPTER X

FIXED PAYMENT MEDICAL SERVICE OFFERED BY GROUP CLINICS, COMMUNITY HEALTH ASSOCIA- TIONS, COMMUNITY HOSPITALS AND MEDICAL BENE- FIT CORPORATIONS

CHAPTERS III to VIII dealt with plans of fixed payment medical service which are the outgrowth of special conditions in the mining and lumber industries. The isolation of the places in which those industries are usually carried on explains why the employer has taken the initiative in organizing company medical service for employees and their families. Without some special arrangement by which a minimum remuneration was assured a physician, such communities would probably be without medical service.

The same thing may be said of the type of contributory hospital service for railroad employees described in Chapter IX. The trunk-line railroad systems which have hospital associations serve sparsely settled regions which lacked adequate hospital facilities until the different railroads provided them.

The four types of fixed payment medical service to be considered in this chapter are significant because they have developed in urban places where no claim has been made that the number of medical practitioners was insufficient or the existing hospital facilities inadequate to meet local demands. These urban plans may be said to embody the efforts of individuals to substitute certainty for uncertainty in the matter of medical and hospital expense. Quite definitely they represent attempts to modify the traditional basis of medical economics.

The organizations which undertake to provide medical or hospital care in consideration of a fixed periodic payment are of four types, as follows: (1) private group clinics; (2) community

MISCELLANEOUS FIXED PAYMENT MEDICAL PLANS

health associations; (3) non-profit community hospitals; (4) medical benefit corporations.

The total number of examples of these forms of fixed payment medical care presented here is so small as to occasion the question why they are considered important enough to justify devoting a chapter to them. Not over a dozen group clinics are known to be offering this form of medical insurance; only two community health associations have been found—both are in New England cities, and one grew out of the other; only three plans of hospital insurance offered by non-profit community hospitals are described; and the number of medical benefit corporations does not exceed half a dozen. Moreover, the total number of persons participating in these four types of plans constitutes a numerically insignificant fraction of the total population.

It is possible, of course, that the few examples cited do not represent all that is going on in the way of experimentation with fixed payment medical service in urban places. The difficulties of making any comprehensive survey are obvious. There is no central source where information as to existing plans of medical or hospital insurance can be had. The American Medical and American Hospital Associations, while they are the leading national bodies in the field of medical practice, and hospital administration, respectively, are not in possession of detailed knowledge as to experimental activities in these two fields. The fragmentary information contained in this chapter was gathered in the course of following "leads" furnished by state and county medical societies, state insurance departments, and others.

The plans about to be described are significant as experiments. What they may yield by way of experience will be of inestimable value in appraising the possibilities of medical and hospital insurance throughout the United States.

INSURANCE MAY BE EITHER INDIVIDUAL OR GROUP

The basis of the arrangement between the organization providing medical service and those entitled to it may be either indi-

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

vidual or group. In the former case, the individual makes his payments direct to the organization; in the latter, the individual makes his fixed periodic payments to some organized group (employees' or other association) which in turn contracts with the organization to provide service to any member of the group requiring treatment, upon proper identification as a contributing member.

The individual type of arrangement is basic with the community health association, the community hospitals, and the medical benefit corporations; the group arrangement is the most common one in the case of the private group clinics.

One of the three community hospital plans of fixed payment service, viz., that of Roanoke Rapids, N. C., is unique, and for this reason is difficult to classify. In this community the plan of fixed payment service to industrial employees was part of the original idea when the hospital was built out of funds provided by local industrial concerns. The bulk of the employed population of the town gain their livelihood in six local mills. A fixed periodic deduction is made from their wages by employers and turned over to the hospital to cover the estimated cost of service received by members of the employed group who use the hospital. This particular plan is closely related to the mining and lumber company plans described in Chapters III to VIII. It has been included in this chapter because the hospital is now owned and operated by a non-profit corporation.

These four types of organization may be further classified in two ways: (1) According to whether they operate on a profit or a non-profit basis; (2) according to whether they provide care through their own medical staff, or arrange with independent practitioners to provide treatment.

The private group clinics operate primarily with a view to profit; that is, the members of the clinic make their living as medical practitioners through this form of organization. Their aim in offering fixed payment service is probably to assure a certain measure of fixed income to their organization. It should be kept in mind that the group clinics also provide medical ser-

MISCELLANEOUS FIXED PAYMENT MEDICAL PLANS

vice on the usual basis of payment by the patient for specific service rendered. Service is provided by the staff of the group clinic.

The medical benefit corporations also operate with a view to profit. They have been found only in the State of California. Except for the fact that the Insurance Department of that State refuses to recognize the contracts they sell as contracts of insurance, terming them "contracts of service," this type of fixed payment medical service might more logically have been included in Chapter XI, which treats of commercial accident and health insurance. The California medical benefit corporations do not have their own employed medical practitioners; neither have they hospitals. In consequence, they make arrangements with independent physicians, surgeons and hospitals to provide the service to which their individual contract holders may be entitled.

The two community health associations (Brattleboro, Vt., and New Bedford, Mass.) operate on a voluntary membership basis, with no idea of profit. Having no medical staff or hospital of their own, they arrange with local hospitals and practitioners to provide service to their members.

The three community hospitals providing care on a fixed payment basis (Dallas, Texas; Grinnell, Iowa; and Roanoke Rapids, N. C.) operate as non-profit institutions. Their motive in offering hospital insurance is to put their finances on a sound basis. The average community hospital consistently operates at a deficit. This deficit is usually made up from voluntary contributions. The insurance basis enables the hospital to count on a fixed amount of money from "insurance members," regardless of the total cost of service provided. Theoretically (and the experience to date is not sufficient to supply a solution to all the detailed administrative problems involved) the hospital can, if the total expense runs higher than was originally estimated, redistribute the cost in the form of an increase in the monthly "dues" to members.

More detailed information about these four types of fixed payment medical service plans will now be presented.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

PRIVATE GROUP CLINICS

The essential features of this relatively new type of organization for medical service are given in the following extract from a report entitled *Private Group Clinics*, by C. Rufus Rorem.¹

"The practice of medicine has traditionally been carried on as the responsibility of the individual practitioner, although variations from the established method are undertaken by industries, governments, or hospital and out-patient departments which have provided medical services for wage-earners or other selected groups.

"*'Private Group Clinic' Defined.* The private group clinic, for the purpose of this analysis, may be defined by several characteristic features—professional, financial and administrative. (1) Its physicians and dentists are engaged in coöperative and contiguous medical practice. They use many facilities in common, particularly office space, laboratories, and medical equipment. (2) All or most of its physicians are associated with the clinic on a full-time basis. (3) Its services include two or more medical specialties, and an attempt is usually made to hold complete facilities available for the patients accepted by the clinic, although some groups avowedly exclude from their services such specialties as obstetrics, ophthalmology, or dentistry. (4) Its patients are the responsibility of the entire group, not merely of individual physicians, although when consultations and special diagnoses are not required, one practitioner may alone treat a given case. (5) Its income is 'pooled,' and its practitioners have little or no direct financial relationship with patients. (6) Its members determine individual incomes by contract among themselves, rather than directly from their services to patients. (7) Its administration is carried on by a business man, rather than a physician, as far as non-medical matters are concerned. (8) Its credit investigations and collection policies are the specialized functions of a business manager rather than the incidental concerns of the several practitioners.

¹ Abstract of Publication No. 8 of the Committee on the Costs of Medical Care; Washington, January 1931.

MISCELLANEOUS FIXED PAYMENT MEDICAL PLANS

"The characteristics listed above distinguish the group clinic from other developments in medical service, such as 'partnerships' between physicians practicing but one medical specialty, 'individual practice' in which assistant physicians extend rather than complement the services of an individual practitioner, or 'free' or 'part-pay' clinics in which physicians serve on a part-time basis. 'Diagnostic' clinics which serve independent practitioners in the study and interpretation of difficult cases should likewise be differentiated from private group clinics as defined in this report."

PRESENT NUMBER OF GROUP CLINICS

Dr. Rorem found that there were about 150 group clinics in the United States, most of them in the middle west. The average number of doctors per clinic is twelve. The importance of group practice is indicated by the existence of a national organization of clinic managers. The sixth annual conference of this organization was held in Toronto in 1931, just before the annual meeting of the American Hospital Association; 50 of the 'strongest private group clinics were represented. It is significant that the 1931 meeting included discussion of the subject of providing medical service for an agreed charge per year. This was referred to as "medical care insurance." A report of this discussion, by Dr. Rorem, was published in *The Modern Hospital* for January 1932. From that report it appears that a substantial number of the private group clinics have entered into arrangements for the medical care of certain groups of persons at annual rates, in addition to carrying on their medical practice on a fee basis for other patients. These agreements are, in substance, according to Dr. Rorem, policies of medical care insurance, although they are not identified with any private insurance companies. "These agreements assure the individual that his expenses for the kinds of medical care which are provided will not exceed the amount stipulated in the agreement. They also assure the clinic physicians that the revenue for the medical care of a group of patients will not fall below a stated amount.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

Dr. Rorem goes on to say: "No two agreements are alike. Some are very inclusive as to types of cases accepted. Others avowedly exclude some classes of persons and medical cases. In most instances, however, the agreements refer to the medical care of employed groups; consequently the prospective patients covered in the agreements tend to be of about the same economic and social status. A series of agreements or plans made by various clinics may be cited. These are arranged roughly in order of scope of service. The earlier examples represent offers of partial service and to relatively small groups. The later ones in the list provide comprehensive medical care, including hospitalization, to large groups of persons."

Dr. Rorem points out that where such "insurance" contracts are made between the private group clinic and an employer, the service may include only injuries occurring in the course of employment, and entitling the injured employee to compensation and medical care at the expense of the employer, under the state workmen's compensation law. In this instance, the fixed charge is paid by the employer, who thus "self-insures" his liability to provide an injured employee with all necessary medical aid arising out of a compensable injury.

The following instances of group clinic practice on an annual charge basis cited by Dr. Rorem in his article will serve as excellent examples of this new development in the field of "medical care insurance."

Clinic "D" is a group of 20 doctors in a city of 300,000 inhabitants. It has an arrangement with a local street railway company, whereby employees may consult one of the clinic physicians free of charge, during a regular "office hour" which he conducts at the company's general office. For this service the clinic receives a specified monthly amount from the company. In addition, there is a special fund for the care of hospitalized cases (non-compensable disabilities), to which employees contribute through a monthly payroll deduction. This fund, administered by the employees' association, pays all physicians', surgeons' and hospital fees up to

MISCELLANEOUS FIXED PAYMENT MEDICAL PLANS

\$50, any excess being paid by the employee. Other services to members of the association and their families are rendered by the clinic on an agreed fee schedule; for an employee, the association pays all charges, and for families, three-fourths, the family paying one-fourth. Hospital care of family members is not included. It is noted that this agreement is three-fold as to degree of financial responsibility on the part of the person eligible for the service: As an employee, he may receive office treatment at no cost to himself; as a contributor to the employees' fund, he is entitled to medical and surgical treatment and a limited amount of hospital service for himself; as a patient requiring care costing more than a maximum amount, he must finance part of his own medical care.

Clinic "E" includes eight doctors, in a city of 15,000 population. The arrangement in this case involves no financial risk to the clinic in rendering service. The Welfare Association of a local department store sends all members to the clinic for medical service. Regular fees on a case basis are paid by the Association from a fund created through monthly payroll deductions plus a general contribution by the company. Each employee is entitled to a maximum allowance of \$75 for medical care in any one year. The manager of the clinic states that the store first asked that the contract be made on the basis of a flat payment of \$100 per month, but there were objections to this plan. On the present basis, the average cost to the Welfare Association has been from \$400 to \$600 a year—considerably less than was anticipated; at the same time, the clinic has received its regular fee for each case.

Clinic "F" comprises 22 practitioners, in a southern city of 300,000 population. It has arrangements with various employee's associations to furnish medical care but not hospitalization at a maximum fee of \$1 per person per month, with the possibility that the cost to the association may be less than this amount. The work is done on a case basis according to an agreed fee schedule. If, for example, a patient undergoes an appendix

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

operation the clinic charges the association for this service; if he requires merely one office call during the year, the association pays only for that one call. If the total charges do not reach the maximum figure of \$1.00 per person per month, the association pays only the actual amount charged. This arrangement was adopted as a means of preventing excessive demands for service. The manager of the clinic states that the plan has not been in operation long enough to demonstrate whether or not a large volume of business can be handled at these rates. The clinic is, however, taking the attitude that these fees are about all the association can afford, and is striving to make its medical and surgical costs meet the figures. The manager believes that when the clinic operates its own hospital, as it plans to do in the near future, costs will materially decrease. Services given under this plan exclude dentistry, maternity care, treatment for venereal diseases and for drug addiction.

Clinic "G" is a group of 10 doctors who own a 75-bed hospital in a city of 50,000 people. Seven years ago these same physicians were offering medical and hospital service at \$1.50 per person per month to several groups of employees. The plan was later discontinued because the County Medical Society adopted a special by-law prohibiting it. The clinic physicians, however, according to a statement of the chief of staff, still believe that the plan is "economically and ethically sound practice." This doctor says valuable lessons were learned from the experiment: the fee of \$1.50 per month was somewhat low for the character of service given; the bulk of the service tended to fall in the first year; the beneficiaries, including employers, liked the plan and protested its withdrawal; the local medical profession generally disapproved the plan as being unfair competition.

Clinic "H," in a large Pacific Coast city, consists of 14 doctors, and owns and operates a 200-bed hospital. It has agreements with employers to provide certain medical and hospital services to employees. The employer deducts \$1.50 per month from each

MISCELLANEOUS FIXED PAYMENT MEDICAL PLANS

employee's wages, consent to this procedure being a condition of employment. Five employers have entered into these agreements, covering from 250 to 1,000 employees each. All of the service is separate from, and in addition to, medical care given under workmen's compensation. It includes medical treatment and hospitalization (limited to 90 days), consisting of ward care in a general hospital. The usual exclusions are made of maternity cases, chronic conditions, venereal disease, insanity, etc.

Clinic "I," a group of 20 physicians in another Pacific Coast city, provides the most extensive and inclusive annual service found by Dr. Rorem in his study of this field. The clinic has agreements with a number of employees' associations, some of which offer as one of the privileges of membership, the right to be certified for medical care by the clinic. Deduction of \$2 per month for each eligible employee is made by the employer, and paid over to the employees' association, which in turn pays the clinic \$2 per month per eligible member. Not all members of the various associations subscribe for the medical service, but the percentage is said to be growing. The plan was inaugurated in 1929. In 1931 more than 5,000 employees and their dependents were covered.

Illustrating the scope of services included in this clinic's various agreements, one with a county employees' association is summarized by Dr. Rorem. Members of the association certified to the clinic receive medical care without further payment. This includes all medical and surgical attention by doctors, i.e., diagnosis, clinical and laboratory tests, X-ray examinations and treatment; surgical operations, professional consultations, and home visits; all medicines and drugs, except insulin; all dressings and splints; complete hospitalization, including "special services," in the ward of a hospital selected by the clinic. A charge is made for orthopedic appliances, eye-glasses, dentistry, crutches, or sick-room furniture. All classes of sickness and disease are treated, including mental cases, maternity, tuberculosis, and venereal disease. Hospitalization is limited to 3 months in any calendar year, and does

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

not include treatment after patients are transferred to state hospitals or tuberculosis sanatoria. The services of outside specialists, where necessary, are paid for by the clinic. The clinic maintains branch offices, and 24-hour telephone service. Patients must visit the offices for treatment, if able. For house-calls at a distance of more than five miles from a clinic office, a charge of not more than \$1 per mile is made. Members of the subscriber's family who live with and are wholly dependent on him, are entitled to the same services, but must pay the cost price of all medicines, drugs, dressings, splints, X-ray films, hospitalization, and outside specialists' services. When a member of the association leaves the employ of the county, he may continue to subscribe for and receive the services of the clinic, by paying \$24 per year in advance directly to the clinic. This clinic also carries on private practice, the doctors of the staff serving all patients without distinction, and usually without knowledge as to whether they are private or subscription patients. The clinic does not own or operate a hospital, but has staff privileges at several of the hospitals of the city, both proprietary and non-profit.

Dr. Rorem's conclusions from the reports submitted by the clinic managers are worth recording here: "The private group clinics represent a special type of organization of group medical service from the standpoint of the physician. It is significant that they should also be experimenting with plans for group payment by patients for their medical care. Service based on annual agreements is usually referred to by the clinic physicians and managers as 'contract' practice, a designation which emphasizes the certainty of revenue to the clinic. From the point of view of the patient the annual agreements are a type of medical care insurance through which the costs of medical care can be systematically provided for in his annual budget. The data which have just been cited, and the interest shown by clinic practitioners and managers in this type of service point to the need for further experimentation along this line."

MISCELLANEOUS FIXED PAYMENT MEDICAL PLANS

NON-PROFIT COMMUNITY HEALTH ASSOCIATIONS

The essential difference between the plan of medical care offered on a fixed payment basis by community health associations and that offered by community hospitals (to be described in the next section of this chapter) is that in the first mentioned type, the risk is carried by an organization separate from the hospital providing the service, whereas in the case of the community hospitals, the institution "insuring" the medical risk also provides the service that may be needed by the member. Two examples of medical care offered by independent community associations will be described. One is in operation in Brattleboro, Vermont, the other in New Bedford, Mass. The latter is, in fact, modeled in its general features on the former.²

BRATTLEBORO MEDICAL INSURANCE PLAN

The Brattleboro medical insurance plan provides for two kinds of service usually needed when the emergency of illness occurs, viz., (1) nursing, and (2) hospital service. There are two Associations: The Thompson Benefit Association for Nursing Service, established in 1926, and the Thompson Benefit Association for Hospital Service, established in 1927.

Brattleboro is perhaps unique as a community in having a foundation known as the Thomas Thompson Trust, created under a bequest some thirty years ago. The trustees of this foundation have been particularly interested in helping to develop the public health facilities of the community. Among these, besides the Brattleboro Hospital (non-profit), with 55 beds, there is the Brattleboro Mutual Aid Association, which provides bedside, visiting and public health nursing by graduate nurses, and attendant

² In Cooperstown, N. Y., a town of about 3,000 population, an experiment in hospital insurance on a community basis is reported to have been inaugurated on January 1, 1930. The Bassett Hospital Guild, for annual fees of \$25 for individuals, or \$100 for families of any size, is reported as agreeing to provide members with medical, surgical and hospital (ward) care, in the Mary Imogene Bassett Hospital. The hospital doctors determine whether the patient needs hospital care. Obstetrical cases are not included. Persons with chronic illnesses are not eligible for the insurance. The plan is still in the experimental stage, and no detailed information was available when this chapter was written regarding results.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

nursing under graduate supervision; prenatal and child welfare health service; dental clinics; school nurse; and a general health education program. The Thompson Trust, by means of the two Benefit Associations mentioned above, and through arrangements with the Brattleboro Hospital and the Mutual Aid Association, established a system of "benefit insurance" under which necessary hospital, surgical and nursing service can be paid for by the ordinary family without hardship.

Brattleboro itself is a town of approximately ten thousand, surrounded by a rural district of about ten thousand more, for which it serves as the business and medical center. The insurance plan originally contemplated the ultimate inclusion in its membership of all families in this area whose incomes may be considered to be "average or less." In practice, we are informed, the insurance is sold to all otherwise eligible applicants, whether of the well-to-do or the smaller income group.

AIM OF THE INSURANCE PLAN

The plan aims to provide protection at small cost for the entire family against certain of the expenses incident to sickness. It seeks to put the best service at the lowest cost within the reach of everyone, without resorting to free service. The plan is believed by its sponsors to be adapted to communities of moderate size, or to special groups. In both instances, a certain amount of personal knowledge of the participants would take the place of expensive administrative machinery, in selecting risks and adjusting claims.

The two Associations were inaugurated by the trustees of the Thomas Thompson Trust. For the Association for Nursing Service \$1,000 was set aside in 1926; for the Association for Hospital Service (1927) the amount set aside was \$1,500. As at present organized, the two Associations have no overhead or operating expenses, since these are borne by the Thomas Thompson Trust. The executive secretary of the Trust acts in a similar capacity for the Associations, and in addition "sells" the insurance. The funds of the two Associations are held in one of the banks of Brattle-

MISCELLANEOUS FIXED PAYMENT MEDICAL PLANS

boro, whose president serves as treasurer of both Associations. This officer issues the checks in payment of claims direct to the Hospital or to the Mutual Aid Association, upon submission of properly approved bills.

In the Association for Hospital Service no benefit is allowed until the member has paid the first \$30 of expenses. This requirement is intended to do away with all small claims, leaving the benefits to be applied on occasions of major expense.

While no physical examination is required for membership, applicants must sign a statement to the effect that to the best of their knowledge they are in good health and have no chronic disease.

Memberships are for either individuals or families. No attempt has as yet been made to arrange for the insurance of employee or other groups.

THE THOMPSON BENEFIT ASSOCIATION FOR NURSING SERVICE

This Association furnishes its members, through the Mutual Aid Association and under the physicians on the staff of the Memorial Hospital, with the services of graduate nurses at one-third of regular rates, and of attendant nurses at one-half regular rates. The "attendant" nurses are women specially trained by the graduate nurses of the Brattleboro Mutual Aid Association, to go into homes where sickness exists, but where expert professional nursing care is not required, and perform all such duties as may be needed to keep the household functioning, including keeping the sick person comfortable, assisting in housework and cooking, and caring for the children. The additional amount due the nurses for their services is paid to them by the Association for Nursing Service, and constitutes the "benefit" received by the member in return for his annual contribution.

If a member has to undergo an operation in the Brattleboro Memorial Hospital (or elsewhere as determined by the Hospital) and special post-operative nursing care is required, the Association for Nursing Service pays for this up to two-thirds of full charges

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

for three days' nursing service, with two-thirds of nurse's board. In pneumonia cases also, one-half the expense of special nursing care in the hospital, including nurse's board, is paid by the Association. (This special post-operative and pneumonia nursing service was not a benefit under the original plan, but was added January 1, 1931.) Nursing care for maternity and chronic cases is not included in the plan. The maximum benefit payable in any one case is \$200.

The annual dues entitling members to the foregoing benefits are: single persons, \$2; married couples, \$3; children under 16 years of age, 50 cents extra.

The membership in the Benefit Association for Nursing Service on November 1, 1930, was 114 families and 96 individuals, an aggregate of 432 persons. The cost of protection to November 1, 1930, is shown to have been 8½ cents per capita per month. The total income of the Association from its establishment in 1926 to November 1, 1930, was \$2,420.51, which sum includes the \$1,000 set aside by the Thomas Thompson Trust in 1926 for the purpose of starting the Association. The total expense for the same period (i.e., the amount paid in claims; there is no "overhead," as previously shown) was \$767.60, leaving a balance of \$1,652.91. If the \$1,000 from the Thompson Trust is deducted, there remains \$652.91 balance from premiums paid in, plus interest earned.

THE THOMPSON BENEFIT ASSOCIATION FOR HOSPITAL SERVICE

The benefits offered by this Association are as follows: In case of surgical operations in the Brattleboro Memorial Hospital (after the first \$30 of all charges have been paid by the member) the Association pays all expenses including surgeons' and hospital charges, up to a maximum of \$300. In case of the need of other than surgical service in the hospital, the Association pays one-half of hospital charges (after the first \$30). The maximum amount in such cases is determined by the hospital directors or their committee, who decide whether the case is a "genu-

MISCELLANEOUS FIXED PAYMENT MEDICAL PLANS

ine emergency." Payments will not be made for any use of the hospital or nurses that is "chiefly a matter of convenience."

Surgical treatment must be furnished under the rules of the Brattleboro Memorial Hospital and by surgeons approved by its directors; all charges must be approved as reasonable by the directors. The directors, or their committee, may advise that the service required be rendered elsewhere than in the Brattleboro Hospital, if the case is one to which its facilities are not adapted.

The annual dues entitling members to the foregoing benefits are: single persons, \$5; married couples, \$7.50; children under 16 years, \$1 each extra.

The membership in the Benefit Association for Hospital Service on November 1, 1930, was 141 families and 142 individuals, comprising 550 persons in all. The cost of protection was 50.3 cents per capita per month. The total income of the Association from its establishment in 1927 to November 1, 1930, was \$6,120.78, which sum includes the \$1,500 set aside by the Thomas Thompson Trust in 1927 for the purpose of starting the Association. The total expense for the same period (i.e., payment of claims for doctors' services and hospital care) was \$5,736.16, leaving a balance of \$384.62. If the \$1,500 from the Trust is deducted, the Association's deficit on November 1, 1930, amounted to \$1,115.38.⁸

Any changes in the terms under which the benefits may be paid must be agreed to by written consent of not less than two-thirds of the "family units" entitled to benefits; a family unit is either: a single person; a husband and wife with or without children; or a parent and child or children under sixteen.

In studying the insurance plan worked out in Brattleboro, it will perhaps be noticed that the family doctor is not directly favored, except when he assists at an operation. The sponsors of the plan believe that he is indirectly benefited, since something is presumably left for his remuneration after the bills of the hospital, the surgeons and the nurses he has had to call upon, have been paid.

⁸ The Trust subsequently added \$1,000 to the Association's treasury.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

NEW BEDFORD MEDICAL INSURANCE PLAN

The New Bedford Health Association was organized in June 1929, and began taking members on July 1 of that year. On May 31, 1931, according to a letter received from the Association, it had 225 contributing members. (The population of New Bedford in 1930 was 112,597.)

The following extracts from the By-laws of the New Bedford Health Association indicate its aims and methods of operation.

Objects: "For the purpose of enabling residents of Greater New Bedford to receive hospital service or other medical care with less financial hardship, a committee of the Bureau called the New Bedford Health Association is hereby created by the Welfare Federation of New Bedford." ⁴

Membership Requirements. "Only residents of Acushnet, Dartmouth, Fairhaven and New Bedford are eligible to membership in this association, and upon any one's removal from the four localities mentioned his or her membership shall immediately terminate. The trustees shall have the right to accept or reject any application for membership. They may terminate any membership at any time on any terms they see fit. They may require such physical examination of any individual either prior to membership or during the membership period, as in their discretion seems appropriate."

Application for Membership. Application for membership is made on a card containing the applicant's name, date and place of birth, residence and business address, and the name of the family doctor. The form of the application is as follows:

NEW BEDFORD HEALTH ASSOCIATION,
NEW BEDFORD, MASS.

ADULT APPLICATION FOR MEMBERSHIP

I, the undersigned, being in good health, hereby apply for Plan.....
..... membership in the New Bedford Health Association of New

⁴ Welfare Federation is the name of the organization which raises funds to cover the operating deficits of New Bedford voluntary charitable and health organizations. It is the local "community chest."

MISCELLANEOUS FIXED PAYMENT MEDICAL PLANS

Bedford, Massachusetts, a voluntary, non-profit organization formed to promote the general health of the community. I hereby agree to contribute a membership fee of \$1.00 when applying for membership and to contribute \$6.00 dues per year payable months in advance, to promote its general work. I hereby agree to be governed by all present and future rules of the New Bedford Health Association; and in case I apply for service, to accept the decision of the trustees as to whether I am entitled to, or shall receive, such service. In case I become over two months in arrears in my dues, I hereby agree that all my rights to service or benefits from the association shall be forfeited and that my membership shall end.

Signed this day of 19.....
Signature
Witness to signature

How Cost of Insurance Is Paid. Each member is given a small book of contribution tickets covering the twelve monthly subscriptions for the year. Membership dues may be paid at various local banks and trust companies. The membership book serves as identification in case of sickness or accident. If a member becomes over two months in arrears he forfeits all rights to service or benefit from the Association and his membership terminates.

Nature of Benefit. "The New Bedford Health Association will pay toward hospital accommodation, surgical, medical or specialist treatment in a hospital or elsewhere, for its members under the rules of the Association as follows:

"A member, if he pays the first \$30 of his sickness expenses, shall be entitled to the above service on terms and in the manner approved by the trustees up to a maximum cost to the association of \$200 in a case involving an operation, in any membership year; and in a case not requiring an operation, up to a maximum cost of \$120 in any membership year."

The member has absolutely free choice of doctor and hospital, the only requirement being that the doctor shall be a registered physician.

The Association contributes toward the expense of eye, ear, nose, throat, or teeth cases only when a surgeon's services are required.

No expense is assumed by the New Bedford Health Associa-

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

tion until a medical examiner, employed by the trustees, determines that the case in question is an actual disability to which the Association should contribute. When the medical examiner certifies that a member is entitled to disability expenses, the treasurer is authorized to pay such medical bills for the member as the secretary certifies are correct.

The Association does not contribute toward expense growing out of the following cases: maternity, alcoholism, narcotic addiction, venereal disease, and progressive chronic diseases.

Administration. The New Bedford Health Association is administered by seven trustees elected by the Board of Directors of the Welfare Federation. The treasurer and secretary of the Federation are treasurer and secretary ex-officio of the New Bedford Health Association. In January of each year the trustees are required to render an annual report of the work of the Association during the past year, including a full and detailed financial statement.

Four trustees constitute a quorum. The trustees have full authority to change the rules and regulations of the Association. They also have power to negotiate agreements with hospitals, doctors, nurses and others to render hospital and medical care to members of the New Bedford Health Association, and to adopt such rules and incur such expenses as are necessary to carry on the work of the Association.

The trustees are not personally liable for any acts or omissions in the conduct of the Association.

The By-laws of the New Bedford Health Association provided that it was to continue for a period of two years from July 1, 1929, unless its reserves became so depleted that the trustees decided that the Association should be liquidated. If on July 1, 1931, the reserves were sufficient in the opinion of the trustees, they were empowered to continue the Association for a further period of four years. At the end of the four-year period the question of the continuance of the Association is to be referred to the Welfare Federation of New Bedford. The first experi-

MISCELLANEOUS FIXED PAYMENT MEDICAL PLANS

mental period of two years has been completed, and the Association is continuing operations.

On June 1, 1931, the balance sheet of the New Bedford Health Association showed as follows:⁵

Guarantee Fund	\$1,654.00	Expenses	\$ 239.87
Contributions	214.35 ^a	Claims	1,401.80
Membership fees	317.00	Investments	1,991.70
Dues	2,017.00	Cash on hand	709.21
Interest	16.90		
Dividends	123.33		
	<hr/>		<hr/>
	\$4,342.58		\$4,342.58

^a Contributed by an individual to pay for "selling" the insurance. A young man does this in his spare time, receiving a commission for each new member he brings into the Association.

The possibilities of the community health association as a method of widening the application of insurance to the purchase of medical care cannot, of course, be deduced from the two experiments discussed above. Their success depends upon the degree to which medical practitioners will cooperate. One difficulty in this type of insurance plan stands out: the individual basis of membership. The expense of recruiting and retaining members on an individual solicitation basis necessarily reduces the total amount available for providing medical and hospital benefit. However, experience in Brattleboro and New Bedford may supply data for improvement in the present form of organization.

NON-PROFIT COMMUNITY HOSPITALS

Three examples of non-profit, community hospitals offering service to individuals, in consideration of a fixed payment in advance, have been found in the course of this investigation. One of these plans (Dallas, Texas) is relatively new, and to date does not offer much by way of experience with this type of hospital insurance. The hospital insurance plan in Grinnell, Iowa, has

⁵ Letter from New Bedford Health Association, June 5, 1931.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

been in operation since 1918; and that of Roanoke Rapids, North Carolina, since 1917.

BAYLOR UNIVERSITY HOSPITAL, DALLAS, TEXAS

In letters dated November 10, 1930, and February 10, 1931, this hospital writes that its plan for dividing the cost of the individual's hospitalization among the total members of a group was first offered to the public on January 1, 1930. In February 1931, there were about 3,000 persons participating in the plan, in groups as follows:

Public school teachers (largest group, 1,200 members); employees of three large banks; graduate nurses; city firemen; city police; employees of a daily newspaper. Only non-compensable disability cases are covered.

The annual fee is from \$6 to \$10 per person, according to the type of room desired, is collected in monthly installments by the group, and transmitted to the Hospital. The plan does not include the services of a physician, such as medical examinations, diagnosis office or home treatment, but only hospitalization for those members of the group whose physicians have sent them to the Hospital as patients.

From printed matter issued by the Hospital, the following information as to the services offered by the plan is taken:

Hospital service in Baylor University Hospital is assured when needed, including operating room service, anesthetics, and laboratory fees, for a period not to exceed 21 days in any 12 months. If further hospitalization is required, a discount of 33 $\frac{1}{3}$ per cent from regular hospital fees is made. The service does not include doctor's fees, either physician's or surgeon's, nor the services of a special private nurse; it does include all usual hospital services of nurses, internes and house staff, medicines, surgical dressings and hypodermics.

The service is given in wards or in private rooms, as previously agreed upon; if all beds of the agreed class are full, the assured patient is placed in a bed of a different price until one

MISCELLANEOUS FIXED PAYMENT MEDICAL PLANS

of assured price is available; if a higher priced bed is desired, membership rates are applied on the cost of such higher priced accommodation.

Membership in the plan ends if and when the person leaves his employment. The dues must be collected and paid as a group.

Obstetrical cases are not included in the plan, but a 50 per cent reduction on regular hospital fees will be allowed. Chronic mental and nervous disorders, tuberculosis, acute venereal infections, and contagious diseases, are accepted only for diagnosis.

Provision is made for times of epidemic or public disaster occasioning over-crowding of the hospital, by declaring that in such an event, the responsibility of the Hospital under the contract shall be discharged by the refund to the assured of twice the amount he has paid during the twelve months immediately preceding.

No patient can be admitted to the Hospital except under the care and upon authorization of some member of the Dallas County Medical Society; all members of the Society are eligible to use the facilities of the Hospital.

No information was available when this chapter was written (May 1932) as to the results with this experiment in hospital insurance.

THE GRINNELL (IOWA) HOSPITAL PLAN

The Grinnell Hospital has operated an insurance plan of hospital service since 1918. Under this plan, an adult is entitled to three weeks' hospital care during any one year, in consideration of the payment in advance of an annual membership fee of \$8. Husband and wife together may be insured for hospital service, for not exceeding three weeks for each of them in consideration of an annual membership payment of \$12. For an additional \$5, one child may be insured for a year along with the parents. Additional children are accepted at the rate of \$2.50 each per annum.

The insured member becomes entitled to hospital service fifteen days after payment of the annual fee. Unless the insurance is renewed by payment fifteen days before the lapse of one year,

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

it expires. If then renewed, fifteen days must elapse before the member becomes entitled to hospital service.

Hospital service covered by the insurance includes room, board, and general nursing care. Medicines, X-ray and other special services, laboratory tests, operating room charges, and special nursing, are not included, and are charged to the patient.

In obstetrical cases, the period during which the insured woman is entitled to free hospital care is two weeks instead of three, plus \$10 per week and \$1 per day for the baby.

A member is admitted to the Hospital only upon recommendation of the attending physician, and upon presentation of the identification or membership ticket.

The remuneration of the family physician is not included in the insurance plan. His bill, as well as that of the attending surgeon in the case of an operation, is outside the insurance arrangement.

Dr. E. E. Harris, of Grinnell, in a letter dated December 10, 1930, states: "The plan originated in a meeting of the hospital staff in which we were considering ways and means of helping the Hospital in a material way. The coöperation of the doctors is very cordial in support of the insurance. . . ." Dr. Harris further stated that he did not believe the insurance plan could be extended to take care of the remuneration of the doctor and the surgeon, however desirable this might appear. He is convinced, however, that the insurance plan can take care of the running expenses of the Hospital and that the success of it is beyond question. He says, "I kept an accurate account of this for the three years I was in charge of the Hospital finances and I found only a single month in which we ran behind, and the amount was only \$3. Of course, the extras help out a great deal, but even these have such a great value to the patient that there is never any complaint of the extra charges. This is especially true of the laboratory service and also the X-ray."

The students at Grinnell College, according to Dr. Harris, are now being offered the opportunity of participating in the insurance plan. Those residing in the dormitories are required

MISCELLANEOUS FIXED PAYMENT MEDICAL PLANS

to take out a card at the beginning of the school year. The cost of the insurance service to them is \$5 per school year of nine months. In return for this annual contribution of \$5, the student gets practically the same care as is given the general public.

THE ROANOKE RAPIDS (N. C.) COMMUNITY HOSPITAL PLAN ⁶

Roanoke Rapids, N. C., reported by the 1930 Census as having 10,612 inhabitants, affords an interesting example of how a number of typical textile company plans of medical service to employees have developed into what is practically medical and hospital insurance for the entire employed population of the community.⁷

Employment in Roanoke Rapids and vicinity is provided chiefly by three cotton textile mills, one paper mill, one fiber-board mill, and an electricity generating station.

The Roanoke Rapids Hospital has 85 beds and is completely equipped for medical and surgical diagnosis and care; and for obstetrical work, eye, ear, nose and throat cases, etc. It has X-ray and physio-therapy equipment. The hospital ranks as Class A, and is accredited for nurses' training. A residence for nurses has recently been added.

The hospital staff consists of five doctors, two of whom are surgeons; three registered, and 30 pupil nurses. None of the doctors confines himself to a specialty, but each is interested in some special field: pediatrics, gynecology, surgery, etc. There is no specialist in eye, ear, nose and throat on the staff, but there is one in the town, who in return for the use of the hospital equipment for his private patients, gives his services free at the hospital for mill and charity patients. Dr. Long says that he is sometimes able to call on neuro-psychiatric and other specialists from other towns and institutions.

⁶ Information as to the Roanoke Rapids plan of medical and hospital insurance was obtained in connection with a visit to that town by a member of the National Bureau staff in December 1930. To Dr. T. W. M. Long, of Roanoke Rapids, the National Bureau is indebted for much of the following information.

⁷ See Chapter I (page 17) for a description of typical company medical service in the southern textile industry.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

The staff physicians are also the "company" doctors for the local industries. Their duties include physical examination of employees and of applicants for work; medical service to employees in their homes; surgical work to injured employees under the North Carolina Workmen's Compensation Act. (Enacted in March of 1929; effective July 1 of that year.) These physicians are free to engage in private practice to the extent that their duties to employers and employees leave them time. They are allowed the use of the hospital for their private patients.

The medical care to which employees of the local industries are entitled by reason of their periodic contributions includes complete care in the hospital in case they go there either as in-patients or out-patients. Medicines are furnished, as well as X-ray work if required. Obstetrical service is available to women contributors. Home care is available to contributing employees and dependent members of their families.

The following history of this enterprise has been given by Dr. Long: The industrial development of Roanoke Rapids began in the late '90s with the establishment of the cotton mills. The medical care began with the "company doctor" employed by these mills soon after their opening. The community was infested with malaria, 50 per cent of the people being infected with it all the time, so that the mills were always operating with debilitated workers. The typhoid and infant mortality rates were also excessively high. With the coöperation of the United States Public Health Service malaria and typhoid were eradicated, and the so-called "summer complaint," which carried off so many babies in their second summer, was abolished. Swamps were drained and oiled, surface wells replaced by driven wells, and open privies by septic tanks.

Meanwhile, endeavoring to provide more adequate care for the sick among the mill workers, Dr. Long and two colleagues opened a small private hospital in a vacant house. It had one nurse, eight beds, and such equipment as the owners could afford out of their resources. It was, of course, inadequate, but its pres-

MISCELLANEOUS FIXED PAYMENT MEDICAL PLANS

ence served to demonstrate the need to the mill owners, and convince them of the value of adequate medical care.

In 1914 Dr. Long proposed to the six local industries mentioned above that they build and equip a hospital large enough to serve the entire community, the cost to be divided among them *pro rata* to the number of employees of each. Dr. Long undertook to secure the coöperation of the employees in meeting the expenses of such a hospital through small, periodic contributions.

The idea was accepted by the local industries and in 1916 the hospital was completed. The employees also agreed to the plan, and in 1917 it was launched. A corporation was then formed under North Carolina laws to operate the hospital as a non-profit, eleemosynary non-taxable institution. To this corporation the local industrial concerns deeded the hospital, whose board of trustees is composed of the managers of the mills, the local physicians (both those engaged in industrial and in private practice), the Mayor of the town, and the Chairman of the Board of County Commissioners, *ex officio*. Apparently, the contributing employees are not directly represented in the hospital corporation. Up to the end of 1930 a capital investment of \$232,000 had been made on land, buildings, furniture and equipment.

The income of the Hospital is composed of (a) the periodic payments of employed contributors, deducted from their wages by local employers and turned over to the Hospital corporation; (b) fees paid by private patients; (c) a contribution from the Duke Foundation of \$1 per day for each "free patient day." Only actual charity patients, not mill patients, are counted in reckoning the amount of this contribution from the Duke Endowment. The teachers in the town also contribute as a group at the rate of 50 cents per person per week. Of this amount, 25 cents goes to the hospital and 25 cents to the hospital physicians for equal division among them. If there is a deficit in the operating expense of the hospital, it is made up by the local industrial corporations, *pro rata* to the number of their employees participating in the medical and hospital insurance scheme.

According to Dr. Long there had been only two deficit years

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

prior to 1930. In all other years the Hospital had been able, by the exercise of close economy, to pay its way. How far the employee contributions fall short of meeting the cost of service to them is shown by the fact that in 1929 the cost of treatment to them amounted to \$62,071.30, while the amount contributed by them through payroll deduction amounted to only \$39,302.90.

For the year 1930 the following information has been kindly furnished by Dr. I. S. Falk, Director of Research of the Committee on the Costs of Medical Care, who has made a study of the Roanoke Rapids plan: "The total cost in 1930 was \$147,536, of which \$89,193, or \$20.10 per person eligible to receive care, was contributed by the mill corporations and their employees. Services covered home care, the care of the ambulatory sick in the offices of the physicians located in the hospital and in other out-patient divisions of the hospital, and all necessary hospital care for workers and their dependents. Home service included visiting nurses, as well as physicians. There were no limitations on the amount of care either in the home, in the out-patient divisions or in the hospital proper, nor were there any limitations with respect to the kind of care, with the exception of dentistry, pharmacy, and refractions and glasses. Major operations and similar services are all included. In 1930, the year to which these figures apply, the practice was that the employees contributed each 25 cents per week by check-off and this money went to the direct support of the hospital. The physicians were paid by the companies and this amounted to an equivalent of 25 cents per employee per week. In addition, the companies paid for the visiting nurses and made up a deficit of about \$10,000 in the operation of the hospital."

The Roanoke Rapids plan has not been immune from the effects of the prolonged business depression. Dr. Falk reports that although the local companies have managed to keep their plants in operation, there has been a considerable reduction in the size of the employed population, and drastic curtailment has taken place in the "welfare" activities of the industries. The financial basis of the insurance scheme has been radically modi-

MISCELLANEOUS FIXED PAYMENT MEDICAL PLANS

fied as a result. As against the former weekly contribution of 25 cents, employed contributors now pay 50 cents. In other words, they are on the same contribution basis as the group of school teachers. Prior to 1932 the salaries of the hospital staff physicians (who are also the company doctors) were paid by the local industries. Now they are remunerated out of a fund created by allocating to them as a group 25 cents of each 50 cents collected.

Until July 1929, North Carolina did not have a workmen's compensation law. Prior to that time, therefore, employers were not under legal obligation to pay the Hospital for treatment of employees injured in the course of their employment. Dr. Long states that since the compensation law became affective, it has been the policy of the Roanoke Rapids Hospital to accept the amount paid by local industries to cover the operating deficit, in lieu of payment on a case-by-case basis from employers, for cases of accidental injury coming under the North Carolina Workmen's Compensation Law. These employers "self-insure" their compensation risk. Dr. Long states further: "The prolonged depression and unemployment has thrown a larger amount of free work on us than in the past, and the \$1 per day per patient from the Duke Endowment does not, of course, take care of this, so we are entirely dependent upon our local industries to make up any deficit that occurs."

Experience with fixed payment medical and hospital service in Roanoke Rapids naturally brings up the question of the effect of a long-continued business depression on this type of insurance scheme. What happens to the "insured contributors" when they cease to be entitled to medical care by reason of the cessation of their periodic contribution? Chapter I showed how the total number of employees in the mining, lumber and steam transportation industries participating in fixed payment medical service plans has declined during the past two years. No information is at hand as to how this particular group of unemployed persons now obtain medical and hospital care. This is a point concerning which it is important to have definite information. The same question arises, of course, under compulsory sickness insurance in

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

the different European countries. The employed contributor is entitled to medical care from the insurance institution for a certain number of weeks after his employment has ceased. After that transition period is over, he must either pay for medical service or get it at the expense of the community as a "charity" patient.

MEDICAL BENEFIT CORPORATIONS

As far as has been discovered, this type of business concern operates only in the State of California. In return for a fixed periodic payment, the medical service corporation guarantees medical, surgical or hospital treatment to the contract holder in case he is disabled by accident or disease. Many of the contracts entitle dependent members of the contract-holder's family to medical and hospital service without additional payment. Medical service is provided on behalf of the corporation issuing the contract by physicians designated by the medical service corporation. Not having hospitals of their own, the medical service corporations arrange with independent institutions to provide hospitalization needed by contract-holders, in accordance with the terms laid down in the contract.

While the California medical benefit corporations endeavor to write group contracts with employers for the benefit of their employees, and while a small number of such group contracts have been written, the great bulk of this medical insurance is in the form of contracts between the corporations and individuals.⁸ Where group contracts are entered into with an employer, the latter collects from each employee electing to participate in the plan the monthly sum agreed upon. The employer does not match any part of the employee's contribution and assumes no responsibility beyond collecting the amounts authorized by employees and paying the total to the medical service corporation.

Six medical benefit corporations have come to our notice. No information is available as to the total number of contracts out-

⁸ The Insurance Department of the State of California has informed us that these medical benefit corporations do not come under its jurisdiction, since their contracts are considered as contracts of service, not of insurance.

MISCELLANEOUS FIXED PAYMENT MEDICAL PLANS

standing at a given moment; the total number of individuals who are guaranteed medical service; the number of claims paid; or the ratio of total claims paid to total receipts. However, there is nothing to indicate that the total numbers of persons covered by medical benefit contracts in California is more than an insignificant fraction of the total population of the state.

The nature and scope of the benefits offered by California medical benefit corporations is indicated in the following summary, prepared from specimen contracts.

Cost of Protection; Method of Payment. The customary method of payment is monthly, in advance. In the case of group arrangements, the employer collects the monthly fee, by an authorized deduction from the employee's pay, and transmits it to the insuring concern. The rate most usually quoted is \$2 per month per employee, for groups of ten to forty-nine employees. One concern quotes the following rates for larger groups: Group of fifty to ninety-nine, \$1.75 per month each; groups of one hundred to one hundred ninety-nine, \$1.65 per month each. In each group, provision is made for including family members and children, age twelve or under. For additional adult family members, the rate runs from \$1.65 to \$1.85 per person per month, depending on the size of the group. For each minor child, the rate is \$1 per month.

Most contracts contain strict provisions as to the payment in advance, and if payment is not made on the stipulated date, the contract ceases to be in force. Thereafter, payment may be accepted at the discretion of the medical benefit corporation. One contract allows ten days grace for payment of dues under an individual contract.

Convertibility under Group (Employer) Contracts. In case a person insured under a group contract ceases to be employed (other than temporary lay-off) he may convert his insurance interest under the group contract into an individual contract, by making application within thirty days, and paying the individual rate in advance. In case of temporary lay-off, the insurance re-

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

mains in force until the end of the period for which payment has been made.

Cancellability of Contracts. "Falsity of any warranty contained in application" is the phraseology used in one contract. Other contracts stipulate that while the insured may cancel, the insurer may not, except for fraud.

Nature of Service Guaranteed. Certain contracts guarantee only hospital service, ordinary office or home treatment by physicians being excluded. The usual provisions, however, as shown by an analysis of several specimen contracts, are as follows:

Physician Service. Medical and surgical treatment, including major and minor operations, at the home of the insured, at the office of the attending physician or at the hospital. Members over 60 years of age are not entitled to continuous home or office treatment for more than 52 weeks. Some contracts limit treatment of home confining or non-confining illness to six months.

Medicines, Drugs and Dressings. The usual provision is that all prescriptions issued by approved physicians will be filled at designated pharmacies, at the expense of the medical benefit corporation.

Medical Benefit, so far as treatment at home or in the doctor's office goes, becomes operative immediately upon payment of the stipulated monthly fee in advance by the contract holder. The contract usually contains a provision that treatment under the contract shall only be given for diseases or non-occupational accidents occurring after the contract has entered into force.

Hospitalization. This includes room, board, regular nurse service, operating room charge, anesthetics, X-ray and other incidental expenses. Two contracts state that "all hospital service must be first approved by an officer" of the medical benefit concern.

Duration of Hospital Benefit. (Limitations on total expense.) The most usual provision is that hospital care shall not exceed 12 weeks in any one year. Some contracts increase the period of hospital care after the insurance has been in force for two years, without lapse. One contract limits the amount the Company will pay for regular hospital services to not exceeding \$6 per day.

MISCELLANEOUS FIXED PAYMENT MEDICAL PLANS

Another contract stipulates that "the Association will pay the Hospital for the member's hospital service as provided, in cities where it maintains offices, as ordered by a physician or officer of the Association (a) at regular hospital rates not to exceed \$50 per week; (b) not to exceed a period of eight weeks for any one sickness or accident, subject otherwise to terms and conditions of this certificate."

Waiting Period Before Hospital Benefit Becomes Operative. Most contracts provide that hospital benefit shall not begin until the fifteenth day following the issuance of the contract.

Ambulance Service. Contracts include ambulance service within city limits, or within a certain distance of the hospital to which or from which insured may be transported.

Maternity Care. Contracts usually exclude maternity care, but make the special condition that after two years of continuous membership on part of both husband and wife, maternity care will be provided.

Dental Care. Contracts provide for a semi-annual examination and cleansing of teeth, but include no dental work beyond this.

Optical Care. Annual examination and "treatment" of eyes are included as benefits. Apparently this does not include cost of new glasses.

Types of Medical Care Excluded. The contracts analyzed exclude medical, surgical and hospital treatment in connection with occupational accidents already covered under the California Workmen's Compensation Act; rest cure in a sanitarium; treatment for venereal disease; obstetrics (except when both husband and wife have been members for 2 years); "diseases not common to both sexes"; dentistry; injuries self-inflicted, or due to temporary insanity. One contract excludes treatment for "injuries received while participating in aeronautics."

Organization for Furnishing Medical Care. None of these six medical benefit corporations has its own clinic or hospital. A list of approved hospitals is given the insured member. Upon entering the hospital he is supposed immediately to notify the concern

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

in which he is insured. As far as our information goes, only one of the medical benefit corporations mentioned above has its own staff of full-time employed physicians. Ordinarily, a list of "approved" dentists, physicians and pharmacists, is maintained.

Procedure by Which Member Gets Medical Care. Contracts usually provide for a special identification card to be given the member. In the case of illness or non-occupational injury, he is supposed to call in an "approved" physician. The identification card serves as authorization to the latter to render his bill to the medical benefit corporation. In case of emergency, any licensed physician may be called for the first treatment. After that, the member must utilize an "approved" physician.

Remuneration of Physicians, Dentists, Pharmacists, and Hospitals. The usual practice appears to be for the practitioner or hospital to render a bill to the medical benefit corporation. One concern states specifically: "Doctors are not paid a salary or hired by the year or month. They are paid for each visit they make. We pay them for calls at their office or at the client's home, according to the compensation rates as made by the State of California."

NEWSPAPER MEDICAL INSURANCE

A recent development is a special agreement worked out between one of the larger medical benefit corporations and a Los Angeles newspaper. As an inducement to become subscribers, readers of the newspaper are offered the services of the medical service corporation at reduced rates. A year's subscription to the paper, and \$1 registration fee, makes the reader a member of the "League". He may choose either of two services. Under Service No. 1, he and all members of his family are entitled to receive, at special reduced rates, the medical, surgical and hospital service provided by the medical corporation; under Service No. 2, the member himself, by payment of \$1.35 per month (a reduction on the regular monthly rate) is entitled to complete service without further charge. If the member ceases to be a subscriber to the newspaper, his dues automatically increase to

MISCELLANEOUS FIXED PAYMENT MEDICAL PLANS

\$1.80 per month; if he is using Service No. 1, he and his family are no longer entitled to the special reduced rates for services rendered by the corporation. Each member receives a regular certificate of agreement, or contract, from the medical service corporation, and the medical, surgical and hospital service guaranteed is the same offered to all clients of the corporation.

CONCLUSIONS

In concluding this summary of experiments at present under way with fixed payment medical service in urban places, it may not be out of place to examine them critically from the standpoint of insurance. The essence of insurance is risk, and any insurance contract involves an undertaking on the part of one party, called the insurer (or carrier) to pay a sum of money (or its equivalent in goods or services) to another party, called the insured, in the event of the happening of the contingency insured against, called the risk, or hazard. In the case of commercial accident and health insurance, the contract can be carried out by the payment of a stipulated sum of money. In other words, the risk is quantitative. Thus, a policy of health insurance ordinarily undertakes to pay to the insured a certain amount of money for a certain number of weeks, in case he is incapacitated by a cause covered by the policy. Where the policy includes medical or hospital benefit, the undertaking is to pay to the insured a stipulated sum of money in case he has incurred expense in connection with any one of several specified ailments. The difference between ordinary health and accident insurance and employers' liability insurance is that under the latter there is an undertaking on the part of the insurance carrier to provide the amount and kind of medical, surgical and hospital care to which an injured employee is entitled under the workmen's compensation law of his state. In other words, the risk under this type of insurance contract is qualitative. The same thing is true of the types of medical and hospital insurance which have been discussed in this chapter. It is plain, therefore, that for these forms of insurance to be successful, they must be based on

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

adequate experience with respect to the frequency and duration of illnesses of different kinds. Such data are at present meager. Data as to costs of treating various types of illness are, of course, indispensable. Such data, to be reliable, must in turn be based on adequate cost accounting systems, both in hospitals and in the offices of private practitioners. Such accounting systems do not as yet exist. Among the useful data which the experimental plans of private group clinics, community health associations and non-profit community hospitals could yield are figures as to costs of various kinds of illness under different types of medical and hospital treatment. A certain degree of standardization of fees for medical and hospital service is also essential to the successful operation of any insurance scheme. Some progress in this direction has already been made through the working out of what are called "fee schedules" for medical and surgical services in connection with workmen's compensation.

From the foregoing description of fixed payment plans of medical service, the reader will have noted that in any insurance plan there are two distinct functions: (1) the function of risk carrying; (2) the function of providing medical service. In the case of the private group clinics and the non-profit community hospitals, both functions are discharged by the same organization. In the case of the community health associations and medical benefit corporations, the risk is carried by one organization and the medical service is provided by another. In these two types of medical service plan, the medical practitioners and hospitals may demand remuneration from the association or corporation on the regular basis of payment for a specific service rendered.

The question arises from a consideration of the plans of fixed payment service offered by private group clinics and community hospitals, whether it is wise for the medical service organization to also assume the insurance risk. The Judicial Council of the American Medical Association has recently voiced apprehension on this score in the following language: "The members of the Judicial Council doubt that it is wise to lead the people in any community to believe that all necessary medical and hospital service, even though chronic diseases and obstetrical care be excepted, can be

MISCELLANEOUS FIXED PAYMENT MEDICAL PLANS

provided for the average family at \$35 a year. In the cases presented to it the Judicial Council has advised against adoption of such plans by community hospitals because it is believed they are not economically sound, in that they may be unfavorably affected by conditions entirely beyond control, under which contracts cannot be fulfilled."

The significance of the combination of group medical practice with group purchase on a fixed payment basis cannot be overestimated. The group principle of medical organization is here to stay; and if a satisfactory basis for providing medical treatment on the insurance principle can be developed out of experiments which several private group clinics have under way at present, a wide extension of fixed payment service may follow. Hitherto, the unwillingness of the medical practitioners to undertake the provision of service on a "contract" basis has been an obstacle to the development of medical insurance. With an increasing number of physicians and surgeons voluntarily adopting the group principle of organization, the way is now open for organized groups of would-be purchasers of medical service, e.g., employee mutual benefit associations, local trade unions, etc., to approach organized groups of medical practitioners with a view to some mutually satisfactory arrangement for the group purchase of medical care on the insurance basis.

Since this chapter was written, information has been received that in Dallas the Methodist Hospital has instituted an insurance plan similar to that of Baylor Hospital. The major difference is that whereas Baylor Hospital contracts directly with employee groups, the Methodist Hospital provides service under an agreement with the National Hospitalization System, a business organization which solicits the contracts, collects the fixed periodic payments and pays the hospital. Of the annual membership fee of \$9, the System retains \$3. About 4,000 members were under contract on March 31, 1932. It is reported that a similar plan has recently been instituted by the System in hospitals in Fort Worth, Texas, Louisville, Ky., and Shreveport, La.

In Rockford, Ill., we learn that a hospital association, similar to the one in Brattleboro, Vt., has been in operation for some years.

In Little Rock, Ark., Trinity Hospital and Clinic has agreements with groups of employees to furnish complete medical and hospital care for \$2 per month per member. House calls are charged extra. Six weeks is the maximum of hospitalization allowed.

CHAPTER XI

MEDICAL AND HOSPITAL BENEFITS PROVIDED UNDER COMMERCIAL ACCIDENT AND HEALTH INSURANCE POLICIES ¹

THE title of this chapter indicates its limitations. It does not aim to be a comprehensive survey of the field of commercial accident and health insurance in the United States. As emphasized in the first chapter, this study is concerned with plans by which individuals and groups in the United States make certain of medical care in case it is needed, by arranging with some institution or organization to provide such service, in consideration of the payment of a fixed amount periodically. And it will be recalled that the plans of group medical service discussed in preceding chapters made no provision for the payment of a monetary benefit to replace the regular income lost by the disabled person.

On the other hand, a health insurance contract which in addition to making a partial indemnification to the insured for loss of regular income, makes him a special payment available only in the event that he has incurred expense for medical or hospital care, is obviously a direct means of insuring against medical expense. The essential difference between the plans which provide medical service "in kind" and those which provide a benefit in money, applicable to meeting the expense of medical care, is that the former undertakes an indefinite responsibility and the latter a very definite one. In the case of the group medical service plans, it is impossible for any one to say in advance how much the cost will be of any given case of sickness. In the case of commercial health and accident insurance the underwriting company does

¹ This chapter was prepared by William H. Wandel.

COMMERCIAL ACCIDENT AND HEALTH INSURANCE

not concern itself with the question of medical care as such. It states in its contract clearly and unequivocally that in the event that the insured incurs expense for such and such a type of disease or surgical operation, it will pay him such and such an amount of money.

To the extent that commercial health insurance policies in force in the United States provide medical, surgical or hospital benefits, even though payable in money and not provided in kind, they are a form of medical insurance as distinguished from income protection. This is the only aspect of commercial health and accident insurance in the United States that is of concern in connection with this study. However, it will undoubtedly be easier for the reader to appreciate the limited scope and extent of medical benefits provided by commercial health and accident policies in the United States, if he is first given a brief exposition of health and accident insurance in general.

Accident and health insurance is defined as a contract by means of which one party, called the insurer, agrees for a consideration to pay another party, the insured, a specified sum upon the occurrence of death, dismemberment, or disability resulting from accident or sickness. The contract is one for the payment of money benefits and is not for service, medical or other. The primary purpose of accident and health insurance is to protect income against expenses incident to the usual accident or sickness. The benefits payable under the policy may be limited to one or more types of loss, such as loss of life, or dismemberment; it may be limited to one or more causes or means of loss, such as specified accidents or disease. The amount of the indemnity may be payable in a lump sum, for loss of life or dismemberment, or as a weekly indemnity, for disability.

HISTORY OF DISABILITY INSURANCE

Commercial health insurance was first written in the United States in 1847. In 1850, limited accident coverage was added to

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

the health contracts. The beginning of general accident insurance is usually associated with the formation of the Travelers Insurance Company in 1863. After a short period of uncertainty this line grew to considerable proportions. In 1898, companies writing accident insurance introduced a clause permitting the payment of weekly indemnity for disability resulting from certain specified diseases. By 1903 the coverage had been extended to all diseases except rheumatism, tuberculosis and insanity, and by 1910 the common practice was to cover all diseases.

In 1896, life insurance companies, under the stimulus of competition, began also to add to their contracts a clause providing for a waiver of premiums in the event of the total and permanent disability of the assured. This clause was soon after broadened to permit the payment of the face value of the policy in installments in such a contingency. Later, in 1916, it reached its present form, under which, in addition to the waiver of premiums, a monthly indemnity of a certain percentage, usually one per cent, of the face value of the policy is assured, and the value of the policy is not impaired thereby.²

Until 1915, commercial accident and health insurance had been written only on a one-year term, and was cancellable at any time by the company upon the return of the unearned premium, calculated on a pro-rata basis. This precaution on the part of the insurer was thought to be necessary because of the high "moral" hazard which exists. However, in 1915, the non-cancellable policy was introduced.³ This form, requiring a medical examination and a higher premium than the regular commercial form, is not subject to cancellation except for non-payment of premiums or the attainment of age sixty or sixty-five, the usual age limits. The premium, too, is not subject to change during the life of the policy. This step, in view of the uncertain losses in this field and the absence of usable underwriting experience was, from the standpoint of the companies, a radical one.

² Morris, E. B., *The Permanent Total Disability Provision in Life Insurance*, Proceedings, Casualty Actuarial Society, XV, No. 31.

³ Knight, cited above, p. 351.

COMMERCIAL ACCIDENT AND HEALTH INSURANCE

Before workmen's compensation laws were passed in this country a form known as "workmen's collective" insurance was sold, protecting the employee against loss caused by occupational accidents. The workmen's compensation laws made compulsory the insurance of accidents arising out of employment, but group coverage since 1911 has been extended to cover non-occupational accidents and all sickness. The importance of such insurance arises out of the fact that large industrial groups are offered coverage at a low rate.

TYPES OF INSURERS

The types of companies offering accident and health insurance are three: Life insurance companies, casualty insurance companies, and fraternal and benefit associations. Life and casualty companies are organized for profit but may be profit-sharing—that is, may be participating or non-participating. The largest life companies are participating; the largest casualty companies are not.

The table on page 256 gives some indication of the aggregate accident and health benefits paid in the United States in 1930. Strict accuracy cannot be claimed for the figures, but the fault of the picture lies in under rather than in over-statement. It will be noted that 80 per cent of the benefits were paid by commercial companies; the premiums collected by these companies would constitute a somewhat larger proportion.

Between 1923 and 1930, premiums on accident and health insurance collected by mutual and stock companies increased from \$89,786,825 to \$154,560,370.⁴

Eighty-eight per cent of the mutual business is done by two companies, 73 per cent by one company.

APPLICATION, PREMIUM PAYMENT AND CLAIM PROCEDURE

The application for accident and health insurance is important; since it is for the company the basis of the underwriting, and for the applicant the basis of the validity of the contract. The

⁴ *Best's Casualty Report, 1931.*

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

ACCIDENT AND HEALTH INSURANCE IN THE UNITED STATES

1930			
<i>Type of Insurer</i>	<i>Number</i>	<i>Assets</i>	<i>Benefits Paid</i>
Commercial Companies		\$21,413,084,493	\$164,218,647
Life—A & H contracts.....	26	7,294,045,220	31,531,380
Life contracts:			
a. Permanent & Total Disability..	183 }		52,045,606
b. Accidental death	132 }	19,583,059,068	24,823,961
Casualty		1,830,025,425	55,817,700
Fraternal Societies:			
Sickness and Accident.....	73 }		7,162,487
Permanent Disability	86 }	753,318,841	4,878,932
Mutual Accident Assns.	125	25,890,039	24,418,111
Sick Benefit Assns.	31	13,660,911	4,766,965
TOTAL		\$22,205,954,284	\$205,445,142

Sources: Spectator Year Book, 1931.
 Best's Casualty Report, 1931.
 The Consolidated Chart, 1931.

questions and statements may be classified under three heads: identification, exposure to hazard, and physical condition of the applicant. For the non-medical forms a medical examination is also required.

CLASSES OF PUBLIC SOLICITED

The classes of the general public approached by insurance salesmen depend upon the cost of coverage. General, or so-called commercial, accident and health insurance is limited for the most part to the business and professional classes. Restricted accident policies are sold to any group. Industrial accident and health insurance, sold on a weekly or monthly premium basis, is available to the lower wage groups, but the coverage is restricted and limited and its cost relatively high because of the expense of collection. Group accident and health insurance is available generally to groups of over 50 because the method of writing this form permits a low rate and because the employer usually bears a portion of the premium.

Certain classes of the population are in practice not solicited for accident and health insurance: those under age eighteen or over age fifty-five or sixty; women, for a large number of forms; occupational groups subject to more than ordinary hazard.

COMMERCIAL ACCIDENT AND HEALTH INSURANCE

Accident and health insurance is usually sold on the basis of a one-year term, and is cancellable at any time by the company upon the return of the unearned premium, but without prejudice to any claim made for disability occurring before cancellation. At the end of the one-year term the company may signify its willingness to continue carrying the risk, at the same or at an altered rate, by sending to the insured a renewal slip; the term is extended another year by the payment of the premium by the insured. There may be no postponement or temporary exemption of payment of premium.

Under the non-cancellable forms, the policy is continued at a uniform rate until the insured reaches a specified age, usually sixty, unless premiums are not paid. A grace period of thirty-one days is allowed, following the due date of premium, during which the premium may be paid. In some policies reinstatement within six months after lapse is permitted if satisfactory evidence of insurability is given.

In the event of disability, three reports are required: first, a report of the injury or sickness itself, which is to be made within ten days of the occurrence or commencement of the cause of disability; second, a report on the physical condition of the insured; and third, a report on the amount of the claim. Forms for such reports are supplied by the local agent and notice to the local agent is considered to be notice to the company.

RATES

Ratemaking in accident insurance and ratemaking in health insurance are quite distinct. In accident insurance the main distinction drawn between risks is that of occupation. This is based partly on actual experience and partly upon underwriting judgment. Not much reliance has yet been placed in the former factor because of the limited extent to which experience has been compiled. This is largely due to the lack of uniformity as to bases of exposure, and the consequent impossibility of combining experience.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

For the determination of rates for accident insurance the occupation of the applicant has major importance. Occupations are divided into ten classifications according to their hazards, the most hazardous requiring a premium six times that of the least. Standard policies are not issued to any but the "Select and Preferred," the "Extra Preferred," and the "Ordinary" risks. The higher ratings are used only to make adjustments in the event that the insured changes occupations. Such an adjustment would determine the amount of benefits purchased under the second rating by the amount of the premium paid for the original rating.⁵ Industrial policies may be issued to occupations as high as "Extra Hazardous," but these are naturally not as liberal as the standard policies.

About sixty per cent of the accident insurance premium is for the weekly indemnity, forty per cent for the principal sum benefits.⁶

In general, for health or sickness insurance, the rates do not vary according to the occupation. The general practice is to use standard rates for Select, Preferred, Extra Preferred, and Ordinary classes, and a rate 30 per cent higher for the more hazardous occupations.⁷

THE MEDICAL BENEFIT CLAUSES

Medical benefits in accident and health insurance are limited to the provisions of money benefits for certain medical expenses: hospital and nurses' fees, operation fees, and doctors' bills. In no instance is direct medical service supplied.

Medical benefits in accident and health insurance are relatively unimportant. Just how unimportant is clear from a consideration of the amount of the claims for medical benefits. In health insurance, the benefits paid under the four clauses amount to approximately 10 per cent of the total benefits paid, or between 5 and 6

⁵ Laird, J. M., *Personal Accident and Health Insurance, Transactions, Actuarial Society of America*, XXIII, p. 373.

⁶ Craig, J. D., *The Actuarial Basis for Premiums and Reserves in Personal Accident and Health Insurance, Proceedings, Casualty Actuarial Society*, XVII, No. 35 (Nov. 1930), p. 55.

⁷ Craig, J. D., cited above, p. 56.

COMMERCIAL ACCIDENT AND HEALTH INSURANCE

per cent of the premiums earned.⁸ In accident insurance, these benefits are approximately 3 per cent of the total benefits paid.⁹

Of the four clauses assuring medical benefits, the two paying surgical operation fees and hospital fees require the bulk of the medical payments, the former accounting for almost half of the total. In health insurance, the total of doctor's and nurse's fees is not over 15 per cent of the total medical benefits. In accident insurance the amount paid for doctors' fees is larger than that under the health policies. In a study made by the Committee on Statistics of the Bureau of Personal Accident and Health Underwriters on an exposure of 400,000 years of male lives under health policies, for the combined policy-years 1924, 1925, and 1926, the following relative cost as to the medical benefits was discovered:

<i>Kind of Benefit</i>	<i>Per cent of Total</i>
Surgical	49.6
Medical Treatment	5.4
Hospital	38.6
Nurse's Fees	6.4

Medical benefit clauses may be divided into two general classes: those which are the chief feature of limited policies and those which are incidental to other benefits in general accident and health policies.¹⁰

In the unsettled and unstandardized state of accident and health insurance underwriting and market conditions, each company issues a multitude of policies, often for no other reason than that competing companies have put into practice certain ideas of their own as to coverage and sales appeal. Thus it has come about that there are a few scattered examples of policies designed to give primarily a medical benefit. These policies are in no sense

⁸ The Committee on Statistics of the Bureau of Personal Accident and Health Underwriters reports 10.2%; Laird, *opus cit.*, p. 377, notes that sickness medical benefits are considered to be 15% of the total claim payments.

⁹ Laird, J. M., *Personal Accident and Health Insurance, Transactions*, Actuarial Society of America, XXIII, p. 374.

¹⁰ In California, contracts are made by associations (incorporated for profit) with private individuals for the sole purpose of assuring medical care. Such contracts are, however, quite outside the conventional field of accident and health insurance. See Chapter X.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

important in insurance, very few being issued. An example pays a weekly indemnity for the cost of sanatorium or hospital care, for the cost of the services of a graduate nurse, if there is no confinement to a hospital or sanatorium; and surgeon's fees for amounts specified in a schedule and ranging from \$10 to \$200, according to the seriousness of the operation, from any cause except self-inflicted injuries, alcoholism, drugs or drug addiction or child-birth. The premiums for such a policy are as follows:

<i>Weekly Payment</i>	<i>Limit to Total Payment</i>	<i>Annual Premium</i>
\$75	\$1,500	\$37.50
50	1,000	25.00
25	500	12.50

Another policy would pay simply hospital benefits for a period not exceeding thirteen weeks for hospitalization for any cause except alcoholism, drug habit, insanity, mental or venereal disease, or child-birth. It would not limit the number of times the hospital was entered or reentered and it could be extended to include all members of the family at the following rates:

<i>Weekly Payment to Hospital for each Individual</i>	<i>Annual Premium per Person</i>	
	<i>Adults</i>	<i>Children under 16</i>
\$70	\$22	\$11
55	18	9
40	14	7
30	10	5
25	8	4

There is no provision in any of these policies to pay a cash benefit for loss of income.

Medical benefit clauses appear in practically all commercial and non-cancellable accident and health policies as well as in some other forms. In general these clauses are four:

1. *Hospital indemnity* may be paid if the insured is confined to a hospital as a result of an injury or sickness covered in the policy. The amount of the hospital indemnity is based upon the weekly income indemnity, ranging from 25 to 100 per cent of that amount. The period for which this special benefit may be

COMMERCIAL ACCIDENT AND HEALTH INSURANCE

paid is invariably limited, the most liberal policies paying twenty weeks, the least liberal ten weeks. The benefit is *in addition* to the income indemnity.

The provision assuring the payment of hospital indemnity is a fairly standard one, the only distinction of importance being that which in some provisions limits the amount of the hospital indemnity to the actual hospital expense incurred, while other provisions permit the payment of the hospital benefit regardless of actual expenses.

2. *Nurse's fees* may be paid *in lieu* of the hospital benefit. The amount of such benefit and the period for which it may be paid are exactly the same as for the hospital benefit. The purpose of this provision is to furnish an alternative to those sick and injured who require special care, but who are either unable or unwilling to go to a hospital.

3. *Operation or Surgical Benefits.* These may be allowed in addition to both the income indemnity and the hospital or nurse's benefits. In some policies they are allowed only when hospital benefits are not paid. Only those operations are covered which are mentioned in the policy, but these include the more serious types. Often the indemnity is not payable if the operation is within six months of the date of the policy. The benefits are also definitely named, but are directly proportional to the amount of the policy. An example of a schedule of surgical benefits is given here. Under this schedule, applicable to a policy assuring a weekly indemnity of \$50, the surgical benefit would vary from \$10 to \$200, according to the seriousness of the operation. There is sometimes a limiting provision specifying that the surgical benefit may not exceed the actual expense incurred for the operation.

4. *Physician's fees* are paid in practically all accident policies where no disability is incurred. The amount paid may be equal to the weekly indemnity but is limited to it. While this provision also exists to a limited degree in health as in accident policies, the tendency is to eliminate it in the former. The benefit is paid *in lieu* of all other benefits.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

THE GENERAL COMMERCIAL ACCIDENT AND HEALTH CONTRACT

The four forms of medical benefits as outlined above are most prominent in commercial accident and health contracts. Although the accident and the health policies were originally two separate contracts, they are now commonly combined, and since medical benefits are common to both, the accident and health contracts will be discussed as one policy, even at the risk of some loss of precision.

The general cancellable form of accident and health insurance is the most popular in this field. It is sold with few exceptions by all casualty companies and by those life insurance companies with accident and health departments. The contract is for a one-year term. The advantage of this to the company is that the insurer may change the rate or refuse to renew the policy if the risk shows evidence of becoming an unhealthy one. In addition, the company reserves in these policies the right to cancel at any time upon the return of a pro-rata share of the premium. This precaution is taken to prevent liability in the event that the policyholder comes to be considered an undesirable risk, physically or morally.

The commercial cancellable policy is sold for the most part to the upper income groups. Women are practically excluded because of their higher morbidity rate and because many of them, since they are not actually producing income, are not in a position to suffer a loss of income through disability. Hazardous risks are also excluded. Examples of those thus excluded are: actors doing stunt work, aviation pilots, members of athletic teams, sportsmen, firemen, handlers and manufacturers of explosives, electrical workers, gymnasts, spirepainters, and seamen. Students are usually excluded because they are not producing income. Physical disability or impairment is, of course, additional ground for exclusion. Finally, age limits of 16 or 18 and 60 or 65 are set.

The provisions of the cancellable policy are broad. These provisions relate to indemnity for death, from accidents; for dis-

ability, either total or partial, from accident or sickness; and for medical expenses.

Insuring clauses differ in specifying under what conditions the liability of the company may be incurred. One company may use different clauses to define its liability. Thus in some policies the loss due to accidental means or to disease must result from those "directly and independently of all other causes." This expression is to bar losses due to preëxisting causes. It introduces a definite uncertainty as to payment of indemnity to the policyholder. Other clauses merely state that the company insures "against disability while this policy is in force and resulting from bodily injury effected through accidental means; and against disability commencing while this policy is in force and resulting from sickness." Such a provision eliminates question of contributory or indirect causes, and while perhaps from the standpoint of the company it may seem too liberal, it gives a desirable certainty to the assured.

In defining disability due to accidental means, additional restrictive phrases often appear. Often the accidental means must be *external* and *violent* as well. While court decisions have been notably liberal in many cases, holding that death by poisoning or by inhalation of gas was death by external, violent, and accidental means, the court decisions have also been inconsistent and a very definite degree of uncertainty may be said to exist here. But that uncertainty is, of course, extended to a lesser extent to all interpretations of the word accident and accidental means. In general, contributory negligence on the part of the assured will not prevent a recovery, if the hazard to which the individual subjected himself was one which would have been undergone by a man of reasonable and ordinary prudence, and if the accident was in consequence thereof.

The disability benefits may be for either total or partial disability. There is a great variation among policies as to the amount of weekly indemnity and the period for which it will be paid, but in general the period of indemnity for total disability is not longer than 52 weeks, and for partial disability not longer than

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

26 weeks, at a fractional part of the usual weekly indemnity. Under accident provisions, principal sum payments may run from \$1,000 to \$75,000 for loss of life, or for temporary or permanent injuries.

Causes of Disability Excluded from Coverage. Under both the accident and the health provisions, certain causes of disability are excluded from coverage. It has already been noted that there are restrictions on the type of accidents covered, which exist because of the insuring clauses limiting the accidents to those caused exclusively by violent, external and accidental means. Accident clauses also specifically exclude "accident, injury, death, or other loss caused directly or indirectly, wholly or partly, by bodily or mental infirmity, bacterial infections (except pyrogenic infections which shall occur with and through an accidental cut or wound), or any other kind of disease." Injuries sustained in an act of war are also often excluded. Other common exclusions are injuries caused by driving an automobile in a speed test,

Rate for Typical Accident Policy

Principal Sum	\$5,000
Weekly Indemnity	25
Total Disability—52 weeks and subsequent indefinite period if assured cannot follow any occupation.	
Partial Disability—\$10 for a maximum of 26 weeks.	
Surgical operation, surgeon's fees, hospital indemnity and nurse's fees.	

Ages 18-59.

<i>Classification</i>	<i>Premium</i>
A	\$20
B	25
C	30
D	35

Rate for Typical Health Policy

Weekly Indemnity	\$25
Total Disability—If confining, for 52 weeks:	
If not confining, \$12.50 for 52 weeks.	
Surgical operations, hospital indemnity, and/or nurse's fees.	

<i>Age</i>	<i>Premium—All Classes</i>
18—50	\$37.50
51—55	\$55.00

COMMERCIAL ACCIDENT AND HEALTH INSURANCE

or engaging in aeronautics, and disability due to hernia or ptomaine poisoning.

Under the health provisions, that disability is excluded for which the insured has not been treated by a licensed physician, or which is caused by venereal disease. If the insured is a female, exclusion is also made of disability from disease of the organs of generation, or surgical or hospital treatment necessitated thereby, or from illness peculiar to females. Sickness as the result of intoxication and arthritis are often excluded.

NON-CANCELLABLE ACCIDENT AND HEALTH INSURANCE

Of other types of accident and health insurance, the non-cancellable policy most closely approaches in form the commercial general policy described above. Its coverage is usually slightly more limited than that of the commercial policy. Hospital and nurse's fees are the only medical benefits usually found. Its cost is high despite the fact that long waiting periods, sixty and ninety days, have been introduced. Its chief characteristic is, of course, that it is not cancellable by the company except for non-payment of premiums: "The . . . Company agrees that during the term of this policy the sole condition for its continuance shall be the timely payment by the insured of the premiums hereon." In application for this form, a medical examination is required.

Non-cancellable insurance is being sold by relatively few companies and accounted in 1930 for but \$18,166,602 of the total \$154,560,370 premiums written for all accident and health insurance. In 1925, the non-cancellable accident and health insurance written amounted to \$10,087,802. Life insurance companies write the bulk of the business and three of these wrote 79 per cent of the premiums in 1930. This condition exists because of the fact that of all forms of accident and health insurance, the non-cancellable policy has been the least profitable. For the last seven years the stock companies have sustained an underwriting loss in this line of 11.6 per cent of earned premium. The company writ-

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

ing the most of this form does so only on members of the Masonic Order.¹¹

The non-cancellable form, because of the relatively high degree of risk involved, is usually limited to occupational groups which are not at all hazardous and, by its cost, is limited to the upper income groups. An example of the cost of the non-cancellable form follows:

RATES FOR TYPICAL NON-CANCELLABLE ACCIDENT AND HEALTH POLICY

				Monthly Indemnity \$100			
				Total Disability—indemnity for duration of disability.			
				Partial Disability—\$50 monthly benefit for duration of disability.			
				Permanent Disability Benefits.			
				Hospital Indemnity—One-fourth monthly indemnity for three months.			
<i>Select and Preferred Classes</i>							
<i>Age</i>	<i>3 mo.</i>	<i>2 mo.</i>	<i>1 mo.</i>	<i>Age</i>	<i>3 mo.</i>	<i>2 mo.</i>	<i>1 mo.</i>
20	27.00	34.00	48.50	38	39.00	46.50	61.50
21	27.50	34.50	49.00	39	40.00	47.50	62.50
22	28.00	35.00	49.50	40	40.50	48.00	63.50
23	28.50	35.50	50.00	41	41.50	49.50	64.50
24	29.00	36.50	51.00	42	42.50	50.50	66.00
25	29.50	37.00	52.00	43	43.50	51.50	67.00
26	30.50	37.50	52.50	44	44.00	52.50	68.00
27	31.00	38.00	53.00	45	45.00	53.50	69.00
28	31.50	39.00	54.00	46	46.50	54.50	70.50
29	32.00	40.00	55.00	47	47.50	55.50	72.00
30	33.00	40.50	55.50	48	48.50	57.00	73.50
31	33.50	41.50	56.00	49	49.50	58.00	75.00
32	34.50	42.00	56.50	50	51.00	59.50	77.00
33	35.00	42.50	57.50	51	52.00	61.00	78.50
34	36.00	43.50	58.50	52	53.50	62.50	80.50
35	36.50	44.00	59.00	53	55.00	64.00	82.00
36	37.50	45.00	60.00	54	56.50	66.00	84.00
37	38.00	45.50	61.00	55	58.50	67.50	86.00

SCHEDULE OF OPERATIONS—SURGICAL BENEFITS

If the single weekly indemnity for total loss of time payable under this policy is \$50, the amounts named below shall be payable. If such weekly indemnity is greater or less than \$50 the amounts shall be increased or reduced proportionately.

Abscess. Incision	\$ 10
Abdomen. Cutting into abdominal cavity for diagnosis or treatment of organs therein	200

¹¹ *Best's Casualty Report, 1931.*

COMMERCIAL ACCIDENT AND HEALTH INSURANCE

Amputation of	
Entire hand, forearm, or foot	\$ 50
Leg or arm	100
Thigh	150
Finger or fingers	20
Aneurism, Operation for tying of artery	70
Appendicitis. Abdomen	200
Bone. Injuries to or disease of. Removal of diseased portion of bone	50
Cancer of lip. Removal of, by cutting operation	50
Carbuncle. Incision	10
Chest. Cutting into thoracic cavity for diagnosis of treatment of organs therein ...	50
Dislocation. Reduction of	
Hip or knee	70
Shoulder, elbow or ankle	50
Wrist or lower jaw	30
Thumb	20
Fingers	10
Eye, Ear, Nose or Throat. Any cutting operation	20
Eye, Removal	100
Excision. Removal of	
Shoulder or hip joint	200
Knee joint	150
Elbow, wrist or ankle joint	100
Toe or toes	20
Fractures. Reduction of	
Nose, lower jaw, collar bone, or shoulder blade	50
Breast bone or ribs	20
Upper arm	70
Forearm	50
Wrist	50
Hand	30
Fingers	10
Bones of the pelvis (except coccyx)	150
Coccyx	20
Thigh	150
Knee cap or leg	100
Bones of foot	30
Toes	20
Goitre. Cutting operation for permanent cure	150
Gunshot wounds. Treatment of, not necessitating amputation or any cutting operation into the abdominal cavity	30
Hydrocele. Incision and treatment of sac	50
Hydrophobia. Pasteur treatment	100
Inflammation of joint. Incision into joint	50
Intestinal obstruction. See abdomen	
Kidney. See abdomen	
Lockjaw. Injection of antitoxin into skull	200
Injection of antitoxin into spinal canal	100
Mastoiditis. Cutting operation for removal of diseased bone	100
Nerve. Cutting operation for stretching	50

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

Rectum. Operation for radical cure	
Hemorrhoids, external	\$ 30
Hemorrhoids, internal	50
Prolapsed	50
Fistula in ano	40
Malignant stricture	200
Skull. Cutting into cranial cavity	200
Spine or spinal cord. Operation with removal or fracture vertebra	200
Stricture Oesophagus. Cutting operation (external) for permanent cure of	200
Stone in bladder. Removal of, by cutting or crushing operation	150
Tapping of	
Abdomen	50
Bladder	30
Chest	30
Ear Drum	20
Hydrocele	20
Joints	20
Trachea. Cutting into for removal of foreign bodies or for relief of difficult breathing	70
Tumors, Removal of, by cutting operation	
Malignant	100
Benign	30
Varicocele. Cutting operation for permanent cure	50
Veins, varicose. Cutting operation for permanent cure	50
Wounds. Suturing	10

INDUSTRIAL DISABILITY INSURANCE

Industrial disability insurance is sold on a monthly or weekly premium basis, to industrial wage-earners in the more hazardous occupations. Sometimes the premium is paid by an order on the paymaster of the employing company.¹² Although these policies are lower in price than those offered to the upper income groups, they are correspondingly more limited in scope and benefits.

Industrial disability insurance is written by two classes of insurance carriers: (1) the large life insurance companies, and (2) smaller casualty companies.¹³ The coverage offered by these two classes of companies is entirely different. The life insurance companies give with their regular industrial insurance, two benefits in the event of total disability through blindness, loss of both hands or both feet: a paid-up life insurance policy for the full face value,

¹² Mowbray, A. H., *Insurance*. New York, 1930, page 177.

¹³ These companies usually write life insurance as well.

COMMERCIAL ACCIDENT AND HEALTH INSURANCE

and one-half of the face value of the life insurance in cash. With some companies the latter benefit has been extended to the full face value. There is no weekly indemnity, no medical benefit, and as may be suspected, the coverage is extremely limited. Considerably less than 1 per cent of the total claim payments are for these benefits.

The largest life insurance companies selling industrial life insurance furnish free nursing service to their policy-holders. This service is defined by the insurer, and is supplied through nurses' associations with which the insurance company contracts. The nurses' association is remunerated on a fee basis. The service is as extensive as the need of the insured, but is limited to nursing. Such service may be extended to all members of a family.

Smaller casualty companies offer what is primarily an accident and health policy with a little life insurance as a supplementary feature. Eighty per cent of the premium is for the accident and health benefit.¹⁴ These benefits include a weekly indemnity and the payment of the principal sum upon total disability caused by blindness, loss of both hands or both feet. There are no medical benefits, no partial disability benefits. The selling of this form of insurance is limited geographically, with the exception of the city of Philadelphia, to the southern and middle-western states. The fact that this insurance is not sold outside of the South and Middle-West is significant. Most of the companies are Southern and a very large proportion of the business is on negro risks.

The cost of industrial accident and health insurance does not vary with the occupation of the assured but is a flat rate of about 5 cents for each \$1 of weekly indemnity.¹⁵ The benefits are usually small, five dollars a week being common. The death benefit purchased with the 25 cents weekly premium on a \$5 weekly indemnity policy would always be less than \$100, and would decrease in size as the assured becomes older.

¹⁴ Carpenter, R. V. *Industrial Insurance in United States*, New York, 1927, p. 29.

¹⁵ Scherr, J. W. *Twenty-five Years of Industrial Accidents and Health Insurance*, *Weekly Underwriter*, March 25, 1929.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

FRATERNAL INSURANCE

Fraternal accident and sickness insurance is sold in various forms by a large number of societies, such as the Woodmen of the World and the Maccabees. In the 1931 *Consolidated Chart*,¹⁶ 123 societies are listed as having paid either sickness and accident claims or permanent disability claims for a total of \$12,041,419 in 1930. These 123 societies had assets of \$753,318,841.

The types of policies issued by the large national societies are extremely varied. In general, it may be said that the coverage and benefits are restricted, the latter usually being limited to a weekly benefit for total disability for a short time, such as sixteen weeks.

Usually no medical benefits are provided in the contract. However, some of the societies maintain hospitals in which the members are entitled to free treatment. Perhaps the largest is the 300-bed hospital of the Security Benefit Association of Topeka, Kansas. Many other societies maintain tuberculosis sanatoria for the benefit of members who may have contracted that disease while others give to victims of tuberculosis an alternative of a cash benefit or a definite period of free sanatorium treatment. Some societies also give free nursing service to members and their families. This is true on a national scale for the Maccabees and for the Women's Benefit Association. In addition, the Maccabees has a relief fund, supported by one per cent of all premiums collected and out of which payment for medical care for members in need of relief may be made.

In addition to the accident and health insurance offered by national fraternal orders is that given by the local lodges. This is often little more than organized charity. Unfortunately it is not possible to determine to what extent benefits are paid by local lodges. Since the amount of benefits is low and the period of indemnity short, the cost of fraternal insurance is also low, the assessments generally being within the range of 25 cents to \$1 a month.

¹⁶ Published by the *Fraternal Monitor*, Rochester, New York.

COMMERCIAL ACCIDENT AND HEALTH INSURANCE

PERMANENT AND TOTAL DISABILITY CLAUSES IN LIFE INSURANCE

Permanent and total disability clauses in life insurance contracts are probably the most extensive, as far as number of insured persons is concerned, of all forms of accident and health insurance. Such protection is now included in the contracts of over 250 life insurance companies, in conjunction with over \$30,000,000,000 of life insurance. Of the new life contracts issued, about 40 per cent contain this feature. The provision is usually valid until the termination of the policy, or until the insured reaches the age of sixty. The form is a type of non-cancellable coverage. The total amount of benefits paid under the total and permanent disability clause in 1930 was \$52,045,606.¹⁷

Total disability is defined as the incapacity (resulting from bodily injury or disease) to engage in any occupation for remuneration or profit; permanent disability is that incapacity which has been continuous for not less than four months.

GROUP INSURANCE

Group insurance is a plan of personal insurance by which coverage is extended under a blanket policy to the lives of an entire group, the individuals of which are subject to essentially the same hazards. The form is written without medical examination, at a rate lower than that which would be charged for individual insurance, and with the provision that the premium for the entire group shall be collected from one source of responsibility. The protection may be against death, disability, or both. Usually the coverage is not extended to disability unless that of death is also included.

Group insurance is a relatively new form of insurance, the first policy having been written in 1911. Yet in 1931 approximately 6,000,000 wage-earners were covered for not less than

¹⁷ During October 1931, life insurance companies announced that they would no longer write life insurance policies containing the total and permanent disability clause. Waiver of premium during the period of disability will, however, still be included in the contract.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

ten billion dollars of life insurance. Group accident and health insurance covers over 2,000,000 wage-earners. On January 1, 1931, the figures for the ten leading companies writing group life insurance and the seven leading companies writing group disability insurance were as follows:

GROUP LIFE AND GROUP DISABILITY INSURANCE IN FORCE
JANUARY 1, 1931

	<i>Life</i>	<i>Temporary Disability</i>
Number of Policies	19,522	6,150
Number of Lives Covered.....	5,660,067	1,905,000
Insurance in Force.....	\$9,750,212,233 ^a
Weekly Benefits	\$18,359,000

^a The Consolidated Chart gives this figure as \$10,204,534,294.

The companies writing group disability insurance are wholly the large life insurance companies; the practice is to write disability insurance only in conjunction with life insurance. About one-half of the business is done by one company.

Coverage Under Group Policy. The group covered by disability insurance conforms with the statutory requirements made for groups covered by life insurance. The group must be composed of not less than fifty employees of a common employer. If all the premium is paid by the employer the entire group must be included but if the premiums are to be shared with the employees, the group may include not less than 75 per cent of the total number. This form of coverage may be extended to groups of less than fifty individuals, but only at higher rates, and usually with the requirement of a physical examination. The group must be homogeneous in respect to exposure to hazard.¹⁸

The contract is made with the employer and he is responsible for the payment of the premium to the insurer. However, the

¹⁸ Many states which have placed statutory restrictions on the groups which may be covered by group insurance have broadened these requirements to admit labor unions. Many other states have never had any law regulating group insurance. The result is that in all but ten states—Connecticut, Florida, Indiana, Iowa, Minnesota, Nebraska, North Carolina, South Dakota, Washington, and Wisconsin—labor unions as well as groups under one employer have the right to coverage.

COMMERCIAL ACCIDENT AND HEALTH INSURANCE

majority of plans now provide for contributions on the part of the employees. These contributions are effected through payroll deductions with the express consent of the employees. The so-called contributory plans are now favored as being the most likely to foster the interest and appreciation of employees. Employees do not have to make out individual applications. Certificates outlining the coverage are, however, given to each employee.

Only those employees are eligible who are working on full time and pay at the time of the issuance of the contract. For new employees there is a waiting period before they become eligible. There are usually no age restrictions.

The amount of the insurance depends upon the type of policy desired and the purpose of the insurance. There are three chief plans determining the amount of the insurance: length of service, flat sum, and amount of wages. For either of the latter two plans the premium is based on the amount of the weekly benefit, or according to the schedule. If the amount of the weekly benefit is dependent upon the wage, the premium is based upon the payroll.

When the premium is based upon the payroll and the employee receives benefits according to his wage, as soon as he is no longer a full-time worker he is not covered by the group contract. When the insurance is on a schedule basis, the employee is covered during the period for which the premium has been paid, whether or not he is working. As premiums are paid monthly, the employee may be insured for a month after leaving employment.

The Group Insurance Contract. While the group disability contract is usually more simple than the commercial policy, the standard provisions are not required, and quite as varied insuring clauses appear as in other forms of accident and health insurance. Inasmuch as the group disability insurance has as one of its purposes the supplementing of the coverage guaranteed by the workmen's compensation laws, occupational accidents and diseases are usually excluded. However, they may be included for an additional premium with the provision that the total benefits

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

shall not exceed a fixed amount or a certain proportion, say two-thirds, of the employee's wage.

Although from the standpoint of the company, group insurance is term insurance, there is no term expressed in the policy. The insuring company has the right, however, to make periodic adjustments in the rate.

Benefits may have a duration of 13, 26 or 52 weeks, but 26 is the favored number. This period will cover 95 per cent of the actual disabilities. There is usually, too, a waiting period of 3, 7 or 14 days. In many contracts, if the disability lasts over a certain period, say thirty days, benefits will be paid as from the beginning of the disability. When disability occurs the workman need communicate only with his employer, who must report the case within ten days to the insurance company.

The excluded injuries and sicknesses found in commercial accident and health insurance are also found here: (1) injuries sustained or sickness contracted outside the continental limits of the United States or Canada or any part of either north of a certain degree or latitude, (2) injuries or sickness caused directly or indirectly by war or riot, or by any act of war, or while participating in or in consequence of having participated in aeronautics, (3) disability for which the injured employee is not treated by a physician, (4) self-inflicted injuries, and (5) sickness or diseases peculiar to women.

There are no medical benefits in group accident and health insurance. It is to be noted here, however, that some large life insurance companies give, in conjunction with their group life policies, a nursing service to all group life policy-holders. Inasmuch as the group disability policy-holders are usually also group life policy-holders, they are also the beneficiaries of this service. This service is in every respect similar to that given to industrial policy-holders. The agency actually administering it is the nurses' association which is engaged by contract by the insurance company.

No provision is made for partial disability. The reason for this is that partial disability seldom exists. A professional or busi-

COMMERCIAL ACCIDENT AND HEALTH INSURANCE

ness man may be able to perform only part of his duties; an industrial worker must be quite able-bodied to retake his place as a worker.

Generally, policies are written only for employees working or living in healthful surroundings, but for an additional premium even the following hazardous occupational groups may be included: lead workers, pottery employees, felt workers, furriers, tannery employees, those engaged in dusty trades, or in those processes using arsenic, mercury, wood alcohol, benzol, carbon bisulphide, aniline dyes, fuming acids, or poisonous gases.

To make more evident the exact field of group disability insurance, it is well to contrast it with that of workmen's compensation. Group disability insurance provides for non-occupational diseases and accidents, while workmen's compensation applies only to occupational accidents and, to a limited extent, to occupational disease. Group insurance is voluntary, while workmen's compensation is compulsory for most industries. In most cases the employee contributes to the premium payment for group disability insurance. This is illegal for workmen's compensation in most states. There are no medical benefits in group disability insurance; in workmen's compensation primary emphasis is placed on full medical, surgical and hospital service, which is given to the employee often beyond the time and money maxima specified in workmen's compensation acts.

Rates. The rates for group insurance vary according to the type of benefit secured. Below are given typical rates for both the schedule and payroll forms, the former being the rate for each \$10 of weekly benefit, the latter the rate for \$100 of payroll:

PREMIUM RATES FOR GROUP INSURANCE

A. Schedule			
Rate per \$10 of Weekly Benefit			
Waiting Period	Maximum Number of Weeks Payable		
	13	26	52
3 days	\$9.72	\$11.63	\$13.11
7 "	8.15	9.99	11.43
14 "	6.17	7.87	9.27

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

PREMIUM RATES FOR GROUP INSURANCE—Continued

B. Payroll

Rate per \$100 of Payroll

Weekly Indemnity	Three-day Waiting Period			Seven-day Waiting Period			Fourteen-day Waiting Period		
	Maximum No. of Weeks Payable								
	13	26	52	13	26	52	13	26	52
50%	.93	1.12	1.26	.78	.96	1.10	.59	.76	.89
55%	1.03	1.23	1.39	.86	1.06	1.21	.65	.83	.98
60%	1.12	1.34	1.51	.94	1.15	1.32	.71	.91	1.07
65%	1.22	1.45	1.64	1.02	1.25	1.43	.77	.98	1.16
66⅔%	1.25	1.49	1.68	1.04	1.28	1.47	.79	1.01	1.19

The above are minimum rates and may be increased after an investigation of the living and working conditions of the group, or if more than 10 per cent of the group are women. The following are the standard percentage increases for the latter contingency.

EXTRA RATES FOR FEMALES

Percentage of Females	Increase in Rate
11-20	15%
21-30	25%
31-40	35%
41-50	45%
51-60	55%
61-70	65%
71-80	75%
81-90	85%
91	95%

Permanent and Total Disability Clause. There may be in the group life insurance contract, as there is in the ordinary individual life insurance contract, a permanent and total disability clause. This clause grants in the event of permanent and total disability before age 60, a waiver of premiums and either the amount of the insurance paid in a lump sum at the end of six months of disability, or the payment of the face value of the policy in installments over a period of five years.

The newest plan is that by which the group covered is a trade union, the premiums being paid wholly or partly by an

COMMERCIAL ACCIDENT AND HEALTH INSURANCE

employees' association, and benefits extended to include indemnity for disability and for old age. Such an arrangement was first made in 1926. Since then several have been completed, these being almost wholly in the field of public service and street railways. The greatest progress, however, has been made by the International Brotherhood of Electrical Workers. The locals of this union have established plans in New York, St. Louis, Baltimore, Chicago, Cleveland, Denver, Kansas City (Missouri), Pittsburgh, Tulsa, and San Antonio.¹⁹

The provisions of the New York plan are generally followed.²⁰ Under it, all members of the local union are covered and the individual does not lose his benefits by changing from one employer to another unless he goes beyond the jurisdiction of the union. The benefits are \$3000 in life insurance, the assurance of a pension of \$40 a month upon the attainment of age 65, and the assurance of a monthly benefit of \$30 for permanent and total disability, this latter benefit to be deducted from the amount of life insurance. In New York the employers pay to a Board of Insurance Trustees of the Electrical Industry of New York, on which there are one union and four employer representatives, a flat rate of \$.20 for each hour worked by each employec. The fund created by these payments has been sufficient to pay the insurance premiums, and to create a reserve so generous that definite action has been taken to reduce the hourly rate of contribution from 20 cents to 17½ cents.

Permanent and total disability is construed under this plan to mean incapacity to work for six months. Thereafter, the monthly benefit of \$30 is paid but, as noted, the amount of these payments is deducted from the life insurance. While the employee must, on leaving the union or the industry, give up his life insurance, if he is over 65 his pension is secure; should he be younger, he may, upon application within 31 days after leaving the union, convert his annuity coverage to an individual annuity contract.

¹⁹ In St. Louis the disability payment is \$40; in Chicago the life insurance is for \$5000 and the disability payment is \$65. The other plans are reported to follow that of New York.

²⁰ *Monthly Labor Review*, February 1930, p. 10; November, 1930, p. 105.

CHAPTER XII

INDUSTRIAL ESTABLISHMENT MUTUAL BENEFIT ASSOCIATIONS PROVIDING MEDICAL AND HOSPITAL CARE

EMPLOYEE mutual benefit associations are of comparatively long standing in American industry. The movement began as a substitute for "passing the hat" at times when disabling illness or accident to the breadwinner threatened to impoverish his family. The enactment of workmen's compensation laws in all but four states of the Union and the consequent transfer to the employer of the burden of indemnification for loss of earning power due to industrial injury, has tended to limit the insurance function of the employee benefit association to indemnification for loss of earnings due to ordinary sickness, or an injury not entitling the employee to compensation under the state law. This type of sick benefit association resembles in principle commercial health and accident insurance, the chief differences between the two types being, of course, that the former operates with no view to profit. The employee mutual benefit associations are less formally organized, are not required to maintain reserves, and in general do not come under the supervision of state insurance departments. Payment of a fixed amount for funeral expenses is also included as a benefit in many employee associations. The cost of the protection against sickness is met out of membership dues.

Data as to the costs, benefits paid in cash, and methods of management of establishment benefit associations were brought together by the United States Bureau of Labor Statistics in 1928, and published in *Bulletin No. 491, Handbook of Labor Statistics*, 1929 edition. The study covered 430 companies engaged in manufacturing or in commercial or transportation enterprises, but

EMPLOYEE MUTUAL BENEFIT ASSOCIATIONS

included only those benefit associations which received some financial support from the employer. Of the 430 establishments, 214 reported having employee benefit associations. One hundred and forty of these establishments were in manufacturing, 10 were in mining companies, 6 in offices, 3 in steam railroads, 8 in electric railroads, 13 in gas, electric and telephone and telegraph companies, 31 in mercantile establishments. Other industries accounted for 3 associations.

Of the 214 establishments having associations, 177 reported total employees numbering 993,252. Seventy-six per cent of these employees, or 758,067, were members of the establishment mutual benefit association. In many associations, there is a period varying from two weeks to a year after the beginning of employment, before an employee is eligible to membership.

Fifty-six associations reported that an initiation fee was charged. These fees varied from 25 cents to \$2, the usual fee being \$1, and in addition to the entrance fee, many of the associations charged a fee of \$1 or \$2 to cover the cost of the physical examination. Dues charged varied according to the proportion of the expense paid by the employer, and the amount of the weekly benefits. In nearly half of the associations, however, the dues ranged between 25 cents and 75 cents per month, while in 81 cases the dues varied according to benefits, but in general kept within these limits.

DISABILITY BENEFITS

Disability benefits in most cases cover both sickness and accident, but usually exclude cases of sickness or injury which entitle the employee to payments under the workmen's compensation laws of the different states. Since most of these laws do not provide for payments for the first week or the first two weeks of disability, the plans frequently provide for payments for the period intervening between the date of injury and the date of the first payment of workmen's compensation benefit. In a few cases, however, employees are paid for disability occurring as the result of employment. Eighteen of the benefit associations paid sick and

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

disability benefits of under \$7 per week; 36 paid \$7 and under \$10; 45 paid \$10 and over; and 88 paid varying sums per week.

Of the companies reporting, 31 stated that membership was either compulsory or that employees were expected to join the association. In some plants membership in the association is automatic, that is, employees become members as soon as employed. One hundred and nine of the associations reported some financial assistance from the employing corporation.

Membership in these societies, especially in the larger ones, was frequently conditioned on passing a physical examination, in which case the examination was given by a physician especially employed for this purpose, or the employee might choose one of several designated.

The management of the benefit associations was participated in largely by employees, except in those cases where the funds were financed entirely by the companies. Many of the associations were managed by the employees alone, while some stipulated that one or more of the offices should be held by company officials. In large plants with many departments it was usual to divide the representation among the different departments so that there would be equality of representation in the management of the association.

In 27 of the societies members were entitled to receive benefits as soon as their application for membership is approved, while 40 had a waiting period of four weeks, 5 of two months, 11 of three months, and 2 of six months. In the remaining 18 cases, the period varied from 3 to 15 days, or was fixed for the first day of the month following admission to membership. In a few cases, although there was a waiting period for sick benefits, employees were eligible for accident relief at once, and several associations required a longer period of membership before death benefits were paid, than for sick and accident benefits.

The necessity of guarding against the feigning of sickness or the making of slight illness an excuse to be absent from work is undoubtedly the reason why so large a proportion of the associations do not pay from the beginning of sickness. Many of the

EMPLOYEE MUTUAL BENEFIT ASSOCIATIONS

associations which provide for a waiting period in cases of sickness pay from the date of injury in accident cases, since the risk of malingering in cases of injury is generally not so great. Of 143 associations reporting on the number of days intervening between the beginning of the disability and the payment of benefits, 92 pay after six to eight days' disability; 6 pay from the first; 18 pay after the third day, 6 pay after four or five days, and only one waits as long as ten days, while a number pay from the first if the disability lasts a stated length of time.

The maximum time for which benefits are paid in any twelve months varies greatly. Twenty associations pay for ten weeks, 45 for three months, 34 for six months, 9 for one year, and 29 for various fractions of a year, while 7 pay for various periods according to length of service. Eight associations report that benefits are paid for more than one year; in 5 of these the length of time is unlimited.

MEDICAL AND SURGICAL CARE

The report of the Bureau of Labor Statistics stated that "in addition to the cash benefits which are the principal features of the benefit funds, a number of the associations do constructive work in promoting healthful conditions among employees, and in furnishing medical and hospital care for them. These services include, in addition to medical and surgical care, treatment by specialists, including X-rays, and various necessary laboratory tests, and nursing service." However, the report from which the above extracts have been taken did not indicate how many of the 214 establishment funds provided medical or hospital benefit.

A study made in 1916 by Edgar Sydenstricker, an investigator connected with the United States Public Health Service, indicated that fifteen years ago the provision of medical, surgical and hospital care was not a benefit of more than a small proportion of the employee mutual benefit associations.¹ On the subject of medical benefit Mr. Sydenstricker's report said as follows:

¹ *Existing Agencies for Health Insurance in the United States*, by Edgar Sydenstricker, Report of Conference on Social Insurance held in Washington, December 1916. Bureau of Labor Statistics Bulletin No. 212, June 1917.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

“Establishment Sick Benefit Funds. Regular employment of physicians by the funds was rare. In only 64 out of 390 funds, or less than 17 per cent, were physicians regularly employed for all or part of their time. The employment of physicians was apparently more frequent in funds jointly supported or supported entirely by employers than in funds supported entirely by employees. Nearly 30 per cent of the former had regularly employed physicians as against less than 10 per cent of the latter. Twelve of the 64 funds having physicians were enabled to do so by the presence of ‘company doctors’ whose services to the fund constituted part or all of the employer’s financial contribution, and 26 were funds which were jointly or entirely supported by employers. In some of the remaining 26 funds supported entirely by employees, the employer participated in the management. It appears safe to say that in the great majority of instances, fund physicians are regularly employed only where the employers have some part in the control and management of the fund.

“So far as present information indicates, the employment of physicians does not imply medical service in every instance. It appears to be true that the medical service of at least some of these physicians is limited. In only 6 of the 390 funds included in this preliminary survey was medical service specified as one of the benefits. The use of the company hospital was provided for in 13 funds, and provisions for other hospital care were made in 12 funds. Medical and surgical supplies were provided in 12 of the funds, which also provided hospital service. In 3 funds the services of physicians were provided to members at reduced rates.

“Medical or hospital service of any kind thus appears to be provided in only a small proportion of establishment funds. Defining medical and hospital service in terms of broadest latitude, the statement may be ventured that in less than a fourth of the establishment funds so far considered are there benefits of this kind, and that the great majority of funds supplying such service are among those partly or wholly supported and controlled by the employees.”

EMPLOYEE MUTUAL BENEFIT ASSOCIATIONS

MUTUAL RELIEF ASSOCIATIONS AMONG GOVERNMENT EMPLOYEES IN WASHINGTON, D. C.

Associations organized for the purpose of paying cash benefits in case of sickness and death have existed in various federal government departments in Washington for many years. The Bureau of Labor Statistics made a survey of these mutual relief associations in 1920, and published its findings as *Bulletin No. 282* (February 1921, Washington, D. C.). Eighty associations, with a total membership of 23,171 employees, were found, distributed among 16 departments or branches of the government service as follows: the Navy Yard, 28 associations; the Government Printing Office, 23; the Bureau of Engraving, 11; the city Post Office, 16; the remaining 12 associations were scattered among 12 other departments.

Fifty of the associations paid sick benefit only, 14 paid death benefit only, and 16 paid both.

The associations paying sick benefits only were the first to be organized, the earliest of these dating back to 1883.

Benefits consisted of a certain amount, ranging from \$10 to \$30 paid weekly for a fixed period (6 to 10 weeks) to members disabled by accident or sickness. In a few of the associations, if the disabled member was entitled to compensation under the Federal employees workmen's compensation act of 1916, no benefit was paid until payments under the act ceased.

Members who drew no sick benefit during the fiscal year of the association, received a dividend pro rated from surplus funds at the close of the year.

The membership dues in a majority of the 50 sick benefit associations were \$1 per month. In a few instances, where there was more than one class of membership, the dues ranged from \$1 to \$3. All associations required the payment of an initiation fee, usually of \$1.

Membership was limited generally as to color, age, sex, occupation, and length of service. The total membership of the 50

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

associations (7,949 on November 30, 1919) was made up very largely of white males.

Forty-six of the 50 associations made complete reports as to receipts, benefits paid, and amount available as dividends, for the fiscal year ending November 30, 1919. The total receipts of these 46 for the year were \$100,296.16. Of this amount, 46 per cent (\$46,289) was paid out as sick benefits, 50 per cent (\$50,129.93) as dividends. The remaining 4 per cent (\$3,876.61) was used for salaries, rent, printing and other expenses.

The 16 organizations which paid both sick and death benefits differed very little in general features from those paying sick benefits only. These 16 associations reported for the year studied (ending November 30, 1919) a total membership of 6,726 persons. Monthly dues ranged from 25 cents to \$2 per month (usually \$1); initiation fees, from 50 cents to \$2. Fourteen of these societies used the assessment method of accumulating the fund from which death benefits were paid. All 16 of these societies submitted figures for the year studied. The total receipts were \$79,248.46; expended on sick benefits, \$32,286.65; on death benefits, \$10,452.78. The amount available for distribution as dividends (12 associations reporting) was \$17,895.

Inquiry of the Bureau of Labor Statistics brings the reply that no revision has been made of Bulletin 282, the material not having been brought up to date.

"The Government Employees' Mutual Relief Association" deserves special mention, because it differed in various ways from the other government employees' societies. This association was organized in 1905 especially to take care of field men in the Reclamation Service, the Geological Survey, and the Forest Service. Later, the Coast and Geodetic Survey, General Land Office, Indian Service, Bureau of Mines, and other similar Bureaus were added.

Funds were accumulated by means of initiation fees (\$1), and dues of \$12 per year. A reserve fund of \$5000 was always maintained.

EMPLOYEE MUTUAL BENEFIT ASSOCIATIONS

Benefits paid were divided into three classes, as follows: (1) Loss of time, \$14 per week, maximum \$150 in any 12 months. (2) Medical attention: doctors' fees up to \$28 per week, or surgical treatment on a fixed schedule basis; medicine, up to \$5 per week; hire of nurse, \$25 per week; hospital expense, up to \$15 per week; further amounts up to \$50 at discretion of governing board; total payment in any 12 months, \$300. (3) Death benefits, \$200, plus actual cost of transportation of body, not exceeding \$100.

A Director of the National Bureau, Dr. Elwood Mead, Commissioner of the Bureau of Reclamation of the Department of the Interior, has kindly given the following account of the "Government Employees' Mutual Relief Association," so far as the field employees of his Bureau were concerned. Dr. Mead writes:

"For many years the Bureau of Reclamation carried on a plan of fixed payment for medical and surgical services for its field employees. This was almost a necessity in the early stages of the work of the Bureau because construction was, as a rule, carried on in remote and more or less inaccessible regions of the country, many miles distant from towns and not within easy access of physicians or hospitals. In these early days it was the practice of the Bureau to take a dollar a month from the pay of each employee to cover the cost of a small hospital and the services of either contract or civil service physicians. Later, as the projects developed and towns and cities grew up on or adjacent to the irrigated land, it became the policy of the Bureau to discontinue the services of both civil service and contract physicians and to utilize the services of local physicians and surgeons.

"In 1920 it was found necessary to increase the deduction from the pay of the employees to the rate of \$1.50 a month and this rate was continued until December 31, 1925, when the hospital fund was discontinued owing to an adverse ruling by the Comptroller General. Under the arrangements adopted by the Bureau, medical, surgical and hospital treatment was provided for field employees in all cases of sickness except chronic or venereal dis-

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

eases or those resulting from alcoholism, and for the treatment of injuries whether received on the work or not, except such as were the result of neglect, misconduct, or alcoholism, and such as did not come within the provisions of the Employees' Compensation Act of September 7, 1916, which, in general, covers only accidents received on the work. A large degree of latitude was given employees in the choice of physicians, but it was the policy that, other things being equal, the Service should, as in the purchase of any other service or commodity, take advantage of the lowest rates offered by reputable physicians. In other words, in localities where there was a fixed scale of charges by all reputable physicians, the employees were given free choice of physicians. In localities where the charges of certain physicians were much higher than those of others whose services would be entirely satisfactory, the choice was limited to the latter. The regulations provided for furnishing an artificial limb or limbs at a cost not to exceed \$250 per limb, without, however, the right of renewal. Similarly, an artificial eye might be furnished an injured employee at a cost not to exceed \$15. Trusses were furnished for slight cases of hernia where the employee did not feel the need for a radical operation. Burial expenses in the locality, including the cost of a local burial lot, embalming, casket, and other actual and necessary expenses, were limited to a total sum of \$200.

"One of the interesting features of the operation of the hospital fund was the inoculation of 4,000 employees with typhoid prophylactic, this treatment being furnished free of charge to all employees paying hospital fees."

MEDICAL CARE RARELY PROVIDED BY EMPLOYEE ASSOCIATIONS

In the hope of learning whether there had been any increase in the proportion of industrial establishment sick benefit funds and associations providing medical and hospital treatment to members, the National Bureau made an inquiry of its own. Not having the names of the 214 establishment funds and associations covered by the report of the Bureau of Labor Statistics (Bulletin

EMPLOYEE MUTUAL BENEFIT ASSOCIATIONS

491), a selection was made of 986 leading corporations in various industries, and letters were addressed to them asking for information. The following table shows that out of 353 corporations replying, 164 had no employee mutual benefit associations. Of the 189 mutual benefit associations, 43 either paid for or provided some kind of medical service.²

INDUSTRY	Total No. of Corporations Reporting	Corporations Reporting No Sick Benefit Fund	Corporations Reporting Sick Benefit Fund		
			Total	Paying Cash Benefits for Loss of Earnings Only	Providing or Paying for Medical Care
Manufacturing	248	113	135	110	25
Retail Trade	49	17	32	26	6
Public Utilities	37	16	21	10	11 *
Insurance	19	18	1	..	1
Total	353	164	189	146	43

* The Employee Mutual Benefit Association of Milwaukee, calling itself "an industrial fraternal union, embracing all crafts and open to all physically capable workers," provides medical treatment to members as a membership benefit, but is not included in this number. This organization has exclusive labor contracts with the Milwaukee Electric Railway and Light Company, the Wisconsin Gas and Electric Company, and the Wisconsin Michigan Power Company. A description of medical benefits provided by this Association is given in Chapter XIII (Trade Unions).

At first glance the proportion of sick benefit funds providing some kind of medical or hospital benefit in addition to regular cash disability benefits may appear relatively high. Because of the small size of the sample, no such generalization is justified, and the data submitted should be taken only as illustration of the

² Public Health Reports (U. S. Public Health Service, Washington) for September 4, 1931, has an article entitled *A Survey of the Work of Employees' Mutual Benefit Associations*. The National Conference on Mutual Benefit Associations sent out a questionnaire to 1,500 companies in the United States thought to have employees' organizations for sickness insurance. Out of 602 companies that replied up to April 1, 1931, 223 reported no form of mutual benefit association. Twenty-seven others reported that the association had been discontinued. Twenty-three other companies had never had a sick-benefit society, but were purchasing sickness insurance for their employees from life insurance companies. Fourteen companies had relief plans financed entirely by the corporation. The remaining 315 had employee sick benefit associations of the type considered in this chapter.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

scope of medical benefits provided by a small number of establishment sick benefit funds.

NATURE OF MEDICAL BENEFITS PROVIDED

Of the 43 establishment sick benefit associations or funds providing a medical or hospital benefit in addition to regular cash benefits, 28 provided a monetary benefit to help the member defray expense actually incurred by him for medical or hospital care, and 15 actually provided some form of medical or hospital treatment "in kind." Of the 28 associations providing a monetary medical benefit, 12 reimbursed the member for the expense of both doctor's services and hospital care; 14 reimbursed him for hospital expense only; 2 reimbursed him for doctor's fees only. In a few instances, the employee benefit association designated the physicians who were to provide service, and the hospitals to which the member was to go for care. Generally, however, these employee associations left the member complete freedom of choice as to physician, surgeon or hospital. On the other hand, the benefit association usually limited definitely the amount of its financial obligation to the member for medical, surgical or hospital expense incurred by him.

In most instances, this limitation of liability on the part of the sick benefit fund is fixed by establishing a maximum amount payable for physicians' and surgeons' fees. In the case of hospital benefit, the limit may be a fixed amount of money, a fixed hospital rate per diem or per week, or a certain number of days' care in the hospital. The following typical definitions of financial liability for hospital benefit will illustrate: "Maximum, 3 weeks, or \$63"; "\$24.50 per week"; "maximum, \$147"; "\$25 per week, maximum \$150"; "eight weeks at ward rate"; "\$2.50 per day, maximum \$100"; "maximum \$375 for both medical and hospital service"; "ward rate"; "\$3 per day, maximum \$30"; "maximum \$50"; "semi-private room"; "fifty per cent of hospital fee, not over \$25 per week." In one sick benefit fund, the medical benefit applied only in case of a non-compensable accident, not in case of

EMPLOYEE MUTUAL BENEFIT ASSOCIATIONS

sickness. Another fund provided a monetary benefit for dental treatment (maximum, \$25 in any one year) and one for optical treatment (maximum, \$7.50 in any one year).

Of the 15 establishment sick benefit associations which assumed direct responsibility for providing medical, surgical or hospital care, one offered complete medical, surgical and hospital treatment through a salaried medical staff, in a hospital owned by the corporation with which the benefit association was connected. Another sick benefit association, connected with a public utility company in Texas, reported that it had a contract with a local private group clinic to provide members with such medical, surgical and hospital care as the clinic would ordinarily offer to individual patients. Out of the association fund created by the dues of the members, the clinic received a fixed amount per member per month. An employees' beneficial association connected with a lumber company in Washington State has a contract with an incorporated hospital association to provide complete medical, surgical and hospital care to members, in return for a fixed amount per member per month, deducted from wages by the employer and paid over to the association.

An example of a comprehensive medical service plan fostered by an employee group is the Stanocola Employees' Medical and Hospital Association, (employees of the Standard Oil Company of Louisiana, at Baton Rouge). The Association owns a completely equipped clinic, and employs seven full-time practitioners who render complete medical service to 2,700 members and their families. The service includes professional treatment at the clinic, house calls, and hospital care in local non-profit hospitals in Baton Rouge. All types of illness and injury are covered. Those coming under the provisions of the Louisiana Workmen's Compensation Law are of course paid for by the employer. For non-compensable cases a maximum expenditure of \$250 for hospital or special nursing care in any one case is allowed. Hospital care for maternity cases is paid for only when specially ordered by the attending physician. The dues are \$3 per month for each employee member, this amount being deducted from wages by the

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

company at the request of the employee, and turned over to the Association. Membership is voluntary, and approximately 75 per cent of the white employees belong. Recently, groups of employees of other industries in the community have requested permission to join the Association, but this privilege has not so far been extended. However, outside persons may avail themselves of the services of the physicians of the clinic as private patients on a regular fee basis.

The remaining 11 sick benefit funds did not concern themselves with providing hospital care to members, undertaking only to provide ordinary medical treatment, through physicians engaged by the association either on a salary, or a fixed fee basis. As far as can be judged from the data received, the medical service offered by these 11 establishment funds was only such as a general practitioner could give in his office or at the home of the member. In a few instances, the physician engaged by the employee association was also the plant physician engaged to provide medical and surgical care to employees injured in the course of employment and entitled to medical aid and compensation under the workmen's compensation law.

From available data it is not feasible to make any estimate of the approximate number of wage earners in the United States enrolled as members of establishment sick benefit funds or associations. It follows that no estimate can be attempted of the number of industrial employees entitled to some kind of medical, surgical or hospital care by virtue of their membership in such funds or associations. The conclusion appears to be justified, however, that employee sick benefit funds play a relatively unimportant rôle in providing medical care to the people of the United States on an insurance basis.

CHAPTER XIII

TRADE UNION SICK BENEFIT FUNDS PROVIDING MEDICAL AND HOSPITAL CARE

THE number of American trade union members who secure medical, surgical or hospital care as a benefit of their membership in local or national unions, is negligible.

A careful canvass of national and international trade unions resulted in the discovery of only six plans by which local unions undertake to provide actual medical or hospital care to members disabled by sickness or non-industrial injury. One of these plans has already been described in Chapter V, in the section devoted to Wyoming. It will be recalled that in the bituminous coal mining industry of that state, the annual wage agreement between the United Mine Workers of America (District No. 22) and the coal operators, includes an arrangement whereby employers and employees contribute to a fund out of which the cost of medical service is paid. The service is administered by a joint committee in each company.

Another miners' union plan is also described in Chapter IV in the section devoted to Colorado. Silverton Miners' Union No. 26, affiliated with the International Union of Mine, Mill, and Smelter Workers, owns and operates the Silverton Miners' Union Hospital, at Silverton, Colorado. Each member of the union pays \$1.50 per month to the hospital, by means of an authorized payroll deduction, for non-compensation medical service. The Company adds 75 cents for each man, which pays for service for industrial injury cases.

The other four union organizations providing medical service to members on a group basis are as follows:

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

1. New York Letter Carriers' Association, Empire Branch, No. 36, New York City.
2. Employees' Mutual Benefit Association, Milwaukee. This is an "Industrial Fraternal Union" having exclusive labor contracts with public utility companies operating in Milwaukee and environs.
3. Women's Local, Bureau of Engraving and Printing, Washington, D. C.
4. The Union Labor Benefit League, Los Angeles, California. This is a trade union organization having affiliated with it many Los Angeles local unions, whose members may secure medical, surgical and hospital service for themselves and their dependents by payment of a special monthly fee in addition to regular union dues.

These four plans will be discussed in some detail.

New York Letter Carriers' Association, Empire Branch, No. 36. This local union reports a total membership of 4,035 regular and substitute letter carriers employed in the New York City Post Offices who are eligible to receive the benefits of the association, in return for payment of dues of \$6 per annum. The scope of the medical care, and the nature of the arrangements entered into by the local union in order to provide medical care to members, are as follows: Five physicians are employed by the association to examine applicants for membership and to provide medical care for members residing in the Borough of Manhattan, one in the Bronx, one in Brooklyn, and one in Queens. Each physician receives a salary of \$600 per annum, with the exception of the physician for the Borough of the Bronx, who receives \$700 per annum, making a total amount of \$3,100 per annum paid out in salaries. In addition, each physician receives \$1 for each applicant for membership examined. Members may call at the office of one of these physicians at any time for consultation or treatment or may call the physician to visit them at their homes if unable to appear at the office. This service, however, does not include major operations. Hospitalization, including necessary operation

TRADE UNION SICK BENEFIT FUNDS

and ward care is provided free of charge in five hospitals: St. Luke's, Presbyterian, Mt. Sinai, St. Vincent's, and Beth Israel. With the exception of one, beds in these hospitals have been endowed to this association by charitable friends of the letter carrier. As members of the Central Trades and Labor Council of Greater New York and vicinity, and by reason of donations the New York Letter Carriers' Association has made to the Medford Tuberculosis Sanitarium and the Union Health and Dental Center, its members are entitled to medical care at cost in these institutions.

Employees' Mutual Benefit Association of Milwaukee. As already pointed out, this association is in reality a trade union organization. Among the benefits offered are the following: Periodic health examinations; sick benefits (cash); dental service at cost; hospital benefit (cash); additional health, sickness, accident and life insurance at cost; free medical and surgical service for members and their dependent families; old age pensions; collective bargaining for wages, hours and conditions of labor; services of association nurse and advisory secretary; educational courses and recreational activities. The medical, surgical and hospital benefits may be summarized as follows:

Treatment (exclusive of the cost of prescriptions) by an Association physician, or a designated physician, at home, or at any hospital to which the member may be removed by order or with the approval of the Medical Director of the Association or an Association physician, during disability not due to compensable accident. The usual exceptions are made as to venereal disease, fighting, etc. The services of specialists are not included under the term "medical attendance." Attendance upon obstetrical cases for married female members and wives of members is a part of the service.

Members receiving necessary hospital care for a non-compensable disability are paid a hospital benefit of \$2 per day (maximum 100 days in any one year) for all days during which

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

they were receiving and paying for care in a hospital or sanatorium approved by the Medical Director of the Association.

Dental service is provided at cost.

Nursing care by Association nurses is provided in serious illness and obstetrical cases. "Confidential" health examinations may be had by members, on voluntary application.

Cash sick benefits of \$1 per day (maximum 200 days) during non-compensable disability, and a death benefit of \$300 are also included in the regular benefit plan of the Association.

The city and its environs is divided into districts, with an Association physician in each district. During the day, a member in need of medical service notifies his foreman or department head, who will call the Association doctor. If he cannot be reached, the Association Medical Department is called. During the night, the member calls his district physician direct, or a special night service call number may be used. Each member is furnished with a list of Association physicians and instructions for securing medical attendance in ordinary or in emergency cases. Members may call at Association physician's offices at any time during regular office hours, for advice and treatment.

Women's Local Union, Bureau of Engraving and Printing, Washington, D. C. This local organization looks after its sick members through a hospital guild. All members of the union in good standing are eligible to belong to the guild. On January 8, 1931, the guild membership was approximately 200. The membership fee is \$1, the dues \$4 per year. In return for this contribution the member is entitled to three weeks' care in a semi-private (2-bed) room at a certain Washington hospital. The guild pays the hospital a lump sum of \$700 per year, to cover service which the hospital may be called upon to render to members. No extra payment is made, even if additional service is required during the course of the year. No physical examination is required for membership in the guild. This union also pays sick and death benefits and carries group life insurance for its members. A monthly fee of \$1 (separate from the optional

TRADE UNION SICK BENEFIT FUNDS

contribution of \$4 per year to the hospital guild) covers this insurance.

Union Labor Benefit League, Los Angeles. According to a printed descriptive pamphlet received by the National Bureau, the Union Labor Benefit League is a voluntary, non-profit organization composed of members of trade union locals in Los Angeles and vicinity. It is organized for the purpose of "protecting trade unionists and dependent members of their families against undue suffering from sickness or injury." It is maintained, and all its services are rendered to its members, through a fund accumulated by payment of membership dues, and on that basis it proposes to be self-supporting.

The medical benefits offered members may be very briefly stated as follows: Medical care in the home, and at central medical offices; major and minor surgery; ear, nose, and throat specialist care; obstetrical service; clinical laboratory service; dental service when needed in conjunction with treatment for sickness; hospital care (after 90 days' membership); medico-legal service; other special benefits.

The foregoing services are stated to be rendered by "ethical, qualified, reputable physicians, surgeons, dentists and hospitals."

The formal arrangement by which the services are rendered is as follows: Each trade union local desiring to affiliate with the League accepts by vote of the members, a "Resolution-Agreement" which provides that all the medical benefits, described in brief above, shall be secured through the "National Protective Society, a non-profit corporation." Each member of the local who subscribes for the service agrees to pay the Society \$1.50 per month, and the financial secretary of the local is authorized to collect this amount each month from each subscribing member, and pay it over to the National Protective Society.

The resolution further authorizes officials of the locals to urge every new member to subscribe at the time of initiation; it also allows the National Protective Society the privilege of canceling the service after six months, on thirty days' notice; and finally,

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

the resolution states that every member of the local who subscribes for the services of the National Protective Society "automatically subscribes to and accepts the Constitution and By-Laws of the Union Labor Benefit League."

Further inquiry brings out that the National Protective Society is a non-profit corporation, organized for the purpose of providing medical, surgical and hospital care to large groups of individuals and their dependents, for a stipulated sum per month. The "membership" is limited to industrial workers. All services are rendered by designated physicians, surgeons, dentists and hospitals.

While the Union Labor Benefit League pamphlet indicates that the plan is on a group basis, the actual agreement is between the individual member and the National Protective Society, as indicated on the subscription card, which reads as follows:

To Union Labor Benefit League:

As a member in good standing of (Name and Number of Local)I hereby subscribe for the medical, surgical, dental, and hospital services of National Protective Society, to be rendered to myself and dependent members of my family as specified in the Resolution-Agreement of the Union Labor Benefit League as of May 10, 1930. Receipt and acceptance of its terms I hereby acknowledge.

Please list the following as dependent members of my family who are to participate in the benefits through my membership:

Name Relation..... Age.....
.....
Signed
Address..... City.....

The Union Labor Benefit League medical service plan went into operation on January 1, 1930. On October 1, 1931, there were approximately 3,400 contributing members (exclusive of dependents), and the total amount received in dues from the inauguration of the plan was \$106,394. The total expenditures over the same period for medical, surgical and hospital service was approximately \$136,640; the number of separate claims paid was 28,000, averaging \$4.88 each.

TRADE UNION SICK BENEFIT FUNDS

The scarcity in the United States of trade union plans which undertake to provide actual medical and hospital service to members does not imply that trade union sick benefit schemes do not play a relatively important rôle, along with industrial establishment sick benefit funds, fraternal societies, and commercial health and accident insurance companies, in protecting the worker's income against loss caused by sickness and accident.

In 1927-28 an investigation of the beneficial activities of American trade unions was made by the Bureau of Labor Statistics.¹ Of 96 American unions of nation-wide scope, the Bureau of Labor Statistics secured data from 78. Of this number, 63 were found paying benefits for death, 14 for disability, 12 for sickness. Eight unions were reported paying tuberculosis benefit or providing for institutional treatment of tubercular members. Two union organizations were found that maintain tuberculosis sanatoria in connection with their homes for the aged. In several instances, local unions affiliated with national unions paid sick benefit, thus providing additional protection to members desiring it.

In a majority of the sick benefit funds studied by the Bureau of Labor Statistics, all members in good standing are entitled to benefits by virtue of their membership in the organization, the cost being covered by the general trade union dues. In some cases, as for instance where insurance is provided by the union, the member may be required to take this protection, paying an additional amount to cover the cost.

Sick benefits paid by national and international unions varied from \$4 to \$10 per week, \$5 being the most common amount. The benefit period ranged from seven to sixteen weeks, thirteen weeks being the most common period.

Several national labor organizations have an insurance plan by which members may take out insurance covering death, accident, or sickness, or all of these, instead of, or in addition to, the regular union sick benefits. In the majority of unions from which

¹ *Beneficial Activities of American Trade Unions*, Bulletin 465, Bureau of Labor Statistics, Washington, September, 1928.

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

data were secured, the insurance is written by a special insurance department of the union; in some cases, especially where group insurance is carried, this is secured from one of the two general union insurance companies—the Union Coöperative Insurance Association, organized by the International Brotherhood of Electrical Workers in 1924, or the Union Labor Life Insurance Company, organized by the American Federation of Labor in 1925. Both of these companies sell individual and group life insurance but no health or accident insurance.

AMOUNT OF TRADE UNION DISABILITY BENEFITS

In the report of the proceedings of the fiftieth annual convention of the American Federation of Labor (1930), under the heading "Benefit Services of National and International Unions," the following figures are given for sick and disability benefits paid out by affiliated unions and the four (unaffiliated) railroad Brotherhoods:

Sick Benefits	1928	\$2,377,746
	1929	2,831,936
Disability Benefits	1928	3,825,578
	1929	2,707,187

The report states that "in a few instances, these benefits include those paid by local unions affiliated with the national and international unions. However, in many instances, our national unions have no figures showing such payments. If it were possible to include all such payments, the total figures appearing here would undoubtedly be doubled."

The distribution by unions of the total of \$2,831,936 expended in 1929 for sick benefits by the various national and international unions and the four Brotherhoods, is given in the table on page 299.

It should be noted, however, that of the above total, \$2,548,394, or over 90 per cent, was expended by ten organizations, and that three of the railroad Brotherhoods together accounted for

TRADE UNION SICK BENEFIT FUNDS

AMOUNT OF SICK BENEFITS PAID BY NATIONAL AND INTERNATIONAL TRADE UNIONS, 1929

Engineers, Brotherhood of Locomotive	\$ 97,232.89
Firemen & Enginemen, Brotherhood of Locomotive	859,267.58 ^a
Railroad Trainmen, Brotherhood of	513,111.23
Bakery & Confectionery Workers, Intl. Union of America	124,803.13
Barbers', Journeymen Intl. Union	235,249.55
Blacksmiths, Drop Forgers & Helpers, Intl. Broth. of	14,000.00
Boot and Shoe Workers' Union	57,756.78
Brick and Clay Workers of America, United	4,600.00
Carpenters & Joiners of America, United Broth. of	100,000.00
Clerks, Post Office, Natl. Federation of	51,961.74
Cloth Hat, Cap & Millinery Workers Intl. Union	5,304.00
Diamond Workers Protective Union of America	4,092.00
Engineers, Intl. Union of Operating	21,400.00
Intl. Photo Engravers Union of North America	29,012.50
Firemen & Oilers, Intl. Broth. of Stationary	12,685.00
Garment Workers Union, Intl. Ladies	17,084.50
Glass Bottle Blowers Assn. of the U. S. & Canada	4,500.00
Laundry Workers, Intl. Union	3,987.00
Leather Workers, United, Intl. Union	800.00
Letter Carriers, Natl. Assn. of	165,163.12 ^b
Mine, Mill & Smelter Workers, Intl. Union of	11,909.46
Molders Union of North America, Intl.	167,983.50
Pattern Makers League of North America	7,053.12
Plumbers & Steamfitters of the U. S. & Canada	161,010.00
Potters, Natl. Broth. of Operative	7,947.76
Quarry Workers, Intl. Union of North America	362.70
Railway Employees, A.A.A. of Street & Electric	124,576.10
Seamen's Union of America, Intl.	9,977.91
Sailors Union of America, Journeymen	13,029.00
Tobacco Workers Intl. Union	2,464.00
Wall Paper Crafts of North America, United	599.00
Wire Weavers Protective Assn., American	1,200.00
Total	\$2,831,936.82

^a Includes payments for disability and tuberculosis.

^b Includes disability benefits.

\$1,469,610, or 51.8 per cent of the total; further, the total amount reported by the Brotherhood of Railroad Firemen and Enginemen, namely, \$859,267, was for the care of members suffering from tuberculosis. In two other instances the total amounts reported include sums paid out to members as indemnification for total or partial disability. The total amount paid out for sickness benefit is thus considerably reduced.

No data are available (except as above) as to the total amounts

MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT

paid out by local unions in the United States in monetary benefits for sickness. The weekly benefits paid, and the number of weeks during which benefits are paid by local union sick benefit funds, conform, in general, to the plans of the national funds.

The relatively few American trade unions which have sickness insurance funds have in general confined their benefits to the payment of cash indemnity to cover loss of regular earnings. One international labor organization which goes beyond this to the extent of paying an additional monetary benefit to help the member defray the expense of medical care in case he has undergone an operation is the Brotherhood of Locomotive Engineers. Through the Locomotive Engineers' Mutual Life and Accident Insurance Association, this union offers life, indemnity and sickness insurance. Sick benefits provide an allowance of two weeks' benefit in the event a surgical operation is performed, and an additional three weeks' benefit for hospital care in the event the insured member is confined in a hospital for 21 days or longer. If he is confined in a hospital less than 21 days he is allowed hospital benefit for the actual number of days so confined. Surgical and hospital benefits are paid in addition to the regular weekly benefits. The Order of Railway Conductors, the Brotherhood of Locomotive Firemen and Enginemen, and the Order of Railway Mail Clerks, offer accident insurance only. Many of the local lodges affiliated with the national railroad brotherhoods provide limited monetary benefits to members to apply on the expense of hospital care necessitated by an injury or sickness arising outside the line of duty, and for which the railroad company does not assume responsibility. The reader will recall that many of the trunk-line railroad systems of the United States have employee hospital associations, membership in the association assuring the employee of hospital care arising out of "duty" or "non-duty" injury or sickness. These employee hospital associations are not officially connected with national or local railroad unions.

Note. The Union Health Center, New York. This institution is not considered in detail in this report because it operates on the coöperative, rather than the insurance, principle.

TRADE UNION SICK BENEFIT FUNDS

According to its report for 1930, "The Union Health Center is a self-paying non-profit organization. Fees from \$1 to \$1.50 are charged members of affiliated unions and an additional small charge is made members of non-affiliated unions. Unemployed members of affiliated unions get free treatment at the request of the secretaries of their unions. Indigent persons, regardless of affiliation, are treated free, time and space permitting."

The Center states that its aim "is to give health information to and spread health education among workers and to render medical and dental services to members of organized labor and their families, at rates conforming to their incomes." The facilities of the Union Health Center are open to all members of organized labor, and a number of additional labor organizations have become affiliated with it. Many unions demand a medical certificate from every applicant for membership. These medical certificates are given after a thorough physical examination in the Union Health Center. The Union Health Center also has charge of the certification for cash sick benefits of members of those unions that have sickness insurance. Its district physicians are sent to the homes of those who are sick and unable to work. This service is either at the expense of the union, or it is given without charge. The Health Center physicians give treatment only when no other physician is in attendance. Diagnosis and certification for tuberculosis benefit are also given by the Union Health Center. General and special clinics are regularly held at the Center.

At the Health Center's own pharmacy, prescriptions are compounded for sums ranging from 25 to 50 cents each. Insulin and other drugs are sold at minimum rates.

The dental department of the Union Health Center is the largest industrial clinic in New York. It aims to provide honest work at reasonable charges to those most in need of it.

An official of the Center states that it would be willing to undertake the provision of medical care to members of affiliated unions, on an insurance basis. Presumably, the local union making the arrangement would offer to its members medical care by the physicians of the Health Center as a special benefit, in consideration of an additional monthly fee paid to the local union. (See, for example, the Union Labor Benefit League, Los Angeles, page 295.) The Center would be remunerated for its services to individual members by the union, not by the member. As late as November 1, 1931, however, no such plan was in operation.

TOPICAL INDEX

A.

- Accident and health insurance (American), 252-277.
- Alabama, coal and iron mining industry:
 - medical service for employees;
 - hospital contract system and workmen's compensation medical aid, 157.
- American Association for Labor Legislation, 34-57.
- American campaign for compulsory sickness insurance, 1914-1920, 34-57.
- Appalachian coal mining industry:
 - medical service for employees;
 - company doctor and hospital contract system in:
 - Pennsylvania, 141;
 - Ohio, 144;
 - West Virginia, 156, 165-192;
 - Virginia, 148;
 - Kentucky, 151;
 - Tennessee, 156;
 - Alabama, 156.
- Arizona metal mining industry:
 - employee medical service, workmen's compensation, 102-105.
- Arkansas bauxite and coal mining industries:
 - employee medical service in, 129;
 - no workmen's compensation law in, 133.

B.

- Bauxite mining industry, Arkansas, employee medical service in, 133.
- Baylor University Hospital, Dallas, Texas, hospital insurance plan, 236.
- Brandeis, Justice Louis D., plea for "workingmen's insurance," 1911, 35.
- Brattleboro, Vt., Community hospital insurance plan, 227.

C.

- California:
 - employer hospitals, 88;
 - medical benefit corporations, 244;
 - workmen's compensation, 88;
 - investigation of compulsory sickness insurance, 1916, 46.
- Coal mining industry:
 - employee medical service in:
 - Washington, 69;
 - Wyoming, 113;
 - Colorado, 117;
 - Utah, 121;
 - Montana, 123;
 - Michigan, 125;
 - Illinois, 125;
 - Indiana, 126;
 - Kansas, 128;
 - Oklahoma, 129;
 - Missouri, 129;

TOPICAL INDEX

- Coal mining industry,
employee medical service in—
continued
Arkansas, 129;
Pennsylvania, 141;
Ohio, 144;
West Virginia, 146, 165-192;
Virginia, 148;
Kentucky, 151;
Tennessee, 156;
Alabama, 156.
- Colorado:
employee medical service in metal
mining industry, 105;
in coal mining industry, 117;
hospital contract system, 120;
workmen's compensation, 97.
- Commercial accident and health in-
surance, 252-277.
- Community health associations:
hospital insurance plans: Brattle-
boro, Vt., 227; New Bed-
ford, Mass., 232.
- Community hospital insurance plans:
Baylor University Hospital, Dal-
las, Tex., 236;
Grinnell, Ia., 237;
Roanoke Rapids, N. C., 239;
Rockford, Ill., 251.
- Compulsory sickness insurance:
European systems, 1, 2, 35;
unsuccessful American campaign
for, 1914-1920, 26, 34-57.
- Connecticut:
investigation into compulsory
sickness insurance, 1917, 50.
- Contract medical practice:
attitude of medical profession
toward:
continued
Washington, 73;
Oregon, 85;
West Virginia, 183-185.
American Medical Association
definition of, 30.
- Cooperstown, N. Y., community
hospital insurance project (foot-
note), 227.
- Copper mining industry:
company doctor and hospital con-
tract system:
Arizona, 102;
Idaho, 98;
Michigan, 138;
Montana, 99;
Nevada, 100;
New Mexico, 105;
Utah, 106.
- D.
- Dallas, Texas, Baylor University
hospital insurance scheme, 236.
- E.
- Employee mutual benefit associa-
tions, 278-290.
- Employee mutual benefit associa-
tion (trade union), Milwaukee,
Wis., 293-295.
- F.
- Fraternal sickness insurance, 270.
- G.
- Georgia, textile industry, employee
health and medical service, 18-20.
- Grinnell, Iowa, community hospital
insurance plan, 237-239.

TOPICAL INDEX

- Group clinics, 220-226.
 Group disability insurance, 271-277.
 Group industrial accident insurance
 (under workmen's compensa-
 tion laws), 268-269.
- H.
- Health insurance:
 commercial, 252-277.
 compulsory:
 European systems of, 1, 2, 35;
 unsuccessful American cam-
 paign for, 1914-1920, 26,
 34-57;
 prospects of enactment by
 American states, 26.
 Hospital associations (incorporated):
 Oregon, 80-86;
 Washington, 64-68.
 Hospital insurance plans:
 Brattleboro, Vt., 227;
 Dallas, Tex., 236;
 Grinnell, Ia., 237;
 New Bedford, Mass., 232;
 Roanoke Rapids, N. C., 239;
 Rockford, Ill., 251.
- I.
- Idaho:
 employee medical service in metal
 mining industry, 98;
 in lumber industry, 110;
 workmen's compensation law, 97;
 hospital contract system, 98, 110.
 Illinois:
 investigation of compulsory sick-
 ness insurance, 1918, 48;
 medical service provided by coal
 mining unions, 125.
- "Income protection" insurance, 6,
 252.
- Indiana:
 coal mining industry, 126-128.
 Industrial health programs (non-
 compensable causes), 268-270.
 Industrial health programs (em-
 ployer's expense), 16.
 Insurance:
 commercial accident and health
 (American), 258-264;
 compulsory, American campaign
 for, 34-57;
 voluntary, 27.
 Iron mining industry:
 employee medical service:
 Alabama, 156-158;
 Colorado, 117;
 Michigan, 133;
 Minnesota, 134.
- K.
- Kansas coal mining industry, 128-
 129.
 Kentucky coal mining industry:
 employee medical service, 151-
 155;
 hospital contract system, 151;
 workmen's compensation, 191.
- L.
- Labor Union League, Los Angeles,
 scheme of medical and hospital
 insurance, 295.
 Lake Superior:
 copper mining industry (Michi-
 gan), 138.

TOPICAL INDEX

- Lake Superior—*continued*
 iron mining industry (Michigan
 and Minnesota):
 company, doctor and hospital
 contract system, 133;
 workmen's compensation, 135.
- Lead and zinc industry, Missouri
 and Oklahoma, 124.
- Lumber industry employee medical
 service and hospital contract
 system:
 California, 88;
 Idaho, 110;
 Oregon, 79;
 Washington, 59.
- M.
- Massachusetts, investigation of
 compulsory sickness insurance,
 1916, 49.
- Medical benefit clauses in commer-
 cial accident and health insur-
 ance, 258.
- Medical benefit corporations, Cali-
 fornia, 244.
- Medical benefits provided by em-
 ployee mutual benefit associa-
 tions, 278;
 by trade union sick benefit funds,
 291.
- Medical profession, attitude of
 toward contract practice:
 Washington, 73;
 Oregon, 85;
 West Virginia, 183-185.
- Michigan copper mining industry:
 medical service for employees:
- Michigan copper mining industry,
 Medical service for employees—
continued
 hospital contract system and
 workmen's compensation,
 138.
- Missouri, lead and zinc industry,
 124.
- Montana:
 coal mining industry, 120;
 metal mining industry, 99.
- Mutual benefit associations (em-
 ployee), 278.
- N.
- Nevada copper mining industry:
 employee medical service; hospital
 contract system; workmen's
 compensation, 100.
- New Bedford, Mass., health insur-
 ance plan, 232.
- New Jersey, investigation of com-
 pulsory sickness insurance,
 1917, 49.
- New Mexico, coal and metal min-
 ing industry:
 company doctor and hospital
 contract system; workmen's
 compensation, 105.
- New York:
 investigation into compulsory
 sickness insurance, 1915-
 1920, 51.
- North Carolina textile industry:
 employee health and medical
 service in, 17;
- Roanoke Rapids, community hos-
 pital insurance plan, 239.

TOPICAL INDEX

O.

Ohio coal mining industry:
 company doctor system, 144;
 investigation into compulsory
 sickness insurance, 1916, 47.
 Oklahoma coal mining industry:
 employee medical service, 128.
 Opposition to compulsory sickness
 insurance, 1918-1920, 51.
 Oregon:
 attitude of medical profession
 toward contract practice, 85;
 hospital contract system, 77;
 incorporated hospital associations,
 80;
 Physicians' and Surgeons' Hospi-
 tal Association, 86;
 workmen's compensation law, 77.

P.

Pennsylvania:
 anthracite coal mining industry,
 139;
 bituminous coal industry, 139;
 hospital service, 140;
 investigation into compulsory
 sickness insurance, 1917, 47.
 Physicians' and Surgeons' Hospital
 Association, Salem, Ore., 86.

R.

Railroad employee hospital associa-
 tions, 193-211.
 Roanoke Rapids, N. C., community
 hospital insurance plan, 239.
 Rockford, Ill., community hospital
 insurance plan, 251.

S.

Self-insurance under workmen's
 compensation laws, 2.
 South Carolina textile industry:
 employee health and medical
 service, 17;
 no workmen's compensation law
 in, 18.

T.

Tennessee coal mining industry:
 company doctor and hospital
 contract system, workmen's
 compensation law, 156.
 Textile industry, southern:
 employee health and medical
 service:
 Georgia, 18;
 North Carolina, 17;
 South Carolina, 17.
 Roanoke Rapids, N. C., 239.
 Thompson Trust, for hospital ser-
 vice, Brattleboro, Vt., 227.
 Trade union sick benefit funds,
 291.

U.

United Mine Workers of America,
 Wyoming, 113.
 Unsuccessful American campaign
 for compulsory sickness insur-
 ance, 1914-1920, 34-57.
 Utah coal and metal mining indus-
 try:
 company doctor and hospital
 contract system; workmen's
 compensation, 120.

TOPICAL INDEX

- v.
- Virginia, coal mining industry:
company doctor and hospital
system; workmen's compen-
sation, 148.
- w.
- Washington coal mining and lum-
ber industries:
incorporated hospital associations,
64;
medical profession, attitude of
towards contract practice, 73;
workmen's compensation law, 58.
- West Virginia coal mining indus-
try:
company doctor system, 146;
hospital contract system, 165;
privately owned hospitals, 170;
criticism by medical practition-
ers, 183;
workmen's compensation law,
192.
- Wisconsin, investigation into com-
pulsory sickness insurance,
1918, 50.
- Wyoming coal mining industry,
113.

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