

**ORGANIZED
PAYMENTS
FOR
MEDICAL
SERVICES**

Revised



Bureau of Medical Economics, American Medical Association
Chicago
1941

Organized Payments for Medical Services

A Report Prepared
by
Bureau of Medical Economics
American Medical Association

Revised
1941

AMERICAN MEDICAL ASSOCIATION
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INTRODUCTION

The quest for greater security has focused attention on the development of new methods or arrangements to minimize the risks that man faces during life. Many devices have been tried, some of them aimed at the basic uncertainty of lack of income, some designed to help the less fortunate to obtain at least a minimum of security. Certain of these devices have so reorganized the previous way of living that the transition often caused as much uncertainty as these changes sought to correct.

In the medical field a large number of new methods or arrangements for distributing medical services have been tried in an effort to provide greater access to the benefits of available medical knowledge and facilities. These changes have created widespread interest and discussion.

The purpose of this report is to describe the main types of the newer organizational arrangements for the distribution of medical care. It is hoped that a better understanding of each of these major organizational arrangements will lead to an appreciation of the problems involved.

This report is especially dedicated to the medical societies throughout the country whose members are courageously maintaining that it is as much the duty of the medical profession to warn the public against unsound medical care plans as it is to inform the public of worthless or dangerous medical fads, fancies or remedies.

This revised edition contains some of the recent developments and experiences of medical societies and independent organizations. As further experience is gained the results will be recorded for the use of those who are interested.

CHAPTER I

CONSISTENT PROGRESS

The record of the American Medical Association, in pursuit of the purpose to which it is dedicated—that of improving the quality of medical care for all the people in the United States—has been one of continuous and consistent progress throughout nearly a century. That Association has directed and continues to exercise its efforts toward the improvement and maintenance of the standards of medical education and licensure, which now insure to the people of this country the services of a medical profession unexcelled anywhere else in the world. It has also established and assisted in the enforcement of standards of purity and effectiveness of drugs, of the value of medical appliances, and of the quality of hospital care, and has directed its efforts in many other directions toward the improvement of medical care.

The American Medical Association has never been unmindful of the necessity of constructive changes in the methods of organizing medical care or in the appropriate functions of the government in protecting the health of the people. At its first meeting in 1847 it urged the establishment of "state medicine," a term which was used at that time to describe what later became known as public health. The organized medical profession has always used its influence for the establishment and proper administration of state and local health departments. It has been more than sixty years since the American Medical Association first advocated the establishment of a National Department of Health, with its head a member of the Cabinet. For many years the Association endeavored to secure the coordination of federal health activities through such a department and the 1938 special session of the House of Delegates

again recommended the establishment of a federal health department with a secretary who shall be a doctor of medicine and a member of the President's Cabinet.

Proper care of patients having mental and nervous diseases has occupied the attention of organized medicine up to the present moment, when the American Medical Association is pointing out the numerous inadequacies of such care in many areas and urging the extension of facilities for such patients.

The establishment of health departments and the building of institutions for mental and nervous diseases merely opened new fields of activity for the American Medical Association. Then began the apparently never-ending struggle against the inroads of spoils politics, governmental ineptitude, and red tape. Years of costly effort have not yet been able to free health departments from political spoils and transform them into unhampered institutions for the protection of the public, and to change "insane asylums" into hospitals for mental diseases. The story of this transformation, still far from completed, can be read in the records of nearly every state and many of the county medical societies. A study of these records will show how little the language of the opponents of organized medicine has changed throughout the years. Medical societies were denounced as "narrow," "obstructive," and "professionally jealous," when they insisted that politicians should be supplanted by physicians in public health and in the care of the insane, and that the fields of governmental activity in health matters should be confined to those functions where political and governmental influence might be helpful and not harmful.

The policy of the American Medical Association pertaining to the activity of the government in regard to medical care was stated briefly in the resolution adopted by the House of Delegates in 1921, which reads:

Resolved, By the House of Delegates of the American Medical Association that it approves and endorses all proper activi-

ties and policies of state and federal governments directed to the prevention of disease and the preservation of the public health.

This was further clarified by the definition of "state medicine" in the following resolution adopted in 1922:

The American Medical Association hereby declares its opposition to all forms of "state medicine" because of the ultimate harm that would come thereby to the public weal through such form of medical practice.

"State medicine" is hereby defined for the purpose of this resolution to be any form of medical treatment, provided, conducted, controlled or subsidized by the federal or any state government, or municipality, excepting such service as is provided by the Army, Navy or Public Health Service, and that which is necessary for the control of communicable diseases, the treatment of mental disease, the treatment of the indigent sick, and such other services as may be approved by and administered under the direction of or by a local county medical society, and are not disapproved by the state medical society of which it is a component part.

CARE OF THE INDIGENT SICK

The medical profession has consistently urged that the general public and the government recognize and assume their responsibilities for the medical care of the indigent. Unfortunately, at this point, as at every other where politics comes into contact with medical care, the result has not been encouraging. The history of the system of "county poor doctors," which set the pattern for the medical care of the indigent, has been a disgraceful chapter in American public life. Notwithstanding the undesirable features of the system, there were, and still are, many "poor physicans" who give good medical care to the indigent in spite of the system. Physicians, generally, thwarted by political influence in their efforts to secure through taxation good medical care for those unable to pay for it, simply assumed the burden themselves as a part of their professional obligations. Up to the present time this voluntary service of physicians in all probability remains the main source of good medical care for the indigent. It will be noticed that the objective of the medical profession is *good*

medical care for all classes of the population regardless of economic status. That is why physicians have donated such care rather than trust the health of any section of the population to methods of distributing medical care which would tend to destroy the value of the service. More recently the burden of medical care for the indigent has grown too great for the physicians to carry alone.

Physicians, assisted by philanthropists, built the first hospitals and have worked continuously for their extension and improvement. Various studies have shown that about ninety per cent of the medical service in hospitals is given without charge.¹ Organized medicine protested only when agencies outside the medical profession introduced methods that lowered the quality of medical service. Some of the greatest efforts to protect the poor against inefficient and even inhuman medical service have been directed by organized medicine against spoils politics in the management of both governmental hospitals for mental patients, which have already been mentioned, and general hospitals. Some of the largest of these institutions have at times been so disgracefully managed as to give rise to numerous newspaper scandals and "horror stories." It has been as difficult to maintain good standards of medical and hospital service in state, county, and city hospitals as in any other type. These experiences do not encourage the confidence of the medical profession in the extension of governmental activities into such a vitally personal service as that of the care of the sick. Yet, just to keep the record straight, it must be repeated that the American Medical Association has always cooperated in every effort by governments to protect the entire population by such standardized, legal activities as are essential to the well-being of the nation and are suited to government direction.

1. Report of the Hospital Survey for New York, New York, United Hospital Fund, 1937, vol. 2, p. 302.

CONTRACT PRACTICE

The United States has always been a country of diversified social conditions, rapid change, and extensive experiment. Throughout its history the American Medical Association has been concerned with methods of organizing the payment and delivery of medical care. It would be hard to suggest any form of such experiments which organized medicine in America has not tested at some time or in which it has not been compelled by circumstances to participate. Canal and railroad construction, mining and lumbering, "one-industry towns," and all the other situations arising out of a continuous series of industrial outposts beyond the boundaries of a developed social organization have led to experiments with every form of contract practice.

The American Medical Association has established measures by which such forms of practice may be judged in a manner similar to that by which it judges drugs, medical appliances, and new forms of diagnosis and treatment, viz., by their effect on the quality of the medical service. There is full recognition of the necessity, in special situations, of providing needed medical care even though such services may be incomplete or only emergency in type. The Association declares in the Principles of Medical Ethics that "contract practice *per se* is not unethical" but surrounds such types of practice with definite safeguards. In spite of these safeguards and of some outstanding and often widely publicized exceptions, experience in meeting high standards of medical service under contract practice has not been such as to encourage its extension, especially in sections of the country already supplied with physicians and provided with medical facilities.

Several studies of the vital statistics in counties where contract practice exists, particularly in coal mining districts, seem to show that death rates, and especially maternal and infant death rates, are significantly higher

in such counties than in counties with comparable environmental conditions having even fewer physicians and less medical facilities but where medical care was given by private practitioners without contract arrangements.² Neither have the advocates of various forms of contract practice or of mutual or "cooperative" health organizations ever offered any proof that morbidity and mortality have been reduced by the operation of plans which deny the right of the patient to a free choice of physician and seek to monopolize the field of medical practice for the benefit of a few contract physicians, who certainly do not monopolize the skill and medical knowledge of the whole community. This test of changes in sickness and death rates is one of the decisive tests by which every type of medical diagnosis or treatment or organization of medical services must be judged.

ACTION ON SICKNESS INSURANCE

During the years 1910-16 when the first extensive propaganda for sickness insurance arose in the United States, the American Medical Association, instead of adopting an attitude of prejudiced hostility, undertook one of the most thorough studies of the subject that had been made in America up to that time. The man chosen to make this study was perhaps the ablest advocate of sickness insurance in this country. Committees were appointed to analyze all the information available and the subject was widely discussed in medical journals. As a result of this investigation, discussion, and deliberation, the House of Delegates in 1920 adopted the following resolution:

Your committee has carefully considered the resolutions on compulsory sickness insurance, and reports with amendments as follows:

Resolved, That the American Medical Association declares its opposition to the institution of any plan embodying the system of compulsory contributory insurance against illness, or any other plan of compulsory insurance which provides for

2. See especially: Lyon, George M.: Infant Mortality Studies in West Virginia, W. Va. M. J. 30: 289 (July) 1934.

medical service to be rendered contributors or their dependents, provided, controlled, or regulated by any state or the federal government.

Shortly after this resolution was adopted, public interest in sickness insurance seems to have almost disappeared but was more acutely aroused after the industrial crisis of 1929 and the succeeding severe depression. The American Medical Association immediately undertook a study of the developments since its previous action in 1916. With full recognition of the changes created by the industrial depression, the American Medical Association and all of its component organizations wholeheartedly cooperated in all the efforts of governmental or private agencies to extend medical care to the great numbers of people whom the depression rendered incapable of paying for such services. State and county medical societies throughout the nation began the most extensive system of experimenting with plans of providing good medical service on terms which could be met by all classes of the population that has ever been undertaken in any country.

Realizing the necessity of guidance in the conduct of such plans and the existence of certain principles essential to the maintenance of good medical service in whatever plans might be undertaken, the House of Delegates in 1934 adopted the following ten principles, designed not only to assist the constituent and the component medical societies but also to encourage them in undertaking such experiments as offered promise of providing good medical service to all sections of the population:

First: All features of medical service in any method of medical practice should be under the control of the medical profession. No other body or individual is legally or educationally equipped to exercise such control.

Second: No third party must be permitted to come between the patient and his physician in any medical relation. All responsibility for the character of medical service must be borne by the profession.

Third: Patient must have absolute freedom to choose a legally qualified doctor of medicine who will serve them from

among all those qualified to practice and who are willing to give service.

Fourth: The method of giving the service must retain a permanent, confidential relation between the patient and a "family physician." This relation must be the fundamental and dominating feature of any system.

Fifth: All medical phases of all institutions involved in the medical service should be under professional control, it being understood that hospital service and medical service should be considered separately. These institutions are but expansions of the equipment of the physician. He is the only one whom the laws of all nations recognize as competent to use them in the delivery of service. The medical profession alone can determine the adequacy and character of such institutions. Their value depends on their operation according to medical standards.

Sixth: In whatever way the cost of medical service may be distributed, it should be paid for by the patient in accordance with his income status and in a manner that is mutually satisfactory.

Seventh: Medical service must have no connection with any cash benefits.

Eighth: Any form of medical service should include within its scope all legally qualified doctors of medicine of the locality covered by its operation who wish to give service under the conditions established.

Ninth: Systems for the relief of low income classes should be limited strictly to those below the "comfort level" standard of incomes.

Tenth: There should be no restrictions on treatment or prescribing not formulated and enforced by the organized medical profession.

SOCIAL SECURITY LEGISLATION

When it was proposed to include a plan of compulsory sickness insurance under the Social Security Bill, representatives of the American Medical Association met and consulted with representatives of government agencies. The House of Delegates was called in special session in 1935 to formulate a policy with respect to this proposed legislation. At this meeting a report was adopted, of which the following sections apply to the subject of sickness insurance and methods of providing medical care:

Your reference committee, believing that regimentation of the medical profession and lay control of medical practice will be fatal to medical progress and inevitably lower the quality of

medical service now available to the American people, condemns unreservedly all propaganda, legislation or political manipulation leading to these ends.

Your reference committee has given careful consideration to the record by the Board of Trustees of the previous actions of this House of Delegates concerning sickness insurance and organized medical care and to the account of the measures taken by the Board of Trustees and the officials of the Association to present this point of view to the government and to the people.

The American Medical Association, embracing in its membership some 100,000 of the physicians of the United States, is by far the largest medical organization in this country. The House of Delegates would point out that the American Medical Association is the only medical organization open to all reputable physicians and established on truly democratic principles, and that this House of Delegates, as constituted, is the only body truly representative of the medical profession.

The House of Delegates commends the Board of Trustees and the officers of the Association for their efforts in presenting correctly, maintaining and promoting the policies and principles, heretofore established by this body.

The primary considerations of the physicians constituting the American Medical Association are the welfare of the people, the preservation of their health and their care in sickness, the advancement of medical science, the improvement of medical care, and the provision of adequate medical service to all the people. These physicians are the only body in the United States qualified by experience and training to guide and suitably control plans for the provision of medical care. The fact that the quality of medical service to the people of the United States today is better than that of any other country in the world is evidence of the extent to which the American medical profession has fulfilled its obligations.

The House of Delegates of the American Medical Association reaffirms its opposition to all forms of compulsory sickness insurance whether administered by the federal government, the governments of the individual states or by any individual industry, community or similar body. It reaffirms, also, its encouragement to local medical organizations to establish plans for the provision of adequate medical service for all of the people, adjusted to present economic conditions, by voluntary budgeting to meet the costs of illness.

The medical profession has given of its utmost to the American people, not only in this but in every previous emergency. It has never required compulsion but has always volunteered its services in anticipation of their need.

The Committee on Economic Security, appointed by the President of the United States, presented in a preliminary report to Congress on January 17 eleven principles which that committee considered fundamental to a proposed plan of compulsory health

insurance. The House of Delegates is glad to recognize that some of the fundamental considerations for an adequate, reliable and safe medical service established by the medical profession through years of experience in medical practice are found by the committee to be essential to its own plans.

However, so many inconsistencies and incompatibilities are apparent in the report of the President's Committee on Economic Security thus far presented that many more facts and details are necessary for a proper consideration.

The House of Delegates recognizes the necessity under conditions of emergency for federal aid in meeting basic needs of the indigent; it deprecates, however, any provision whereby federal subsidies for medical services are administered and controlled by a lay bureau. While the desirability of adequate medical service for crippled children and for the preservation of child and maternal health is beyond question, the House of Delegates deplors and protests those sections of the Wagner bill which place in the Children's Bureau of the Department of Labor the responsibility for the administration of funds for these purposes.

The House of Delegates condemns as pernicious that section of the Wagner bill which creates a social insurance board without specification of the character of its personnel to administer functions essentially medical in character and demanding technical knowledge not available to those without medical training.

The so-called Epstein bill, proposed by the American Association for Social Security, now being promoted with propaganda in the individual states, is a vicious, deceptive, dangerous and demoralizing measure. An analysis of this proposed law has been published by the American Medical Association. It introduces such hazardous principles as multiple taxation, inordinate costs, extravagant administration and an inevitable trend toward social and financial bankruptcy.

The committee has studied this matter from a broad standpoint, considering many plans submitted by the Bureau of Medical Economics as well as those conveyed in resolution from the floor of the House of Delegates. It reiterates the fact that there is no model plan which is a cure-all for the social ills any more than there is a panacea for the physical ills that affect mankind. There are now more than 150 plans for medical service undergoing study and trial in various communities in the United States. Your Bureau of Medical Economics has studied these plans and is now ready and willing to advise medical societies in the creation and operation of such plans. The plans developed by the Bureau of Medical Economics will serve the people of the community in the prevention of disease, the maintenance of health and with curative care in illness. They must at the same time meet apparent economic factors and protect the public welfare by safeguarding to the medical profession the functions of control of medical standards and the

continued advancement of medical educational requirements. They must not destroy that initiative which is vital to the highest type of medical service.

In the establishment of all such plans, county medical societies must be guided by the ten fundamental principles adopted by this House of Delegates at the annual session in June 1934. The House of Delegates would again emphasize particularly the necessity for separate provision for hospital facilities and the physician's services. Payment for medical service, whether by prepayment plans, instalment purchase or so-called voluntary hospital insurance plans, must hold, as absolutely distinct, remuneration for hospital care on the one hand and the individual, personal, scientific ministrations of the physician on the other.

Your reference committee suggests that the Board of Trustees request the Bureau of Medical Economics to study further the plans now existing and such as may develop, with special reference to the way in which they meet the needs of their communities, to the costs of operation, to the quality of service rendered, to the effects of such service on the medical profession and to the applicability to rural, village, urban and industrial population, and to develop for presentation at the meeting of the American Medical Association in June model skeleton plans adapted to the needs of populations of various types.

At the regular meeting of the House of Delegates in 1935, a special report on "Medical Service Plans" was adopted which listed some two hundred experiments which were being conducted by state and county medical societies. Further suggestions were developed in this report as to the principles which should be observed in such experiments. The following paragraph from the report adopted by the House of Delegates indicates the attitude of the American Medical Association on insurance as a method of paying for medical service:

There is nothing inherently good or bad, from a medical point of view, in different methods of collection. Insurance, taxation, budgeting, advance financing and all other methods are nothing more than tools with which to conduct an economic transaction. They remain nothing more than this and can be discussed impartially *if they are kept strictly within the economic sphere.* The problem is to select the best method for every purpose. The chief thing to keep in mind is that *all forms of collection should be isolated from any control of service and be kept exclusively in the economic field.* [Italics in original.]

HOSPITALIZATION INSURANCE

The general economic conditions after 1930 placed many hospitals in a critical financial condition. There had been some excessive and extravagant overbuilding of hospitals, together with a great deal of loose financial management. Hospital incomes, especially from private beds, were greatly decreased and at the same time the demand for free service was greatly increased. At about this time hospitals in a number of places were importuned to adopt plans of prepayment for hospital care similar to those which had been adopted in Grinnell, Iowa, and Dallas, Texas.

It has been stated repeatedly—without the slightest foundation—that the American Medical Association opposed group hospitalization or hospital insurance. When the movement toward such insurance threatened to become a commercial craze and was being exploited by numerous promoters for profit, the American Medical Association did condemn the unsound and dangerous features of such plans and in so doing aroused the antagonism of some of the leading advocates of group hospitalization. Some of those who criticized this attitude of the American Medical Association have since admitted that the schemes condemned by the Association were undesirable.

There is nothing new about the attitude of organized medicine toward hospitalization insurance. The test to which reference has previously been made and which has been the universal standard of acceptance or rejection of methods, procedures and remedies by the medical profession was applied to hospitalization; this was the test of whether the plan as a whole or any of its proposed features would result in lowering the quality of medical service. In 1937 the House of Delegates adopted principles which were considered necessary to safeguard the quality of medical service under hospital insurance.

1. The plan of organization should conform to state statutes and case law. The majority of the governing body of the

hospital insurance plan should be chosen from among members of official hospital groups and members of medical societies. Great care should be taken to assure the nonprofit character of these new ventures.

2. The plan should include all reputable hospitals. The qualifications of the participating hospitals should be closely supervised. Member hospitals should be limited to those on the Hospital Register of the American Medical Association or to those approved by the state departments of public health or other state agencies in those states in which there is approval, registration or licensing of hospitals.

3. The medical profession should have a voice in the organization and administration of the plan. Since hospitals were founded to serve as facilitating means to the practice of medicine, the medical profession must concern itself intimately with plans likely to affect the relations of hospitals to physicians.

4. The subscriber's contract should exclude all medical services—contract provisions should be limited exclusively to hospital facilities. If hospital service is limited to include only hospital room accommodations such as bed, board, operating room, medicines, surgical dressings and general nursing care, the distinction between hospital service and medical service will be clear.

5. The plan should be operated on an insurance accounting basis with due consideration for earned and unearned premiums, administrative costs and reserves for contingencies and unanticipated losses. Supervision by state insurance departments has been advantageous for both the buyer and the seller of insurance contracts. Laws permitting the formation of hospital service corporations should not remove the benefits of such supervision or violate the principles enumerated.

6. There should be an upper income limit for subscribers. If group hospitalization plans are designed to aid persons with limited means to secure hospital services, they should render such service at less than regular rates. If no consideration in rates is made for persons with limited means, group hospitalization plans lose their altruistic purpose and there may be little justification for an income limit.

7. There should be no commercial or high pressure salesmanship or exorbitant or misleading advertising to secure subscribers. Such tactics are contrary to medical and hospital ethics and are against sound public policy.

8. There should be no diversion of funds to individuals or corporations seeking to secure subscribers for a profit. The moment hospitals lose their traditional character as institutions of charity and humanitarianism, the entire voluntary hospital system will break down.

9. Group hospitalization plans should not be utilized primarily or chiefly as means to increase bed occupancy or to liquidate hospital indebtedness. Such plans, if they are necessary, should place emphasis on public welfare and not on hospital finances.

10. Group hospitalization plans should not be considered a panacea for the economic ills of hospitals. They can serve only a small portion of those persons needing hospital services. Hospitals must continue to develop efficient methods of administration and service independent of any insurance method of selling their accommodations.

These principles are designed to protect the patient, ensure a high quality of service, and prevent the introduction of any third party into the personal relations of patient and physician. The only objection that can be raised to any of these principles is that they would interfere with the financial interests of lay organizers or administrators of hospital insurance schemes.

The attitude toward plans for organizing the payment for medical service and for group hospitalization was further clarified at the meeting of the House of Delegates in San Francisco in 1938 by the following statements which were adopted by the House of Delegates:

Your committee is unanimously of the opinion that state and county medical societies cannot afford not to develop for their respective jurisdictions the most accurate and complete information that will enable them, with the assistance of the correlated professions and other agencies concerned with medical and preventive medical services and facilities, to maintain, continuously, medical care that is sufficient in amount and satisfactory in quality.

Since it is contemplated in the resolutions passed by the Board of Trustees that some state and county medical societies may find it necessary to develop preferable procedures for supplying the needs where medical services are insufficient or unavailable, it is urged that these medical societies be guided in the development of these procedures by the ten principles adopted by the House of Delegates in 1934. The application of these ten principles to specific suggestions or proposals for the organization of medical services may be facilitated by utilizing the method of direct cash payments to individual members. Your committee unanimously concurs in the suggestion and recommends that the American Medical Association adopt the principle that in any plan or arrangement for the provision of medical services the benefits shall be paid in cash directly to the individual member. Thus, the direct control of medical

services may be avoided. Cash benefits only will not disturb or alter the relations of patients, physicians and hospitals.

Your committee has considered in detail that portion of the report of the Board of Trustees devoted to the Bureau of Medical Economics under the heading "Group Hospitalization" and also the separate statement of the Bureau of Medical Economics entitled "Group Hospitalization Insurance." Your committee commends the clarity and forcefulness of these statements and recommends that the ten principles adopted in 1937 as the policy of the American Medical Association be amplified by the addition of the following statement to Principle 4:

If for any reason it is found desirable or necessary to include special medical services such as anesthesia, radiology, pathology or medical services provided by outpatient departments, these services may be included only on the condition that specified cash payments be made by the hospitalization organization directly to the subscribers for the cost of the services.

Disapproval of the inclusion of special medical services on a service basis in hospitalization insurance contracts will then be explicit but a constructive alternative arrangement will be possible.

The conditions under which state and county medical societies were urged to conduct their experiments in devising supplementary means of supplying good medical service to all sections of the population, regardless of income, have been set forth. The attitude of the American Medical Association toward methods of payment of medical bills has been clearly defined. The position that benefits should be paid to the patients in cash in the same manner as premiums are collected from them, and that the administration of the method of payment should not be permitted to affect the quality of the medical service is plainly stated.

NATIONAL HEALTH PROGRAM

The National Health Conference was called in Washington on July 18-20, 1938, to consider the National Health Program. This program, which was presented with little opportunity for thorough or dispassionate discussion or modification, was based largely on a survey conducted by the United States Public Health

Service through the use of WPA clients. The accuracy of many of the basic conclusions of this survey is open to strong suspicion.³

A special session of the House of Delegates was called September 16 and 17, 1938, to consider the proposed National Health Program. At this session all proposals by any component organization of the American Medical Association or by any of the delegates were also presented and considered, and the following report was unanimously adopted:

Since it is evident that the physicians of this nation, as represented by the members of this House of Delegates convened in special session, favor definite and decisive action now, your committee submits the following for your approval:

1. Under Recommendation I on Expansion of Public Health Services: (1) Your committee recommends the establishment of a federal department of health with a secretary who shall be a doctor of medicine and a member of the President's Cabinet. (2) The general principles outlined by the Technical Committee for the expansion of Public Health and Maternal and Child Health Services are approved and the American Medical Association definitely seeks to cooperate in developing efficient and economical ways and means of putting into effect this recommendation. (3) Any expenditures made for the expansion of public health and maternal and child health services should not include the treatment of disease except so far as this cannot be successfully accomplished through the private practitioner.

2. Under Recommendation II on Expansion of Hospital Facilities: Your committee favors the expansion of general hospital facilities where need exists. The hospital situation would indicate that there is at present greater need for the use of existing hospital facilities than for additional hospitals.

Your committee heartily recommends the approval of the recommendation of the technical committee stressing the use of existing hospital facilities. The stability and efficiency of many existing church and voluntary hospitals could be assured by the payment to them of the costs of the necessary hospitalization of the medically indigent.

3. Under Recommendation III on Medical Care for the Medically Needy: Your committee advocates recognition of the principle that the complete medical care of the indigent is a responsibility of the community, medical and allied professions and that such care should be organized by local governmental units and supported by tax funds.

3. For a report and discussion of this Conference, see: J. A. M. A. 111:432 (July 30) 1938.

Since the indigent now constitute a large group in the population, your committee recognizes that the necessity for state aid for medical care may arise in poorer communities and the federal government may need to provide funds when the state is unable to meet these emergencies.

Reports of the Bureau of the Census, of the U. S. Public Health Service and of life insurance companies show that great progress has been made in the United States in the reduction of morbidity and mortality among all classes of people. This reflects the good quality of medical care now provided. Your committee wishes to see continued and improved the methods and practices which have brought us to this present high plane.

Your committee wishes to see established well coordinated programs in the various states in the nation, for improvement of food, housing and the other environmental conditions which have the greatest influence on the health of our citizens. Your committee wishes also to see established a definite and far reaching public health program for the education and information of all the people in order that they may take advantage of the present medical service available in this country.

In the face of the vanishing support of philanthropy, the medical profession as a whole will welcome the appropriation of funds to provide medical care for the medically needy, provided, first, that the public welfare administrative procedures are simplified and coordinated; and, second, that the provision of medical services is arranged by responsible local public officials in cooperation with the local medical profession and its allied groups.

Your committee feels that in each state a system should be developed to meet the recommendation of the National Health Conference in conformity with its suggestion that "The role of the federal government should be principally that of giving financial and technical aid to the states in their development of sound programs through procedures largely of their own choice."

4. Under Recommendation IV on a General Program of Medical Care: Your committee approves the principle of hospital service insurance which is being widely adopted throughout the country. It is susceptible of great expansion along sound lines, and your committee particularly recommends it as a community project. Experience in the operation of hospital service insurance or group hospitalization plans has demonstrated that these plans should confine themselves to provision of hospital facilities and should not include any type of medical care.

Your committee recognizes that health needs and means to supply such needs vary throughout the United States. Studies indicate that health needs are not identical in different localities but that they usually depend on local conditions and therefore are primarily local problems. Your committee therefore encourages county or district medical societies, with the

approval of the state medical society of which each is a component part, to develop appropriate means to meet their local requirements.

In addition to insurance for hospitalization your committee believes it is practicable to develop cash indemnity insurance plans to cover, in whole or in part, the costs of emergency or prolonged illness. Agencies set up to provide such insurance should comply with state statutes and regulations to insure their soundness and financial responsibility and have the approval of the county and state medical societies under which they operate.

Your committee is not willing to foster any system of compulsory health insurance. Your committee is convinced that it is a complicated, bureaucratic system which has no place in a democratic state. It would undoubtedly set up a far reaching tax system with great increase in the cost of government. That it would lend itself to political control and manipulation there is no doubt.

Your committee recognizes the soundness of the principles of workmen's compensation laws and recommends the expansion of such legislation to provide for meeting the costs of illness sustained as a result of employment in industry.

Your committee repeats its conviction that voluntary indemnity insurance may assist many income groups to finance their sickness costs without subsidy. Further development of group hospitalization and establishment of insurance plans on the indemnity principle to cover the cost of illness will assist in solution of these problems.

5. Under Recommendation V on Insurance Against Loss of Wages During Sickness: In essence, the recommendation deals with compensation of loss of wages during sickness. Your committee unreservedly endorses this principle, as it has distinct influence toward recovery and tends to reduce permanent disability. It is, however, in the interest of good medical care that the attending physician be relieved of the duty of certification of illness and recovery, which function should be performed by a qualified medical employee of the disbursing agency.

6. To facilitate the accomplishment of these objectives, your committee recommends that a committee of not more than seven physicians representative of the practicing profession, under the chairmanship of Dr. Irvin Abell, President of the American Medical Association, be appointed by the Speaker to confer and consult with the proper federal representatives relative to the proposed National Health Program.

A UNIFORM POLICY

The American Medical Association, as is shown by the above record of its official actions, has pursued a consistent policy for almost a century. An attempt has

always been made to adjust that policy to meet new developments in the science and art of medicine or in the social conditions under which medicine must be practiced, but in the midst of all these changes the one objective which has always been kept in view has been the maintenance of that system of medical care that is most effective in the control and alleviation of sickness and the advancement of medical knowledge.

For more than sixty years the American Medical Association has urged the creation of a national department of health, with a physician at its head who will be a member of the President's Cabinet. It believes that the present multitude of health activities in the federal government could thus be organized in such a way as to ensure and to maintain efficiency in administration and higher standards of health care in all fields of governmental activity.

The organized medical profession has continuously and consistently urged the creation of efficient, adequately supported public health departments—national, state, and local. It has always used its influence to maintain the efficiency of such departments by excluding political influence and ensuring competent scientific direction. The component units of the American Medical Association have cooperated, when possible, with such public health departments in all fields to which their activities were suited. Many comparisons of sickness and death rates in various localities have shown that public health departments have gained in the ability to prevent sickness and to postpone death in a very close relation to the degree to which public health, preventive medicine and private medical practice have been coordinated.

The American Medical Association and all the state and county medical societies have a record unequaled by any other body in the community in the effort to secure good medical care for those without resources. Here, again, the Association has opposed the efforts of

forces outside the medical profession to make a kind of spoils system of medical care for the indigent. It has joined wholeheartedly in every effort to utilize such resources as governments and philanthropy have been able to contribute in supplying medical care for the poor. Without the cooperation of organized medicine, the Federal Emergency Relief Administration would have been greatly handicapped in so far as the program of that Administration pertained to medical relief. State and county medical societies have been almost the only organizations that have experimented with and successfully developed new and more effective methods of providing good medical care to the indigent. While the medical profession has given freely of its resources to an extent never requested of any other group, it has recognized that the burden of caring for the indigent is not a purely medical one but is one that should be borne by all of society, and therefore the profession has welcomed public or private assistance in bearing this burden and has sought to develop the most efficient methods of utilizing such resources.

Throughout all history the medical profession has recognized the necessity of adjusting its charges to the income of the sick. It knows that methods of supplying an absolutely essential service such as medical care to people with diverse incomes should be based on the application of what has come to be known as the "sliding scale of fees." This is true whether the money for the payment of medical care is raised by taxation, insurance, or any other method. In an effort to discover appropriate methods to supplement the private practice of medicine, the American Medical Association has experimented more widely than any other organization or institution in seeking ways to organize the distribution of the burden of medical costs without destroying the value of medical service.

Instead of presenting an unfounded opposition to schemes of compulsory sickness insurance, the Ameri-

can Medical Association has given to such schemes more study, over a longer period, than the individuals or institutions that advocate such systems of insurance. This study, which has covered all existing systems throughout the world, has led to the conclusion that any scheme by which medical service is treated as a commodity that can be purchased wholesale by governmental or lay organizations and distributed at retail to patients results in a superficial service that not only delays the conquest of disease but actually increases some forms of sickness and has not been shown to be as helpful as other methods in reducing mortality.

As has been shown by the quotations from official records already given, there has been no opposition to the use of the principle of insurance purely as a means of meeting the cost of medical care when there was no interference with the quality of the service. This was clearly stated in 1934, was repeated again at San Francisco in 1938, and further and more definitely stated at the special session in Chicago in the same year. If insurance is used only for the purpose of meeting the costs of medical care and is, like all other systems of insurance, maintained on a cash basis as to both premiums and benefits, there can then be no hocus-pocus by which the cash paid as premiums is transformed into an inferior service which the patient cannot judge; under such conditions there can be no objection to the use of the insurance principle.

There is, therefore, nothing strikingly novel in the statement adopted at the special session of the House of Delegates in 1938. It is fundamentally a continuation of trends that have existed for nearly a century in some cases and policies that have been universal throughout the history of medicine. This statement does organize and develop these trends and policies into an integrated program capable of supplying the needs of present society.

CHAPTER II

CARE OF THE INDIGENT

The term "indigent" designates those who have been declared by some public or private investigating body as being incapable of providing themselves with the essentials of life. Custom has decreed that medical care is among the essentials to be provided not only for those who are in need of public relief for food, clothing, and shelter, but also for those who, even if they are able to provide these necessities for themselves, do not have sufficient additional income with which to meet the emergencies caused by sickness. This latter class of persons has been designated as "medically indigent." The following definition of this group was suggested at the Special Session of the House of Delegates of the American Medical Association in September 1938:

A person is medically indigent when he is unable, in the place in which he resides, through his own resources, to provide himself and his dependents with proper medical, dental, nursing, hospital, pharmaceutical, and therapeutic appliance care without depriving himself or his dependents of necessary food, clothing, shelter and similar necessities of life, as determined by the local authority charged with the duty of dispensing relief for the medically indigent.

The principal source of medical care for the indigent, at all times has been the gratuitous medical services furnished by physicians in private practice. It has been estimated that such care in the United States in recent years has been about \$1,000,000 a day, as measured by the fees which would usually be charged for such services. Some local investigations seem to indicate that the amount of service so given might reach an even larger sum.

In the city of Camden, New Jersey, it was estimated that during the year 1935 physicians gave free services

amounting to \$926,250.⁴ In Los Angeles County the conclusion of a study was that the "members of the Los Angeles County Medical Association give annually in private practice services worth \$3,120,000."⁵ In addition, the added expenses of services given in hospitals and clinics raised this sum, according to the report of the study, to the "staggering figure" of \$31,490,700 in 1930.

In Westchester County, New York, it was estimated that, reckoning a full day's medical attendance at \$3, a major operation at \$100, a minor operation at \$25, an obstetrical delivery at \$50, and a treatment or consultation in the dispensary or outpatient department at \$2, "the medical staffs of Westchester County Hospitals have contributed in one year's service" medical care considered to be worth \$1,857,873.⁶

The Philadelphia County Medical Society in 1932 estimated that the "contribution in free work by Philadelphia physicians amounts to \$20,000,000 a year."⁷

A Special Committee on the Distribution of Medical Services in Wisconsin stated in 1932 "that the medical profession of Wisconsin is probably giving this year in uncompensated service to the indigent something more than eight millions of dollars."⁸

The report for 1938 of the Health Security Administration of Washington, D. C., a central hospital routing agency financed by the Community Chest, states that a conservative estimate of the contribution of free medical services rendered by physicians in hospitals was in excess of \$12,000,000 during the four years of operation of the agency.

4. Money Value of Free Medical Service, J. M. Soc. New Jersey 23: 495 (Sept.) 1936.

5. The Medical Profession, Still Following Ancient Custom, Gives Without Stint to the Demands of Charity, The Bulletin of the Los Angeles County Medical Association 62: 791, 800, 802 (Nov. 3) 1932.

6. Westchester Medical Bulletin 1: 8 (Dec.) 1933.

7. Philadelphia, Pa., Bulletin (newspaper clipping) (Oct. 26) 1932.

8. Care of the Indigent, State Medical Society of Wisconsin, (Oct. 31) 1932. (Mimeographed report.)

PUBLIC DUTY TO CARE FOR THE INDIGENT

The medical profession does not complain of this gratuitous service; neither does it boast of it. It is accepted as compliance in part with that principle of medical ethics which says: "The poverty of a patient and the mutual professional obligation of physicians should command the gratuitous services of a physician." The medical profession has always recognized that this obligation to provide medical care is shared by the profession with the entire body of society, and has urged that the public, through whatever agencies it may choose, undertake at least its share of this obligation. On this point, the House of Delegates of 1930 said:

(a) The physician is no more obligated to provide for the care of the indigent sick than his fellow citizen.

(b) In mutual charitable undertakings for the care of the sick, each citizen contributes what he has: the layman, physical necessities; the physician, professional skill. But each has a right to protect himself from exploitation, and to judge of the merit of the recipients of his bounty.

The component units of the American Medical Association have cooperated with the public in those plans to supply medical care to the indigent that did not involve such infractions of the principles of good medical practice as to destroy or harm the medical service.

DEVELOPMENTS SINCE 1930

Until the industrial debacle of 1929, the public contribution to the supply of medical care for the indigent was principally through salaried county, city, or township physicians. The evils of this method have been continuously pointed out and denounced by medical societies.⁹ Such physicians, in spite of the exceptions to almost any rule applying to human beings, were often of an inferior type, selected for their political affiliations and then overworked and underpaid. They were outstanding examples of the sort of "state medicine"

9. Care of the Indigent Sick, Bureau of Medical Economics, Chicago American Medical Association, 1934, p. 33.

that is condemned in the resolution quoted in the previous chapter regarding the giving of medical treatment to any section of the general public. This type of medical care for the indigent has been characterized by Joseph W. Mountin, Surgeon, United States Public Health Service, as follows:¹⁰

In some of our political subdivisions the officials, feeling that they should do something, but in an economical way, establish the job of poor doctor, awarding it to the lowest bidder. They get exactly what they bargain for, a poor physician who renders poor medical service to a limited number of the poor—a sort of three graces in reverse.

Like most political essays into the field of the practice of medicine, the county doctor system tended to injure the patient, the public, and the practitioner. One of the latter, speaking of his own experience as a county physician, supplemented by reports from other physicians occupying similar positions, says:¹¹

. . . I do not hesitate to make the statement that county physicians are subject to impositions so gross as to be intolerable. Emergency calls are made in scores of instances where no emergency exists, many unnecessary night calls are made and these for long trips over bad roads to places which it would be difficult to reach even in the daytime, only to find there had been little or no occasion for such a call. Many times I have been asked to sit down and wait while some one goes to the neighbors to call the patient. Why is this? Just because it is free.

Any method or system of distributing medical care which disregards quality of service, especially for the indigent, is dangerous to the future of medicine and destructive of good public policy. One of the most important elements of good medical care is the close, personal, confidential relation between the patient and the physician of his choice. Suspicion, deceit, fear of betrayal of confidence, or any form of compulsion on either side are destructive of this relation and of the

10. Mountin, Joseph W.: *The Disability Factor in Dependency*, Report of Meeting of American Public Welfare Association, Indianapolis, May 27, 1937, Chicago, American Public Welfare Association, p. 13.

11. Spohn, E. L.: *Care of County Indigents*, *Northwest Med.* 34: 21 (Jan.) 1935.

results which should follow it. Contract practice is one of the methods which interferes with mutual confidence and the freedom of the patient to choose his own physician. This interference inevitably tends to destroy the value of the information necessary for good medical care. Furthermore, contract practice imposes on the poor this destructive restriction of choice of a physician chiefly because of their economic status.

The logical procedure, before attempting to develop a community health program, or even a health program for the indigent, would be to make a diagnosis of the community needs, that such local resources as are available may be utilized with the utmost efficiency for the benefit of all. Included in this diagnosis should be an appraisal of the methods now being employed for the distribution of medical care. Communities might well ask if present systems of distributing these services are conserving resources by coordination of investigation, by elimination of duplicating services, and by a periodic revision of the standards of eligibility for relief in accordance with fluctuations in the costs of living. It is not enough to know how many persons need medical care—the number of those who need and desire medical services must also be determined. In all this stocktaking, one item should never be overlooked; that is, the physicians of the community are the only ones who by training, licensure, and experience are competent to give medical service, and it is to the county medical societies and individual physicians in private practice that communities should look for advice and assistance in arranging medical services for any group.

The Board of Trustees of the American Medical Association in 1937 adopted resolutions designed to assist and encourage state and county medical societies to collect information concerning the prevailing need for medical and preventive medical services and to formulate preferable procedures to supply these needs in accordance with established policies and local conditions.

STUDY OF MEDICAL CARE

In accordance with the resolutions adopted by the Board of Trustees a Study of Medical Care was made during 1938 by state and county medical societies. Only a few of the general conclusions which seemed justifiable from the assembled data are given here. The complete report appears in the publication "Medical Care in the United States—Demand and Supply," 1939, prepared by the Bureau of Medical Economics.

This survey not only sought to bring out the facts concerning the need and supply of medical care, but to lay the foundation for whatever changes might be helpful in meeting any deficiency in the supply of medical care. County medical societies were asked to assemble the original forms and to analyze the facts which they revealed. It was suggested that medical societies should also assemble any additional information bearing on the subject of the survey and should then prepare a report, copies of which were to be sent to their respective state medical societies and to the American Medical Association. It was suggested that this report might well form the basis of proposed improvements in the local medical and health programs. Not all of the county medical societies carried out all of the details of this suggestion. A considerable number, however, did prepare such reports, some of them constituting fairly large bound volumes of typewritten or mimeographed material which contained suggestions as to the methods of introducing needed improvements.

The state medical societies also were asked to assemble the county society reports and to include a number of items of information applying to the state as a whole. Some of the state medical societies also prepared extensive bound volumes of the information assembled in the course of the study and the societies' recommendations as to future action. Many of the state and county medical society reports state that measures have already been taken to supply some of the defi-

ciencies which the survey revealed. It is already evident that one of the results of the survey will be the introduction of appropriate improvements, some of them of a minor character and others of a more extensive nature requiring changes in the general program of medical care. Furthermore, the material assembled in this survey is available for the development of future programs. This material is open for examination by any public or private body or individual interested in improving the conditions of medical care in this country.

Because of the unknown factors in the two basic elements of "illness" and "medical care," no attempt was made to determine statistically the number of persons ill or the number and nature of illnesses which exist at any given time. Neither was there any attempt to decide what constituted "adequate medical care." It was assumed that the individuals themselves were to continue to decide when they desired medical care and that, except for such public health and preventive measures as are essential to the protection of society as a whole, they should not be compelled to accept undesired medical service. All sources of information on the need and supply of medical services were questioned as to the extent to which it was possible for the persons who desired such services to obtain them. The survey showed that, while there are probably at all times and in all places, some deficiencies in medical care, these deficiencies are believed to be much less in the United States than in any other country and that in only a few localities is any important percentage of the population unable to obtain the medical care which it needs and desires.

Broad generalizations are almost never wholly true. There has already been a plethora of such half-true or wholly untrue generalizations based on other surveys. This summary of the survey of the demand and supply of medical care is not intended to add any more generalizations of this unreliable character.

Almost any national generalization concerning the need and supply of medical care would be false and misleading. In some states the greatest need is for increased facilities in institutions for the care of nervous and mental diseases. In others, the prominent need seems to be an extension of some phase of public health services. In many localities there seems to be a demand for more clinics; probably still more communities would abolish or restrict the scope of existing clinics. In some few states the medical care for the indigent seems to be adequately administered and supported, but in the majority of states there is unmistakable complaint of the inadequacy of such arrangements. There is frequent complaint in some states of inadequate provision for the medical care of transients. Dental care is an important need everywhere. The practical test of the adequacy of facilities for personal diagnosis and treatment would appear to be whether there are sufficient facilities available to supply those who express a desire for such care. Unless the public is willing to support legislation to compel everyone to accept personal medical care whenever some government agent would decide that such service was needed, medical care must continue to be given only when desired and sought by the individual.

A careful examination of the reported facts and of the opinions expressed by those best qualified to judge seems to justify the conclusion that, with the exception of isolated localities, there is no important section of the population of the United States that now fails to receive the medical care that it needs and *desires*. Physicians everywhere have shown not only by their reports in this survey but by their actions throughout many years that they have been willing to give service far beyond their obligations to the profession or as citizens to ensure that no one should be deprived of needed and desired medical care. Nurses, hospitals, schools, welfare workers and every other organization in touch with medical

needs testified, in their reports, that there are few instances where it is impossible to secure needed and *desired* medical care.

FEDERAL EMERGENCY RELIEF ADMINISTRATION

By 1933 the number of people in need of medical care and all other forms of relief had become so large as to overburden the resources of the medical profession as well as of private philanthropy and local governmental bodies. The criticisms directed by organized medicine against contract doctors were so thoroughly supported by factual data and the position itself had so nearly ceased to be a political asset that there was little objection in most cases to its abolition. With the revival of local financial resources, there are now signs of renewed attempts to restore contract poor doctors as a part of the medical machinery of relief.

The entrance of the federal government into the administration of relief in 1933 not only altered fundamentally the whole organization of relief, medical or otherwise, but also established new patterns of administration and started new trends of development, the outcome of which are as yet not visible.

The Federal Emergency Relief Administration undertook to provide at least a minimum of medical care for those whose indigency was proved. Since it was then and always will be impossible to set up any form of medical care in which physicians will not be the most essential factor, the Federal Emergency Relief Administration sought the cooperation of the American Medical Association in formulating and operating a plan of medical care. The result of this cooperation was the onetime well-known "Rules and Regulations No. 7." It should be understood that while the American Medical Association, when asked for assistance by public authorities, has always done the best that it could to contribute to the formulation of workable plans, this does not blind the profession to defects. The first section of these Rules and Regulations laid down a policy

which was not only responsible for whatever degree of success was attained under the plan but which also fixed a pattern, the outlines of which had long been evident, for all future schemes of medical care. This section reads:

1. *Policy.*—A uniform policy with regard to the provision of medical, nursing and dental care for indigent persons in their homes, shall be made the basis of an agreement between the relief administration and the organized medical, nursing, and dental professions, state and/or local. The essence of such a policy should be:

(a) An agreement by the relief administration to recognize within legal and economic limitations, the traditional family and family-physician relationship in the authorization of medical care for indigent persons in their homes; the traditional physician-nurse relationship in the authorization of bedside nursing care; the traditional dentist-patient relationship in the authorization of emergency dental care; and

(b) An agreement by the physician, nurse (or nursing organization), and dentist to furnish the same type of service to an indigent person as would be rendered to a private patient, but that such authorized service shall be a minimum consistent with good professional judgment, and shall be charged for at an agreed rate which makes due allowance for the conservation of relief funds.

The common aim should be the provision of good medical service at a low cost—to the mutual benefit of indigent patient, physician, nurse, dentist, and taxpayer.

The degree to which the Federal Emergency Relief Administration plan succeeded in supplying even the fundamental elements of good medical care to those who came within its scope is measured almost exactly by the extent to which this policy was carried out, although in some places it was disliked and occasionally it was sabotaged by persons not a part of the medical profession. Efforts were made in some areas to reinstate contract physicians or to turn the administration over to politicians and thereby to hamper the application and maintenance of those professional standards of medicine which are essential to the protection of the health of the public.¹²

12. For a more complete contemporary discussion of the workings of the Federal Emergency Relief Administration, see footnote 9, pp. 46-123.

The Federal Emergency Relief Administration as an attempt to establish a national pattern of medical care for the indigent was not wholly successful because a single, uniform pattern of medical practice under such widely diversified conditions is an impossible objective. In spite of the fact that the plan did permit considerable local flexibility, a careful study of its workings throughout the country will disclose that in some states the local variations were so extensive that little was left of the original plan while other states did not even attempt its introduction.

Other elements which affected arrangements for medical care for the indigent were of almost equal importance. Medical societies recognized that changing conditions were making it impossible for the gratuitous service of physicians alone to meet the situation. Centers of poverty in large cities and in the "depressed regions" of farming sections had arisen in which the total resources in the locality were insufficient to supply to the indigent all the necessities of life, including good medical care. Physicians in such districts found it increasingly difficult to derive a living from a diminishing number of self-supporting people and at the same time carry, without any remuneration, the burden of medical care for the indigent population. However willing the great body of physicians might be to give their share of gratuitous service, this localization of population groups with very low incomes or no income at all, made it impossible to distribute the burden of medical care in any equitable manner.

MEDICAL SOCIETY EXPERIMENTS

With that willingness to experiment which, in spite of its critics, the medical profession has shown to as great a degree in the social as in the scientific field, a large number of county medical societies attempted to develop methods of meeting this situation. The first objective was a high standard of medical care for the

indigents and, as far as possible, an equal distribution of the burden of gratuitous care on the whole body of organized physicians. The most successful of these plans, although none of them has escaped some criticism from their creators and administrators, came to be known as the "Iowa Plan" because of its origin in that state.

In the beginning, some of the county medical societies simply proposed to assume the responsibility for the medical care of the indigent in return for whatever sums were available. The county medical societies then arranged, first, for a free choice of physician from among all their members and, second, some regular routine of assignment of members to those patients who did not express a choice of physician, so as to secure as nearly an equitable distribution of the burden on the entire profession as was possible. Since it had always been recognized that this service was a part of the duty assumed on entering the profession, the original schemes did not provide for any distribution of the money received among the individual physicians rendering service. The funds received from county officials went directly into the treasury of the county medical societies, where it was used for whatever purposes it was felt would best advance the interests of the profession. Among the more common ways in which it was expended were for the payment of medical society dues, rent of medical society headquarters, accommodations, purchase of books or periodicals for the local medical library, payment of premiums for malpractice insurance, etc.

DEVELOPMENTS IN COUNTY MEDICAL SOCIETY PLANS

Recent social changes have been extraordinarily rapid and in few places have these changes been more rapid than in the medical care of the indigent. As numerous counties adopted plans to care for the indigent, the original pattern was more or less modified. When 10

to 30 per cent, and in some localities even more, of the population were forced to depend on some form of relief agency for medical care, the necessary expenditures by relief authorities became too large to be treated in the same manner as was done in the early experiments. At the same time the incomes of physicians dropped and so much of their time was devoted to care of the indigent that county medical societies were compelled to apportion the money received from relief authorities among their members according to the services rendered.

Two main types of county medical society plans are described in a study made by the State Board of Social Welfare of Kansas.¹³

(1) A contract plan, whereby the county paid to the local medical society or a group of organized doctors at stated intervals a specified lump sum, in return for which all members signing the contract agreed to furnish needed medical services to public assistance clients. The sum was either placed in the group's treasury for educational purposes, or prorated among the members.

(2) A fee method of payment open to physicians, whereby a schedule of fees was established by agreement of the county welfare board with the medical society, or with unorganized physicians; or whereby the amount of payment was set by the county board or the county director of social welfare.

The Committee's evaluation of these two types of plans makes their features still clearer. The Committee set up the following standards for the evaluation of programs:¹⁴

It was the consensus of the Committee that the most desirable plan for providing medical care to public assistance recipients would:

1. Allow the county board to estimate, budget and control the expenditures for medical care;
2. Provide for an individual accounting of services rendered so that state and federal reimbursement may be obtained;
3. Provide the most adequate medical facilities and professional services;

13. Medical Assistance in Kansas, Research Study No. 4, May 1938, Division of Research and Statistics, State Board of Social Welfare of Kansas, pp. v-vi.

14. Footnote 13, p. ix.

4. Maintain the traditional physician-patient relationship in which the recipient needing medical care may consult a physician of his own choosing;

5. Provide compensation for all physicians rendering medical services to public assistance recipients.

In regard to the "Lump Sum, Paid Organized Group," the Committee said:¹⁵

Contract arrangements with the members of the county medical society, the physicians to be compensated for their services on a lump sum or controlled fee schedule basis, exhibited the greatest number of advantages. These advantages were:

1. The contract enables the county board of social welfare to budget and control expenditures for medical care.

2. Under the controlled fee schedule, an individual accounting of services rendered can be made, to permit reimbursement from state funds.

3. More adequate services were considered to be available under a contract with an organized group than is possible under other methods.

4. Clients are permitted a free choice among those physicians agreeing to the contract.

5. Compensation is provided for all physicians in the group who render services to public assistance recipients, thus eliminating a large share of the burden of free services found necessary under most present systems.

6. In addition, it was believed that the provision of a committee of physicians selected by the medical society to function as a liaison committee between the physicians and the county board of social welfare, would result in solving many of the difficulties and misunderstandings associated with the provision of county medical care.

The plan has the present disadvantage of not being able to provide for federal reimbursement on amounts paid the group for medical services rendered social security recipients.

Of the "Organized Group, or All Physicians, Paid on Fee Basis," the Committee said:¹⁶

The advantages of this plan are:

1. The individual recipient may call any physician entering into the agreement. The personal relationship between the physician and the patient is thus maintained.

2. All the doctors have an opportunity to share in the counties' expenditures for medical assistance.

15. Footnote 13, pp. ix-x.

16. Footnote 13, p. xi.

3. Reimbursement from state and federal funds is easily secured on authorized medical services.

These advantages were considered to be outweighed, however, by the difficulty of controlling total cost. The uncontrolled fee schedule plan places on the county director the necessity of determining what services the sick recipients are to receive. This is an undesirable situation, for no layman is qualified to determine the kind and amount of medical attention which people need. The only alternative is to make no limitation on the services payable, which is impossible in view of the limited funds available.

It is noticeable that any of these plans is preferred to the system of "county doctors," whether these are paid a salary or fees.¹⁷

County medical society plans for furnishing medical care to the indigent are so diverse in their character and sometimes so transient in their operation that no complete or up-to-date census of them has been possible. It is, however, a safe estimate that more than two hundred such plans were in operation in the United States in 1938. Some have been found unsatisfactory and have been abandoned. Many of them have been changed in type. Some have evolved into medical service plans for the low income groups, while still others have become an integral part of a statewide organization and have thereby lost much of their local identity. Because such experiments are now in operation and probably will continue, and since such plans are based on somewhat different types of contract between the county medical society and the administrators of poor relief, some samples of these contracts are given.

LUMP SUM CONTRACTS

This contract made and entered into by and between the county of Washington, State of Iowa, by its board of supervisors, hereinafter referred to as the county and the Washington County medical society, hereinafter referred to as the society, and pursuant to resolution of the Board of Supervisors of said Washington County duly passed on the day of 19...

17. For further discussion and opinions on the defects of county doctors, see: Report of the Committee on Medical Care, American Public Welfare Association, Annual Meeting, Seattle, Washington, June 1, 1938, pp. 36-37.

WITNESSETH:

The county agrees to pay to the Society the sum of Eighteen Hundred Dollars, payable as follows:

One fourth of the above amount to be paid on or before 19., one fourth on or before the of 19., and one fourth on or before the of19...

In consideration thereof the society agrees to furnish all medical services needed by the poor people of Washington County, Iowa, during the year beginning 19., and ending 19., and said society further agrees to furnish all medicines and supplies for said poor people except as follows, to-wit:

Vaccines, serums and anti-toxins to be furnished by the county when needed upon proper order of the township board or the overseer of the poor.

Executed at Washington, Iowa, this day of A.D. 19...

COUNTY OF WASHINGTON, STATE OF IOWA

By
Chairman of County Board of Supervisors

ATTEST:

.....
County Auditor

By
Committee

COOPERATION WITH HEALTH DEPARTMENT
CONTRACT

THIS AGREEMENT, made the day of January, 1934, between the Board of County Commissioners of Butler County, State of Kansas, of the first part, and

.....
Butler County Members of the Butler-Greenwood County Medical Society, of the second part:

WITNESSETH:

That the Board of County Commissioners of Butler County, State of Kansas, agrees to employ the party of the second part for the purpose of furnishing medical and surgical care to the pauper poor of Butler County, State of Kansas, and for the added purpose of assisting the County Health Officer of Butler County, State of Kansas, in performing the regular duties of that office, both purposes subject to the terms and conditions stated below. The party of the second part agrees to furnish medical and surgical aid to the pauper poor of Butler County, State of Kansas, and to assist the County Health Officer of

Butler County, State of Kansas, in performing the regular duties of that office, both subject to the terms and conditions stated below.

It is understood and agreed that the party of the first part furnish the party of the second part a list of all recognized paupers in Butler County, State of Kansas, and that this list be corrected by the party of the first part once each month and that the persons whose names appear on such list may be furnished medical and surgical care by the party of the second part without further authority than the presence of their names on such list.

It is further agreed that when persons whose names do not appear on said list apply for medical and surgical aid, authority to render such aid at the expense of Butler County, State of Kansas, must be had from the Commissioner of the Poor of Butler County, State of Kansas, or from the Chairman of the Board of County Commissioners of Butler County, State of Kansas.

It is further agreed, that, in cases of extreme emergency where the proper authority to render such medical and surgical aid as may be indicated is lacking, bills for such services may be rendered to the Board of County Commissioners of Butler County, State of Kansas, for their consideration.

It is further agreed that all medical and surgical service will be rendered to the regularly listed paupers of Butler County, State of Kansas, by the party of the second part for the consideration of \$350 per month, payable to the Butler-Greenwood County Medical Society.

It is further agreed that the party of the second part shall furnish only such drugs and medicines as are immediately necessary, with the exception of endocrine products, the various so-called specific sera, and donor's blood for transfusion purposes. Prescription services with all dispensing physicians and drug stores is to continue unmolested by these agreements.

It is further agreed that the party of the first part will elect one of the members of the party of the second part as County Health Officer and that he is to fulfill the duties of that office for the salary of \$75 per month, payable to him by the party of the first part. He, in turn, will appoint the other members of the party of the second part as Deputy Health Officers; but, the Health Officer will be accountable for all of the reports and responsibilities of that office. All postage and long distance calls necessary to fulfill the duties of County Health Officer are to be furnished by the party of the first part. All automobile mileage necessary to fulfill the duties of the County Health Officer are to be furnished by the party of the first part at the rate of five (5c) cents per mile both ways.

It is further agreed by both parties represented in this contract that sixty (60) days' notice by either party may void this agreement.

IN WITNESS WHEREOF, the parties hereto have hereunto set their hands the day and year first above written.

.....

 Party of the First Part.

.....

 Party of the Second Part.

ADDENDA :

It is also understood that the indigents' names shall be listed alphabetically by the party of the first part and divided equally by the party of the first part among the alphabetically listed names of the party of the second part in localities where there is more than one doctor.

The party of the first part further agrees to notify indigents to whom they shall apply for medical aid. It is also agreed by the party of the first part that a revision of the pauper list shall be made the first of each month and the members of the party of the second part be notified of changes in his list in order that an equal division of indigents may be maintained.

MEDICAL SOCIETY SURVEYS

As it became evident that experiments with and development of systematic methods of furnishing medical care to the indigent should be conducted by the medical profession, state medical associations undertook investigations to obtain a sound factual foundation for further experimentation. Any list of the states that have made such studies will seem to be making invidious omissions because of the impossibility of including all. The following list of states is offered frankly as little more than a sample of the work that has been done in these areas by state medical societies: California, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, New Jersey, Pennsylvania, West Virginia, and Wisconsin. These studies have, on the whole, attempted to maintain scientific accuracy as to definitions of "illness," "indigency," and other items involved, which is so noticeably absent from other more widely advertised studies.

PLAN WITH FEE SCHEDULE

As soon as county medical societies recognized that this problem of the medical care of the indigent was more nearly permanent and much more extensive than had been thought at the beginning, many state medical societies endeavored to organize and standardize county society plans along state lines. An incomplete list of the states where this further step in experimenting with, testing, and approving such organizations has developed to the point where certain standards have appeared includes: Iowa, Kansas, Michigan, Minnesota, New Jersey, Pennsylvania, and Wisconsin.

After several meetings between representatives of the Pennsylvania Public Assistance Department and the various medical and allied health groups planning to participate in the delivery of medical service to the indigent throughout the state under coordinated state and county administration, a bulletin was sent out by the chairman of the Committee in Public Health Legislation of the Medical Society of the State of Pennsylvania.¹⁸ This Bulletin suggested that each county medical society should immediately appoint a committee of three members "to act as a subadvisory committee to the county Central Healing Arts Advisory Committee to the County Public Assistance Board." The Bulletin continues with the following instructions: "Select one of the members of your county medical society committee to act as a member of the county Central Healing Arts Advisory Committee to the County Public Assistance Board, which shall also include at least one member of the County Public Assistance Board. . . . After your county medical society committee is formed, call on the other groups of the allied healing arts profession in your county to do likewise; then call on your County Public Assistance Board, the personnel of which

18. *Pennsylvania M. J.* 42: 163 (Nov.) 1938.

is herewith enclosed, for the purpose of outlining a plan in your county." The following Enclosure accompanied this Bulletin :

Enclosure (B)

Effective September 15, 1938

\$1 for office calls.

\$2 for home visits in urban sections and within 5 miles of physician's office in rural sections.

Five cents a mile expense allowed for over 5 miles in rural sections in addition to fee.

\$25 for obstetric cases. This shall include delivery and adequate pre- and postnatal care.

For home and office treatment of surgical conditions, as fractures and operations, the fee shall be arranged with the County Advisory Healing Arts Committee in consultation with the proper professional subcommittee. It is understood that 50 per cent of the usual fee for such conditions will constitute a working basis.

Home and office roentgen-ray fee of \$5 in all fractures or suspected fractures where it is necessary to determine the presence or absence of fractures.

All cases requiring long period of treatment or hospitalization must be referred to the proper County Advisory Committee and through them to the County Central Healing Arts Advisory Committee.

It is understood that this service shall be a minimum consistent with good medical practice and bills rendered shall be in accordance with the conditions treated.

All bills shall be itemized and rendered the fifth of the month following that in which the service was rendered.

In all differences of opinion relative to these fees and regulations, the proper subcommittee shall meet with the County Central Healing Arts Advisory Committee in an attempt to arrange a satisfactory settlement of the dispute.

Due to the lack of sufficient funds to operate the program over any extensive period, we believe that this is to be a tentative, experimental program.

In a number of counties there is no formal contract. The county relief authorities simply agree with the county medical society upon a fee schedule and the appointment by the medical society of a committee to maintain the standards of medical service, enforce medical discipline, and arbitrate disputed bills. This type of arrangement seems to have appeared first in Iowa

where the medical society contract plan originated. It has now been established in some form in Minnesota and Pennsylvania, and probably in other states.

The Iowa State Medical Society, out of longer experience than any other state with this type of medical care, has, with legal advice and after careful consideration of results, adopted the following suggestions as to forms of county contracts :

FORMS FOR COUNTY CONTRACTS

The forms and procedure here outlined for use in making contracts between county medical societies and boards of supervisors for care of the indigent sick are recommended by the Medical Economics Committee of the Iowa State Medical Society for the following reasons: (1) incorporation is unnecessary, (2) the procedure is perfectly legal, (3) the personal liability of each physician is limited to his own acts and (4) the forms are simple and business-like. The following material will be found.

I. Appointment and Authorization of Agent

II. Bid

III. Contract

IMPORTANT INSTRUCTIONS

THE FORM FOR "APPOINTMENT AND AUTHORIZATION OF AGENT" AND THE PARAGRAPH NUMBERED 5 OF THE "CONTRACT" SHOULD BE USED AS THEY ARE. The opening paragraph and the paragraph numbered 4 of the Bid, and the two first paragraphs and the paragraph numbered 4 of the Contract, should also be used with little, if any, change.

It should further be noted that it is not necessary for a society which is incorporated to dissolve the corporation, since the contract is made, not by the society, but severally by the individual physicians. This latter fact is very clearly set forth in paragraph 5 of the Contract and that clause has as its purpose the limiting of the liability of each individual physician to his own acts.

These forms are in main those developed for the Marion County Medical Society by its attorney, one addition having been made from the form devised for the Polk County, Wisconsin, Medical Society. Other legal opinions have approved them and the attorney general's office has concurred. Thus, these forms and this procedure seem to avoid the illegality of incorporation and still afford the safety for members and the businesslike procedure for the county provided by incorporation.

The paragraph numbered 1 of both Bid and Contract should set forth the general terms and list the services to be included

in the contract. Paragraph 2 should be used for any special modifications and paragraph 3 may of course be modified to suit the situation. (Note: Assistance in devising the specific terms of the contract may be procured from a study of the contracts in force in other counties, copies of which are available in the state society office.)

* * * * *

APPOINTMENT AND AUTHORIZATION OF AGENT

We, the undersigned, all being duly licensed to practice medicine in the state of Iowa, and being engaged in the practice of medicine in County, Iowa, do hereby severally, and as a group, constitute and appoint, one of our number, as our agent, and the agent of each of us, for the purposes hereinafter expressed, and do hereby authorize and empower him, as such agent, to submit to the Board of Supervisors of County, Iowa, for us and in our behalf and in our names, from time to time, lump sum bids for the medical care of the indigent poor of County, Iowa, upon such terms and conditions as he in his discretion may deem expedient and appropriate, such care to be furnished in each individual case by such one of us as may be called upon to perform such service.

And in the event that such bid or bids be accepted by the Board of Supervisors of County, Iowa, we hereby authorize and empower the said as our agent, to enter into, and execute in our names, a contract to perform the services specified in the bid or bids above contemplated and for the amount or amounts specified in said bid or bids which shall be in full payment for the services to be rendered by any one or more or all of us pursuant to the terms of such contract.

And further, in the event that such bid or bids be accepted and contract or contracts entered into, we, and each of us, do hereby authorize and empower the said as our agent, to collect, receive and receipt for the amount or amounts payable under such contract or contracts, and payment of the contract price to him, and his receipt therefor, shall operate to fully discharge the obligation of County, Iowa, and the Board of Supervisors of County, Iowa, under such contract or contracts.

It is the intention and purpose in executing this instrument to authorize and empower the said, as our agent, in making such bid or bids and/or contract or contracts and/or in receiving and receipting for the contract price, to bind us, and each of us, as fully, and to all intents and purposes the same, as though such bids, contracts and/or receipts were executed by each and all of us individually, and to give and grant unto our said agent full power of substitu-

tion in the premises, and this appointment and authorization shall be binding until revoked in writing and such revocation filed in the office of the Auditor of County, Iowa.

Executed this day of A. D. 193...

(To be signed by all physicians who are to be parties)

* * * * *

BID

We, the undersigned, by, our agent, all being duly licensed to practice medicine in the state of Iowa, and being engaged in the practice of medicine in County, Iowa, do hereby propose to render to (the pauper poor of County, Iowa, as the same are defined in Section 5297 of the Code, including inmates of the County Farm and excluding persons confined in the County Jail) the services hereinafter specified upon the terms hereinafter set forth, to-wit:

1. The services to be rendered shall include
- 2.
3. The services to be rendered shall be for the period of one year from and after the date of entering into a contract hereunder.
4. There shall be paid to the undersigned for the services specified above the sum of \$..... in four equal installments of \$..... each, to be paid on the day of to

Name of Agent

authorized by each and all of the undersigned to receive and receipt for such payments, and the payments of said sums to the said shall fully discharge the obligations of County, Iowa, under any contract entered into in pursuance of this bid.

Executed this day of A. D. 193...

.....
.....
.....
By.....

Agent

(The names of all physicians who are parties should be type-written in the place for the signature and the bid signed only by the agent.)

(The Bid and the Appointment and Authorization of Agent should both be filed with the County Auditor.)

(The class of persons to whom services are to be furnished and terms and conditions of the proposed contract may be modified to meet local conditions or the desires of the parties.)

(The contract should be drawn to strictly conform to the Bid.)

CONTRACT

This Agreement made and entered into this day of A. D. 193..., by and between, by, their duly authorized agent, (Name of Agent)

parties of the first part, and the Board of Supervisors of..... County, Iowa, on behalf of said County, parties of the second part, Witnesseth:

That parties of the first part, each and all of whom are duly licensed to practice medicine in the state of Iowa, and engaged in the practice of medicine in County, Iowa, shall render to (the pauper poor of County, Iowa, as the same are defined in Section 5297 of the Code, including inmates of the County Farm and excluding persons confined in the County Jail) the services hereinafter provided for upon the terms and conditions and for the consideration hereinafter expressed.

1. The services to be rendered under this contract shall include

2.

3. The services to be rendered under this contract shall be for the period of one year from and after the date hereof.

4. Parties of the second part shall pay for the services provided for herein the sum of \$..... in four equal quarterly installments of \$..... each to be paid on the day of to, and the

Name of Agent

said is hereby authorized by each and all of the parties of the first part to receive and receipt for such payments, and the payments of said sums to the said shall fully discharge the obligations of parties of the second part hereunder.

5. It is mutually agreed by all the parties hereto that this contract is a several contract by and between the first party and each of the second parties, and that the second parties are not bound jointly; and that this contract is not made for the benefit of any county patient; and that the default, malfeasance, or misfeasance of any party of the second part shall not be attributable to any other party of the second part.

Executed this day of A. D. 193...

.....
By.....

Agent

Parties of the First Part
Board of Supervisors of
..... County, Iowa,
and County,
Iowa.

By.....
Parties of the Second Part.

(The names of all physicians who are parties should be type-written in the place for signature and the contract signed only by the agent.)

(The terms of the contract and bid may be modified and changed to meet local conditions or the desires of the parties.)

The Report of the Secretary of the Iowa State Medical Society to the House of Delegates of that Society for the year 1937 summarized the lessons learned through experimentation with county society contract plans as follows:

A survey of the different forms of county society contracts for the care of the indigent reveals the fact that the majority of the counties are no longer dependent on the state for funds to carry on this work. Many of the counties have returned to a type of service which is governed by a contract entered into by the county medical society and the board of supervisors. Some of these contracts are based on a fee schedule, and some on a lump sum payment. Many of them are working satisfactorily, but others do not have the support and enthusiasm of the medical society.

There is one thing which has been called to the attention of the Secretary, and that is that in those counties where there is an auditing committee of physicians which functions efficiently, the set-up is more satisfactory than in those counties where such an auditing committee is more nominal than real. It is the responsibility of the county medical society to audit the bills for medical service, and when this is properly done, there is less dissatisfaction, no matter what plan is in force in that county.

Another point which seems to merit consideration is that each county medical society should formulate its own fee schedule and be governed by it. Instances might be cited wherein the fees demanded for the care of indigent patients are higher than the fees charged private patients by the same physician.

The central office of the State Society does not feel that it should determine the fees for medical service for each county, nor dictate what plan of medical care should be followed. Conditions vary too greatly in the individual counties for any one plan to work equally well in all sections of the state. A plan which is successful in an urban county would not be suitable for a rural community. The State Society feels very strongly that it should act, through its central office, as a clearing house of information. It should have on file a copy of every county contract, and should know the good and bad points of each contract. It should be ready to furnish information regarding all plans whenever such a request is made. Only by an accu-

rate and complete compilation of data regarding county society contracts will it be possible to determine what plans will work to the best interests of all concerned.

The whole problem of medical care for the indigent has been greatly affected not only by the Social Security legislation, which will be discussed in the next chapter, but by the creation of forms of federal relief such as the Works Progress Administration, the Public Works Administration, old age pensions, the Farm Security Administration, and unemployment compensation. So far as the first three of these categories are concerned, the relief given is seldom sufficient to provide for more than such necessities as food, clothing, and shelter, and the recipients still remain in the class of the "medically indigent." Reports from several states indicate that plans for the care of the indigent will in the future be compelled to take into consideration these classes of persons. This will almost certainly require further adjustments of most existing plans and also the development of sympathetic working relations between the administrators of such forms of assistance and medical societies.

NECESSITY OF MEDICAL SOCIETY COOPERATION

The experiments conducted by organized medicine have demonstrated the need of continuous cooperation between the state and county medical societies. The state medical society can be expected to have a wider foundation of knowledge and experience than almost any component society. In so far as uniformity and standardization are possible within the boundaries of a state, it is the function of the state medical society to determine such standards. It is therefore urged that no county medical society undertake any experiment in the organization of medical care without consultation with and approval of the state medical society.

Another point that should be kept in mind in considering the formulation of any plan is the need for thorough investigation and preparation. In plans con-

fined to the care of the indigent there may not always be time for any such extensive or even preliminary study. The medical society is confronted with a situation that at times may need to be decided on quickly. It is seldom, however, that there is not time to obtain information concerning the results of experiments that have been conducted elsewhere and to use such information in formulating any plan that may be undertaken.

One vital phase of the problem of the care of the indigent is the cost of or at least the expenditure for medical service. The available figures pertaining to the costs of medical care are so confused by large items of gratuitous and low-pay care and by an intermixture of other than purely medical elements that not only are the variations between different localities so wide as to bar any common conclusions, but all figures must be considered as of somewhat doubtful accuracy. In Minnesota, for example, out of a total expenditure for relief of \$11,358,077 in 1937, there was an expenditure for medical care of \$381,754 or 3.3 per cent of the total expenditure.¹⁹ At this time—December 31, 1937—the “case load for direct relief, W.P.A., and Social Security Aids” was 278,053 persons. The medical care was assumed to cover persons in all of these categories, but the load differed so widely that the extent to which variation in elements entered into the total at any one time or to which proper medical care was given to each of the various classes of relief clients cannot be determined. It is perhaps of little importance to note that, using the figures given above, the average amount expended for medical care for all of these clients would be \$1.37 per person per year; this is manifestly too low an amount to ensure any semblance of good medical care.

Oakland County, Michigan, was one of the first counties to undertake, first under the Federal Emergency

19. Facts and Figures on Medical Relief in Minnesota, Minnesota State Medical Association, Feb. 26, 1938. (Mimeographed.)

Relief Administration and later in cooperation with the administrators of public relief, the task of furnishing medical service to the indigent. The very carefully kept financial records of the Oakland County Emergency Relief Administration show that for the four years, 1934 to 1937, inclusive, the average cost per case per year actually treated was \$18.50, and the cost per person per year on relief was \$4.40.

As a part of the American Medical Association Study of Need and Supply of Medical Care, Jefferson County, Iowa, reported that in 1937 "the annual expense for medical care of the 2,019 indigent people amounted to an average of approximately \$3.50 per person. The actual expense of the 482 cases which received medical attention, hospitalization, laboratory, dental attention, etc., was about \$15 per case."

A recent report of the Medical Economics Committee of the Iowa State Medical Society says, regarding state action on payment for medical care: ²⁰

On September 28 the members of the state relief committee met and informed the Medical Economics Committee that they had agreed to allow the sum of \$2.00 per month for unemployment relief cases and \$2.50 per month for regular county cases where the medical grant was furnished by the state. This is a very satisfactory allotment, and with careful administration by the county medical relief committee should pay the bills for the relief work on the reduced fee schedule in full. In addition to the amount allotted, the state committee had previously offered to allow any unused funds during light months to accumulate, so that they might be used by the medical committee in later months when there might be a heavier medical load. After the plan has been in operation for a short time sufficient funds will undoubtedly accumulate to carry, without any cut, the medical relief load during months when there is an unusually heavy demand.

Another much more detailed study made in Michigan ²¹ showed that in the systems of relief in eight of the counties surveyed, which exclude many of the

20. Increased Compensation for Medical Relief, *J. Iowa M. Soc.* 28: 499 (Oct.) 1938.

21. Sinai, Nathan; Hall, Marguerite F.; Hogue, V. M., and Steep, Miriam: Medical Relief in Michigan—A Study of the Experiences in Ten Counties, Ann Arbor, Michigan, Edwards Brothers, Inc., 1938, p. 123.

expenditures for nursing and administration, the median cost of medical care (including some hospitalization and nursing) per person on relief during 1934 was \$11.44. We are warned that this "is not to be interpreted as a final figure that covers the costs of all medical relief in the eight counties." When the "total cost of medical relief including all hospital care is charged against the population on general relief, as a suggested method of estimating future costs, the total reaches \$17.09 per person" per year.

These figures are given as illustrations of the wide variation in such estimates as are obtainable from present information rather than as guides in calculating the costs for any particular plan of medical relief. Practically every plan designed to assist low income groups or the indigent to obtain good medical care involves important reductions—often about one half—in the customary fees paid to physicians for similar services.

In attempting to calculate the cost of medical care for the indigent, a number of items must be included which are not met with in ordinary business transactions. Usually the funds available are too small to afford good medical care at current prices for service and medical supplies. There is almost always an important element of gratuitous service on the part of physicians, dentists, pharmacists, and hospitals. One of the problems that the county medical society must solve is to spread what funds are available in such a way as to deliver the best possible medical service. A county medical society must approach these problems honestly, with a determination to uphold the standards of medical practice and medical ethics even at some sacrifice in the payments made to its members and with full recognition of the fact that they are thereby assuming a portion of the financial burden which should be borne by the entire community. This reduction in the amount received for services rendered represents the physicians' contribution to the care of the indigent.

CHAPTER III

EFFECTS OF SOCIAL SECURITY LEGISLATION

The entire picture of care for the indigent has been changed by state enactment of some phases of the Social Security Act. These are now in operation in fifty-one jurisdictions—forty-eight states, Hawaii, Alaska, and the District of Columbia. This law, which is based on a close integration of federal and state plans, called for special legislation in every state which desired to take advantage of the terms of the federal act.

One especially significant phase of the majority of such laws was the creation of branches of state government usually known by some such title as "department of social security and public welfare."²² While these departments are primarily established to meet the provisions of the Social Security Act in regard to old age, unemployment, care for the blind, maternal and child welfare, crippled children, and other types of what has come to be known as "categorical relief," it was but natural that in many states general poor relief and medical care for the indigent should also be placed under the control of such departments. The typical organization of these departments includes a salaried director, and an appointed board, the duties and powers of which vary widely from state to state. It is claimed that these boards are usually representative of the

22. *New State and Local Departments of Public Welfare—1937, Outlined Digests of Recent Laws*, American Public Welfare Association, Chicago, October 1, 1937; *The Legal Basis of Public Medical Care in Twelve States*, American Public Welfare Association, Chicago, October 1936; *Poor Relief Laws: A Digest*, Public Administration Service, No. 37, American Public Welfare Association, Chicago, 1934; *Welfare, Relief and Recovery Legislation, Federal and State, 1933-1934*, Public Administration Service No. 45, American Public Welfare Association, Chicago, 1935; *Characteristics of State Plans for Aid to the Blind*, Publication No. 17, Bureau of Public Assistance, Social Security Board, Washington, D. C., 1938; and *Characteristics of State Plans for Aid to Dependent Children*, Publication No. 18, Bureau of Public Assistance, Social Security Board, Washington, D. C., 1938.

organizations, professions, and interests concerned with public welfare. Since many phases of the Social Security Act deal with medical care, it was deemed advisable to appoint as a member of such boards a physician, who in many cases is recommended by the state medical society.

The arrangements under nearly all of these new state welfare or social security laws provide for county boards modeled after the state organization and on which the county medical society often has a representative. Most of these laws have been enacted since 1936 and it is too early to determine the full effect of such legislation and administrative organization on the care of the indigent.

The provisions of the Reorganization Act of 1939 (Public No. 19, 76th Cong., approved April 3, 1939) and the President's Reorganization Plan No. 1 (effective July 1, 1939, under Public Res. 20, 76th Cong., approved June 7, 1939) established the Federal Security Agency which comprises the Social Security Board; the Public Health Service, formerly under the Treasury Department; the Office of Education, formerly under the Department of the Interior; the Civilian Conservation Corps; and the National Youth Administration, formerly under the Works Progress Administration.

The changes effected by the Social Security Act Amendments of 1939 are substantial and comprehensive in that they modify all titles of the original act. The most important changes are those dealing with the Federal old-age insurance program, which was revised and expanded to form a program for Federal old-age and survivors insurance. Other amendments related to the Federal-State systems of unemployment insurance and public assistance. The amendments also increased the amounts authorized for Federal grants to states for maternal and child health, crippled children, child welfare, vocational rehabilitation, and public health, under programs of the Social Security Act directed by Federal agencies other than the Social Security Board.²³

Certain titles in the Social Security Act are closely related to medical relief. These are: Title IV, grants-

23. Fourth Annual Report of the Social Security Board, 1939, Washington, D. C., United States Government Printing Office, 1940, pp. 166-167.

in-aid to the states to assist them in giving aid to dependent children; Title V, grants-in-aid to states to increase the funds available for services relating to maternal and child welfare, the care of crippled children, and vocational rehabilitation; Title VI, grants-in-aid made to states for developing their public health services and assisting the United States Public Health Service to carry on scientific research.²⁴

The major changes in the financial provisions of the public-assistance programs are summarized below.²⁵

Federal grants to states for approved old-age assistance plans represent:

1939 Provisions

Effective Jan. 1, 1940, one-half the state's expenditures for assistance payments, not including amounts by which individual payments exceed \$40 a month per recipient, plus—

Five per cent of this amount, which may be used for administration, assistance, or both.

Federal grants for approved plans for aid to dependent children are made on the following basis:

1939 Provisions

Effective Jan. 1, 1940, one-half the state's expenditures for assistance and administration, not including amounts by which monthly payments exceed \$18 for the first child and \$12 for each additional child aided in the same home.

Federal funds may be used to aid children up to the age of 16, or 18 provided they are regularly attending school.

Federal grants for approved plans for aid to the needy blind represent:

1939 Provisions

Effective Jan. 1, 1940, one-half the state's expenditures for assistance payments, not including amounts by which individual payments exceed \$40 a month per recipient, plus—
One-half the state's total administrative expenditures.

Additional Federal funds have been authorized for the health and welfare programs administered by other Federal agencies under the Social Security Act. The addition of \$7,612,000

24. McDavitt, T. V.: *The Social Security Act and Its Relation to the Medical Profession*, A. M. A. Bull. 31:42 (Feb.) 1936.

25. Fourth Annual Report of the Social Security Board, 1939, Washington, D. C., United States Government Printing Office, 1940, pp. 179-180.

brings to \$25,700,000 the total Federal authorization for these services. The changes in annual authorizations for these programs are as follows:

Program	1939 Provisions
Maternal and child health.....	\$ 5,820,000
Services for crippled children.....	3,870,000
Child welfare services.....	1,510,000
Vocational rehabilitation	3,500,000
Public health	11,000,000

Effective Jan. 1, 1940, Puerto Rico may participate under the Social Security Act in all these health and welfare programs.

SECTIONS ON MATERNAL AND CHILD WELFARE

The sections of Title V and those sections of Title VI pertaining to the development of public health services are so largely concerned with health and medical care that in a majority of the states their administration and supervision have been confided to the state health departments. The administration of services to crippled children has also been allocated to state health departments in some cases. Aid to indigent children under Title V is usually administered by the state department of public welfare, state board of charities, or some similar department.²⁶

The section on vocational rehabilitation, under Title V, is administered by a Federal Board of Vocational Rehabilitation, sometimes in cooperation with state boards or commissions charged with the administration of workmen's compensation. In West Virginia the Bureau of Industrial Hygiene of the State Health Department cooperates on the rehabilitation program with the State Department of Mines, the State Compensation Department, and the State Department of Labor. It is in connection with this bureau that the West Virginia State Medical Association has done some remarkable work in industrial rehabilitation. The West

26. State Agencies Administering Services under Title V, Parts 1, 2 and 3 of the Social Security Act, mimeographed bulletin issued by the Children's Bureau, U. S. Department of Labor, Washington, D. C., January 3, 1938.

Virginia State Medical Association has developed this program to an extent where it has received nationwide attention and where it is accepted as a permanent activity of the rehabilitation program under social security.

Other forms of benefits that may be made available under the provisions of the Social Security Act are receiving consideration by the Social Security Board. These benefits, if found feasible, would provide cash compensation for loss of wages due to disability from sickness.

At the special session of the House of Delegates, Sept. 16 and 17, 1938, called to consider a proposed National Health Program, the recommendations on insurance against loss of wages during sickness received the following endorsement:

In essence, the recommendation deals with compensation of loss of wages during sickness. Your committee unreservedly endorses this principle, as it has distinct influence toward recovery and tends to reduce permanent disability. It is, however, in the interest of good medical care that the attending physician be relieved of the duty of certification of illness and recovery, which function should be performed by a qualified medical employee of the disbursing agency.

This form of cash compensation during disability is now attracting general interest. The New Hampshire legislature in 1939 passed "an act establishing a commission for the purpose of studying the possibilities of protecting individuals unemployed because of sickness or ill health." This commission has just reported in favor of the enactment of legislation for this purpose. The commission made a study of the frequency of disabling illness among New Hampshire workers and found that there were 112 cases of such disability per thousand employees.²⁷ This is a somewhat lower rate than has been found under most of the compulsory sickness insurance schemes of Europe. The average

27. Commission on Disability Benefits, Report to His Excellency Robert O. Blood, Governor of New Hampshire, Concord, N. H., Concord Press, 1941.

period of incapacity was found to be five calendar weeks. There was a considerably higher rate of disability in the low income classes as compared with those receiving over \$1,500 a year. It was found that not over 29 per cent of the employees are at present covered by any form of disability insurance. In 1939 the companies doing an accident and health insurance business in the state received \$583,243.43 as premiums and paid losses amounting to \$299,335.72. While it was recognized that there are some difficulties in certification of incapacity for work by a private physician, it was thought that "Administrative machinery can be devised to provide checks on malingering which admittedly is possible under the family physician plan." The plan proposed a tax of 1 per cent on earnings, which it was believed would be more than adequate to provide benefits of one half of average earnings during the previous year for sixteen weeks of disability, after one week's waiting period, in any one year. It was proposed that the plan be administered by the workmen's compensation authorities. Since only sixteen weeks of disability would be paid for, the plan would make no provision for permanent disability. This recommendation was based on the thought that "Insurance against invalidity or permanent disability is partially provided in the Federal Old Age and Survivors' Insurance Program."

The Social Security Board is investigating social insurance for permanently disabled workers.²⁸ The board evidently disagrees with the New Hampshire commission and believes that permanent disability at least should be handled in connection with old age benefits. The discussion by the chairman, Mr. A. J. Altmeyer, recognizes the difficulty of avoiding duplications with compensation benefits. He proposes that the disability to be insured is not to be confined to industrial injuries

28. Altmeyer, A. J.: *Social Insurance for Permanently Disabled Workers*, Social Security Bulletin 4:3, number 3, Washington, D. C., Social Security Board, Federal Security Agency, March 1941.

and diseases. At the present time the person who is unemployed because of illness not only receives no benefit from unemployment insurance but, because of his inability to earn wages while disabled, may lose his privilege of receiving unemployment compensation should he return to work. It is suggested that, "after the introduction of disability insurance, periods of certified disability during which the worker is in receipt of disability benefits can be readily entered on the wage record of the worker, and his eligibility for old age and survivors benefits can be determined by omission of these periods. Thus, in effect, the insurance rights of the worker would be maintained during periods of certified disability." It is proposed that such disability insurance be accompanied by provisions for rehabilitation, and attention is called to the rehabilitation program in West Virginia which was originated by the West Virginia State Medical Association.

MEDICAL SOCIETY COOPERATION

The activities authorized under the above mentioned sections of the Social Security Act have required and received much cooperative effort from state and county medical societies. The selection of specialists for the care of crippled children and the blind is in nearly all states related to some extent to the regulations, standards and boards that have been developed with some assistance from the American Medical Association for the certification of specialists. The fixing of standards of service should be assigned to organized medicine which has the necessary competence in this field.

Representatives of the American Medical Association cooperated with the federal authorities in developing the program for maternal and child welfare. State medical societies have been urged to assist in developing this program in their respective states and in numerous instances the states have appointed advisory committees to work with the state board of health in carrying out the provisions of the law.

One of the most significant effects of the Social Security legislation is that in nearly every state it has brought first the state medical societies and later nearly all of the county medical societies into close cooperation and administrative relations with governmental administrative bodies. Were it not for those critics who are constantly making statements to the contrary, it would be almost unnecessary to say that state or county medical societies offered their services in organizing, developing, and making as effective as possible the provisions of the Social Security legislation for the benefit of public health. The opinion of the organized profession as to the desirability of such legislation has not been permitted to interfere with its efforts to be as helpful as possible in making available to the American people the most effective measures for the prevention and control of disease.

In developing this cooperation, it has been necessary for state and county medical societies to devise administrative methods and bodies that need to be coordinated in any plan participated in by these societies for the provision of medical care for any section of the people, and especially for any section of the indigent, dependent, or low-income classes. A few examples of the types of organization that have arisen in response to the cooperative efforts of medical societies and public administrators of Social Security may indicate lines of development.

In Ohio the State Division of Public Assistance, which administers the medical and health program of the section on dependent children, after consultation with the State Department of Health and officials of the Ohio State Medical Association, has recommended the creation of a professional advisory committee of five in each county, to assist the county administrator and county board of public assistance.²⁹

29. Advice and Guidance of County Medical Societies Will Be Sought in Medical Plan for Dependent Children, Ohio State M. J. 33:1145 (Oct.) 1937.

In New Jersey the state medical society rejected the proposal that federal officials should come into the state and supervise the expenditure of funds in the maternal and child health field. As a result, the supervision of the medical work was finally delegated to the Medical Society of New Jersey. The "Field Physicians" to be appointed in New Jersey under this law are to be "local physicians in general practice with general experience in maternal welfare and child health." Such a physician is to be active in his county medical society and make regular reports to it concerning his work. He is to be chosen from three members nominated by the county medical society.³⁰

MICHIGAN FILTER SYSTEM

In Michigan the following points in regard to the administration of the maternal and child health sections of the Social Security Act were agreed to by the State Health Department and the Michigan State Medical Society:³¹

I. That before any program is set up in the county its county medical society will be contacted in a meeting of that society.

II. That the county medical society will immediately appoint an advisory committee of physicians whose advice will at all times be taken into consideration and that no plan will be put into effect of which this advisory committee does not approve.

III. That the program will include no clinics, treatments, or advice with reference to treatment of any kind—in other words, the program includes cooperation only with the private physician.

IV. That any overactivity of lay groups as a result of this educational program will be discouraged and curtailed as far as possible according to the advice of the advisory committee of physicians.

V. That contemplated lectures to lay groups will first be presented in synopsis form to the local county medical society or its advisory committee and that detailed copies will be provided to each member of the society before presentation to lay groups.

30. *The Field Physician, J. M. Soc. New Jersey* 34: 482 (Aug.) 1937.
 31. *J. Michigan M. Soc.* 35: 415 (June) 1936.

VI. That copies of the whole county plan including these stipulations, will be presented to each individual physician when the plan is put into effect in a county.

VII. The plan as presented by the State Department of Health will cover mainly activities in rural areas. It has been approved by the Maternal Health Committee, the Preventive Medicine Committee, and the Public Relations Committee of the Michigan State Medical Society.

In most of the other states the plan was developed in cooperation first with the state medical society and later with county medical societies.

One of the important features of the maternal welfare and child health section of the Social Security Act is the encouragement of graduate work in obstetrics. Even before Social Security funds became available a large number of state medical societies had such a program in operation and in a majority of cases the federal and state funds more recently made available were used simply to expand and extend this work. Here, as in a great number of other cases, the medical societies were several years ahead of government organizations in experimenting with and developing features later included in the Social Security Act. The organized medical profession and the medical colleges have cooperated in developing special training centers for health officials. The Social Security Act provided stipends for applicants for such training administered by the United States Public Health Service. Application for this special training was made through the state boards of health and the applicants were in most cases required to have an M.D. degree.

Although questions were raised as to the possible effect of governmental funds and political influence on this program, the medical profession participated in the program with the same objective of maintaining high standards of medical service and the principles of practice most essential to public welfare as is the motive in private medical practice.

In a few instances medical directors or other officials who were physicians were placed on a salary, but the

great majority of the administrative work required in organizing and conducting the medical features of the Social Security Act was contributed freely and willingly by state and county medical societies.

MATERNAL WELFARE IN PENNSYLVANIA

The Commission on Maternal Welfare of the Medical Society of the State of Pennsylvania submitted the following program of cooperation with the Bureau of Maternal and Child Health of the Pennsylvania State Department of Health. This program is suggestive of the work undertaken by state and county medical societies in furthering cooperation in this field.³²

I. *The State Medical Society.*

A. Maternal Welfare Committees.

County societies not having a maternal welfare committee were named and the member of the commission from that district was asked to secure one if possible. All county maternal welfare chairmen will be urged to function more actively and asked just what they can do to improve obstetric practice in their counties. Regular reports regarding obstetric data will be requested.

The county committees could be instrumental in having more obstetric papers at regular county medical meetings, assist in establishing prenatal clinics where needed, and give much assistance to the Maternal Welfare Commission.

- B. The State Medical Society should encourage the formation of obstetric sections in the larger counties, and joint hospital obstetric staff conferences in smaller communities to which all practitioners should be cordially invited.
- C. Encourage the development of the newly created Scientific Section on Obstetrics and Gynecology in the State Society.
- D. See that more articles dealing with obstetrics are published in the *Pennsylvania Medical Journal*.
- E. Help secure more extensive and better training in obstetrics for interns.
- F. Secure better technic among physicians through extension of graduate training in obstetrics throughout Pennsylvania.

32. *Pennsylvania M. J.* 41: 421 (Feb.) 1938. For a similar program in Missouri, see: *Maternal and Child Health Work Under the Social Security Act*, *J. Missouri M. A.* 33: 203 (May) 1936.

II. *The State Department of Health.*

- A. *The Postgraduate Education Course.* It was believed that the Committee on Maternal Welfare of the county medical society should be the sponsoring group when possible, the time for the presentation of the courses to be decided largely by the sponsors.

The criticism was made that not enough time or thought has been given in some cases prior to announcing the institutes, some of which were planned in counties when highway conditions are at their worst; again, the subjects for discussion were not always well chosen, and the dates often conflicted with other previously arranged meetings.

Due to travel conditions it was believed that for the northwestern section it would be more practical to bring teachers from Cleveland or Buffalo; for the south central part, teachers from Baltimore could easily serve; for the northeastern section, teachers from New York City. This would also tend to lend interest to the teaching.

It was thought that the Obstetric and Pediatric Institutes need not all be given early in the winter, that conditions would be more suitable in some places in the late spring.

- B. *Literature.* The State Department of Health to furnish and The Medical Society of the State of Pennsylvania to distribute booklets on maternity care.

The need for some type of written instruction for both physicians and nurses was discussed. For the physicians, the booklet, *Standards for Prenatal Care*; for the nurses, *Routines for Maternity Nursing*; and for both physicians and nurses, the booklet, *Maternal Care*, edited by Dr. F. L. Adair.

It was thought that if such material could be furnished by the Health Department and distributed by the State Medical Society, it might prove as helpful as any local effort.

- C. *Education of the Public.* The important task is to teach the people what good obstetric care is and how they can get it. This can best be begun by the public health nurse. Realizing that the nurse must first be helped in this work, plans were discussed for institutes and various plans for refresher courses, as given in some other states, the education of the public to be continued by the establishment of prenatal clinics in various communities, especially in outlying districts where there is little conception of what prenatal care really means.

- D. *Survey Analysis of Maternal Deaths.* If notices of maternal deaths could be sent promptly from Harrisburg to chairmen of maternal welfare committees of the county medical societies, it would help greatly, especially in the counties where an effort is being made to analyze such deaths.

A desire was expressed for closer cooperation between the maternal welfare committees of county medical societies and the Bureau of Maternal and Child Health of the State Department of Health.

The proposed maternal and child health program for Luzerne County was discussed and suggestions given regarding its presentation to the Society for further consideration.

DEVELOPMENT OF PUBLIC HEALTH SERVICES

Title VI provides for grants-in-aid to develop public health services for training public health officers and for research. Its administration has been conducted by the United States Public Health Service in close cooperation with existing state departments of health. State medical societies have been the originators of most of these departments and have been their strongest friends in efforts to secure adequate support; it appears that state and county medical societies have not withheld their cooperation on this new program under the Social Security Act.

One of the developments under this Section of the Social Security Act has been the extension of whole-time county health services. The additional funds made available and the interest aroused have led to a rapid increase in such county health departments. These increased in number from 594 in 1935 to 1,577 in 1940.³³ These local health services are largely dependent upon subsidies from sources outside the counties in which they are located.

In most cases the county medical societies have offered counsel and assistance to these county health departments in the preparation of their programs of

³³. Annual Report of the Surgeon General of the Public Health Service of the United States, for the Fiscal Year 1940, p. 4.

activities. Their work is largely confined to control of environmental conditions and such measures as can be applied to the community as a whole or to considerable sections of the community. The typical organization of these health departments includes a public health nursing service which cooperates with physicians in private practice. State and county medical societies are, as far as possible, working with such county health departments to increase the interest and activity of practicing physicians in preventive medicine and public health measures.

COOPERATION IN MICHIGAN

The following instructions issued by the Public Relations Committee of the Michigan State Medical Society to all county medical societies on the organization of county health units set forth the attitude and policies which have been suggested by organized medicine in relation to the extension of public health activity in that state.³⁴

* * * * *

4. *County Health Units.* Social Security funds are being used in Michigan to encourage the installation of county health units. To county medical societies interested in the organization of such a unit, the Public Relations Committee recommends the following suggestions for presentation to proper authorities before approval:

A. The Committee strongly favors the establishment of whole-time county health departments. Where population is sparse, district health departments would be organized to cover two or more counties. Such health departments should employ a full-time health officer and adequately trained personnel, including one or more public health nurses.

(a) In order to obtain the establishment of a county health unit, the Committee advocates the active participation in a campaign to educate the public in the advantages of such a unit; i. e., economy of operation and a better and more complete service.

1. Through cooperation with other interested groups.
2. Through newspaper stories.

34. Letter No. 3, dated June 5, 1936, from the Public Relations Committee of the Michigan State Medical Society to all county medical societies of Michigan. (Mimeographed.)

3. Through a Speakers' Bureau (to contact Lions, Kiwanis, Parent-Teacher Associations, etc.).

4. Contacts with public officials.

B. The Committee believes that there are many preventive medical procedures which can be more efficiently and effectively carried on through the cooperation of qualified and properly prepared practicing physicians, cooperating physicians rendering services *in their own offices*. Every practicing physician should become in fact a practitioner in preventive as well as curative medicine.

C. That portion of the program for the protection of young children against smallpox and diphtheria has been found an excellent means of stimulating the interest of the practicing physician and has served as a stepping stone in a program involving general medical participation in public health services.

D. The Committee feels that the two prime essentials are first, an alert and interested local medical profession and second, a full-time local health department, the function of which shall be purely administrative and educational, and *not actively engaged in practice of medicine*.

E. It has been found in Detroit and elsewhere that the usual publicity methods employed in health education will not suffice to procure the protection of the majority of preschool children against diphtheria. There is required a personal contact between a health educator and the parent. The public health nurse with house visitation is the most effective contact agent. Therefore, every county health department should have a sufficient number of public health nurses to carry on this type of educational work.

F. The Committee feels that it is just and proper that the physician should be reimbursed from the public funds for services rendered to indigents and there should, if possible, be set aside in each county an appropriation with which to pay the physician a small honorarium for services to individuals unable to pay. The Committee feels, however, that failure to secure such an appropriation should not militate against the plan since it is to the interest of the individual, the community and the physician to bring about such a program of medical participation.

G. The Committee feels that for the time being the work in Michigan should be carried on preferably in areas with full-time and adequate local health service.

H. There should be organized in each county medical society, a local committee to work with the health officer and other public officials.

J. It is recommended that each such area select its committee in September and that a meeting be arranged with such committee members and the Preventive Medicine Committee of the State Medical Society to be held not later than November.

The Michigan State Medical Society has also made a contribution to the operation of that section of the federal Social Security Act which deals with crippled children. This is the establishment of what was described in the previous chapter as the "filter system," which functions as follows:³⁵

A. The County Medical Society appoints in each county of the state:

1. A Medical Filter: a board of physicians who shall decide on each applicant as to
 - (a) medical need,
 - (b) medical necessity and urgency,
 - (c) necessary period of hospitalization and treatment.

B. The judge of probate appoints, with advice and counsel of the county medical society's representatives,

1. An Economic Filter: a social servicing agency which shall determine:
 - (a) whether the patient can pay the existing fee of the private physician,
 - (b) whether the parent is temporarily unemployed or a worker in the low-wage bracket who can pay the fee of the private physician on a "deferred payment plan."
 - (c) whether the parent is one who cannot now or apparently at any future time pay anything to his private physician.

An applicant under the Afflicted and Crippled Child Act should be referred *first* to the *economic filter*. If he is judged to fall in the economic group, he is worthy of consideration by the *medical filter*, to which he should *next* be referred. If his condition is medically needy or urgent, his commitment by the judge of probate should follow. All other cases *rejected* by either filter should return as private patients to the physicians of their choice for disposition.

The "afflicted children's" act is a state act, but the "crippled children's" act is a part of the federal system of Social Security. This filter system has now become a legal part of the operation of Social Security in Michigan by an executive order issued by the governor on June 4, 1936, providing that no state money shall be paid for the care and treatment of afflicted or crippled children until there shall have been a physical examination by the Medical Committee of the Filter Board.³⁶

35. J. A. M. A. 107: 1057 (Sept. 26) 1936.

36. Footnote 35.

LEGAL PROVISIONS IN WISCONSIN

In Wisconsin the method of organization of medical care for the indigent through contracts by county medical societies described in the previous chapter has been given legal recognition and has been extended in connection with pensions for the aged, the blind, and dependent children to cover the care of the "medically indigent."³⁷ This is done through the following Section of Chapter 148 of the Wisconsin Statutes:

Sec. 148.01 (3). The state society, or a county society in manner approved by the state society, may undertake and coordinate all sickness care of indigents and low income groups, through contracts with public officials, and with physicians and others, and by the use of contributions, cooperative funds and other means, provided only that free choice of physician within such contracts shall be retained and that responsibility of physician to patient and all other contract and tort relationships with patient shall remain as though the dealings were direct between physician and patient.

In applying the provisions of this section to the care of indigent children, the law requires that the payment for medical care is to be in cash and included in the monthly check to the mother. This is a recognition of the principle of cash indemnity insurance for the medical care of this class of patient under the Social Security Law.

RELIEF PLAN IN WASHINGTON

In 1935 a plan, which was discontinued for lack of funds in 1938, merged Social Security and medical-dental care for the indigent in a single department.³⁸ This department, known as the State Department of Social Security of Washington, approved a plan for medical-dental care which is based on one "previously in effect under the Federal Emergency Relief Administration and follows closely the plans submitted by the

37. Keith, George M.: Social Security Aids; Medical Examinations and Care in Their Administration, Wisconsin M. J. 37: 418 (May) 1938.

38. Mimeographed Rules and Regulations regarding medical and dental care for recipients of public assistance, Bulletin Ad.-#12, State Department of Social Security, Washington, August 3, 1937.

Washington State Medical Association and by the Washington State Dental Association." The plan is in line with the following Resolution passed by the Washington State Association of County Commissioners in their Annual Meeting held in Yakima from June 24 to 26, 1937:

WHEREAS, It is the desire of the county commissioners of the State of Washington to extend the best possible medical service consistent with funds available to the people of the State of Washington who must depend upon public support for such services.

WHEREAS, Our principles of American liberty and independence dictate that such service should include a free choice of physician; and

WHEREAS, The State Social Security Act provides funds for medical services and empowers the several boards of County Commissioners to contract for such services.

Be It Resolved, That we, the Washington State Association of County Commissioners, endorse the adoption by county boards of medical programs which provide for contracts with and between their local medical and dental profession adapted to local conditions and granting free choice of physician.

A State Medical-Dental Board was established "to be composed of one or more but not to exceed three representatives of the Executive Board of the State Association of County Commissioners, the State Director of Health, the State Director of Social Security, a committee of three physicians elected or appointed by the Washington State Medical Association or its duly authorized agency, and three dentists elected or appointed by the Washington State Dental Association." A similarly constituted County Medical-Dental Board was created in each county. The physicians and dentists appointed by the respective county medical-dental groups are to supervise and administer the medical-dental program of their respective counties.

Any licensed physician or dentist who agrees to abide by the rules and regulations is entitled to practice under the agreement and can be chosen freely by any of the patients covered. A fee schedule was established with

the provision that this schedule "shall be subject to prorating in keeping with the budgeted funds available for the Medical-Dental Program for the county." This fee schedule covers the following items:

First office or home visit.....	\$ 3.00
Subsequent home visits.....	2.50
Subsequent office visits.....	2.00
Obstetrical Care—Prenatal on per call basis but not to exceed the maximum of.....	10.00
Delivery (when in the home) including post-natal care	20.00
Delivery (when in the hospital or maternity home) including postnatal care.....	10.00

Fractures and Dislocation cases shall be at the State Department of Labor and Industries rates.

X-Rays (when authorized by the Medical Executive Committee) shall be at the State Department of Labor and Industries rates.

Eye examinations (refractions and subsequent checkup)	5.00
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Special physical examination or special examination by a psychiatrist in certain Child Welfare cases (not subject to prorating).....	3.00
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Requisition must read "Special—Net—not subject to prorating."

Special operative procedures where included shall as nearly as possible be billed to conform to the State Department of Labor and Industries fee schedule. (Subject to change and adjustment of the State Medical-Dental Board.)

Only one call will be allowed regardless of the number of patients seen in a family on the same visit.

A mileage of 50 cents per mile one way from beyond city limits will be allowed per trip irrespective of the number of homes or patients visited, except as follows:

No mileage shall be allowed on the first three miles from city center.

Fees for all services shall be subject to the approval of the State Medical Executive Committee.

In the organization of medical services for any county where a public health department exists, it is essential that the activities of the health department be correlated with any similar program of the medical society for protecting the health of the people and furnishing medical care to any section of the population.

CHAPTER IV

FARM SECURITY ADMINISTRATION

The Rural Resettlement Administration, now the Farm Security Administration, early in 1936 proposed plans to enable the farm clients of the Administration to provide for themselves medical services on an annual prepayment basis.

In order to qualify for a Farm Security Administration loan, assuming that Federal funds are available, the farmer applicant must meet five Farm Security Administration requirements:

1. He must be unable to obtain either funds or credit from any other source. (He must be unable to borrow money from a local bank, relative, or individual, with which to make a crop.)

2. The applicant must actually have a farm background (he must have a knowledge of how to run a farm), or must have derived the larger part of his income for the last six months from farming operations.

3. The applicant for the loan must have been recommended for such loan by a local county committee. (This committee is generally composed of two or three farmers and one or two business men who have a knowledge of their local people, and whose approval of the loan is based on the committee's belief that the applicant has the stamina to justify the effort in the field of rehabilitation.)

4. The applicant must actually be able to do the farm work. (Loans are *not* made to those who are too old to work the farm, or who have some handicap which cannot be corrected and which prevents their doing farm work.)

5. The applicant must either own an equity in his own farm, or be in a position to rent a farm, or to continue renting the farm on which he lives.

Standard farm plan clients, that is loan clients of the Farm Security Administration, are required to pay for their medical services out of farm income if such income is sufficient to cover farm operating costs and family living, including needed medical care. Loans can be made to farmers only if it is possible to prepare a

balanced farm plan showing that income, using average production and price figures, will be sufficient to take care of family living costs, farm operating costs, and repayment of the loan. In the family living costs table, provisions are made for anticipated medical needs. Therefore, unless unusual medical needs arise or unless income falls below average, the farmer is required to meet these medical costs out of farm income. If, however, he cannot meet emergency medical needs out of income, subsistence grants while funds are available can be made to the farmer for the purpose of paying the medical bill.

TYPES OF PLANS

A variety of plans to provide emergency medical care for eligible low-income farm families have been proposed by the Farm Security Administration, many of which have been put into operation with the participation of state and county medical societies and other professional groups throughout the different states. These plans differ greatly in the form of organization but in general there are three types of plans. In most states the clients obtain from the Farm Security Administration a loan which is pooled with a trustee who then pays physicians' bills on a monthly pro rata basis. Under a second arrangement the funds loaned to eligible clients are placed in the hands of a trustee, but separate accounts are kept for each family—the physician continuing to render service without remuneration when the funds for a given family are exhausted. One variation of this second arrangement is a postpayment plan whereby a client has the assurance that he can borrow funds from the Farm Security Administration if he is unable to pay for emergency medical needs. The third arrangement provides for the organization of an association of Farm Security Administration clients to hire one or more physicians on a salary or per capita payment basis to provide necessary medical services.

POOLED FUND PLANS

Under the first type of plan the clients in each county obtain from the Farm Security Administration loans which are pooled with a trustee who then pays physicians' bills on a monthly pro rata basis. The most recent form of agreement used for such a plan is as follows:

MEMORANDUM OF UNDERSTANDING BETWEEN
THE PHYSICIANS OF COUNTY,
..... AND THE FARM SECURITY ADMINISTRATION.

- 1—The Farm Security Administration agrees to lend its clients in County an average of \$..... per family per year to be used for medical care. This amount is based upon the ability of the families to pay as determined by the expected net income according to the farm and home plans.
- 2—These funds are to be placed in the hands of a Trustee, agreed upon by the physicians concerned and the Farm Security Administration Supervisor in the County.
- 3—The said Trustee will be duly bonded. The cost of such bond will be paid out of these funds. His duty shall be to deposit funds entrusted to him in a bank agreed upon by the physicians and the Farm Security Administration County Supervisor, to keep a correct record of all clients to whom money is loaned for medical care, the individual amounts loaned to each client and pay for medical services within the limitations fixed by this agreement.
- 4—That the funds so loaned these clients for medical care shall be divided as follows:
 - (a) Medical care.....%
 - (b) Drugs%
 - (c) Hospitalization%
 - (d) Emergencies, Transportation and Incidentals.....%
- 5—Each client shall have the privilege of choosing any physician entering into this agreement but shall confine his choice, as much as possible, to those physicians within a reasonable distance.
- 6—The physician will render such services as in his opinion are necessary. At the end of each month the physician will furnish the Trustee an itemized statement of the services rendered and the charge for each item.
- 7—The schedule of charges for services to these clients shall be on the basis of the usual professional charge for similar services rendered people of moderate means in the same community.

- 8—The physicians of County will give the Farm Security Administration Supervisor a list of the names of the physicians agreeing to render services under this agreement.
- 9—The Farm Security Administration Supervisor of.....
..... County will give to each physician agreeing to render services under this agreement a list of the clients who have paid to the Trustee the necessary funds to entitle them to this medical care.
- 10—These funds will be divided into twelve equal monthly allotments and all bills shall be paid on a pro rata basis.
- 11—Any residue left in any monthly allotment will be carried forward to the end of the year and applied on any or all unpaid balances that have accrued, or applied on unpaid balances at such periods as the physicians may direct.
- 12—If at the end of the year the total amount of physicians' bills exceed the total amount of money made available on the basis of these loans, such unpaid balance will be considered paid.
- 13—In the event a question is raised by any client or the Farm Security Administration County Supervisor concerning any statement rendered or any other matter affecting the physicians working under this agreement, it shall be referred to a committee selected by the physicians so concerned. The committee shall ascertain the facts concerning the services rendered and charges made and a recommendation from the committee shall be final.
- 14—It is understood that the medical services provided for under this agreement shall embrace such services as shall be performed by the family physician in the home of the client or in the office of the physician, including prenatal, obstetrical and post-natal service. In case hospitalization is necessary, the physician agrees to render the usual assistance in placing the patient in a hospital. In the event the client makes excessive demands on physicians for unnecessary services such fact shall be reported to the local County Supervisor who will consider this fact, judging the client's eligibility for a further participation and benefits under this agreement.

In several other areas the following proposal has been offered by the Farm Security Administration for consideration of the medical societies.

RESOLUTION PROPOSED FOR CONSIDERATION
OF MEDICAL SOCIETY

WHEREAS, The Farm Security Administration, United States Department of Agriculture, is responsible for the rehabilitation

of certain low-income and destitute farm families, and it is considered that adequate medical care is a vital factor in their rehabilitation, and

WHEREAS, The Farm Security Administration is in a position to loan to those rehabilitation clients a sum of money for medical care purposes, which sum is based entirely on the ability of the family to repay, and

WHEREAS, Representatives of the Farm Security Administration desire that funds loaned for medical care be set aside to be used for that one purpose only, and have sought the cooperation of the Medical Society in establishing some simple mechanism to accomplish this purpose,

Therefore, Be It Resolved, That the Medical Society approves the general plan outlined in the subsequent provisions, and approves the participation of such of its members as desire to take part in the program of general practitioner care for rehabilitation clients of the Farm Security Administration outlined in the following provisions:

I. The Farm Security Administration will loan to individual clients a sum for general practitioner care based on the client's ability to pay. These loans must all be repaid, along with similar loans made to the clients for other purposes. Study of the economic condition of these clients, as revealed in the comprehensive farm and home plans, indicates that loans in the following amounts can be made: single persons, \$12.00; couples, \$16.00; family of 3, \$17.00; family of four, \$18.00; family of 5, \$19.00; family of 6 or more, \$20.00. When obstetrical care is required, the client will be required to contribute an additional \$10.00. The participation of a family will be voluntary. The family is defined as the husband and wife and those children or other dependents provided for in the Supervisor's Farm Plan.

II. Each client will place the medical care loan in the hands of a Trustee and will authorize the Trustee to hold his money and to act for him in the manner to be outlined. The Trustee will deposit these funds in a special account in an approved local bank. From this fund will be deducted the equivalent of fifty cents (50c) from the amount loaned each family for one year, to be used for administrative expenses including bonding fee, stationery and postage, etc. The remainder of the fund will be available for the payment of physicians' bills.

III. The Medical Society will make available to local representatives of the Farm Security Administration a list of those doctors of medicine who wish to participate in the program. This list will be distributed to the various rehabilitation clients in Each client will have complete freedom of choice of physician.

IV. Physicians participating in the program will render the following services to clients and dependent members of their families:

A. Medical care in the office and home such as is ordinarily rendered by a general practitioner of medicine, including obstetrical care, the treatment of simple fractures and minor injuries, and the provision of ordinary drugs and dressings such as the physician himself may dispense or employ in the office or home. In chronic cases, office or home calls will be limited to one a week, except for some acute exacerbation of the disease.

B. Preventive Services:

1. Each client and member of his family shall be entitled to an annual physical examination, for which the physician shall charge the usual office call fee.
2. The clients shall be entitled to desirable immunization and other prophylactic measures not available through the county health program, the client to pay the cost of materials not furnished through the health department, and the physician to charge for such service the usual office call fee.

V. The mechanism of payment of physicians' bills will be as follows:

- A. A pooled fund will be created, including all the loans, to be handled by the Trustee as outlined above in Provision 2. After setting aside the equivalent of fifty cents (50c) per family for administrative expense, the remainder of the fund will be divided into twelfths, and one-twelfth of the total amount will then be available for the payment of physicians' bills each month. The additional contributions of clients for obstetrical care will be added to the funds available for the month the patient is confined.
- B. The Medical Society will agree to a definite fee schedule to be used as a basis for the charges for services rendered. This schedule will include the fees for office and home calls, obstetrical care, etc.
- C. Physicians will submit monthly bills for services to the Trustee. Such bills must be in the hands of the Trustee by the 10th of each month, for services rendered during the previous month.
- D. The Trustee will submit all bills for review and approval to a committee of physicians appointed by the
..... Medical Society.

E. The Trustee will then pay approved bills in the following manner:

1. The bills will be paid in full if there are sufficient funds available for the month in question.
2. If funds are insufficient to pay the bills in full, all available funds will be distributed to the physicians on a pro rata basis.
3. If there is a surplus after bills for a given month are paid, this surplus will be held over to be available as needed during the subsequent month or months.
4. Any surplus at the end of a twelve-month period will be used to pay unpaid balance still owing on physicians' bills on a pro rata basis.
5. If there is a surplus after a twelve-month period, after all payments have been made as above, such surplus will be made available for use the following year, or, in the event the plan be discontinued, will be returned to the clients on a pro rata basis, in proportion to their original loans.
6. It is understood that at the conclusion of a twelve-month period, after all payments have been made as above, the bills will be written off as paid in full.

VI. The clients of the Farm Security Administration will be instructed that any patient requiring care must go to the physician's office rather than call the physician to the home except when the condition of the patient warrants a home call. It will be also emphasized that home calls must be requested during the day when at all possible, rather than at night.

VII. Any abuses on the part of patients may be brought to the attention of the committee appointed by the Medical Society to review the bills. This committee may bring such cases to the attention of the state Supervisor of the Farm Security Administration, who will advise the client that further abuses shall be discontinued.

VIII. Any physician may withdraw from participation in the plan by giving written notice of such intention to the Trustee. In that event, the physician will receive payment for services already rendered in the same manner and to the same extent that he would have received the same had he not withdrawn.

IX. If for any reason a physician is not in a position to render a certain service when called upon to do so by the client, it is expected that the physician will assist the client in securing the services of another physician who is a participant in the program.

Most of the plans that the Farm Security Administration has in operation are based on these types of

agreements. A state-wide "Mutual Aid Corporation" has been organized in both North Dakota and South Dakota to handle the disbursement of the funds instead of a designated trustee for a single county.

LOAN PLANS

In the second type of plan the funds loaned to the eligible clients are placed in the hands of a trustee but separate accounts are kept for each family. As the physician renders service to each family, he submits his bill at the agreed schedule of fees to the trustee for payment. If the funds of a given family are exhausted before the end of the year, the physician continues to render service without further remuneration; if the funds on deposit for a family are not utilized during the year, they are refunded to the family. Following is an example of an agreement for this type of plan:

RESOLUTION ADOPTED BY THE COUNTY, MEDICAL SOCIETY

The County Medical Society will cooperate with and assist the Farm Security Administration in an effort to make available to low-income farm families reasonably adequate medical service, provided the principles and procedures outlined are adhered to by the Farm Security Administration.

Provision 1. That the Farm Security Administration loan to its clients participating in the proposed medical care association a specified sum of money. This sum will vary, ranging from \$10.00 to \$60.00 per family per annum. The exact amount for a given family will depend upon the estimated income of the farmer and his ability to pay, and the amount of medical services which probably will be needed, the exact amount in each case to be determined by conference between the Doctor of Medicine and the farmer, using as a basis the economic condition of the farmer as shown by the farm and home plan worked out by the Farm Security Administration. The participation of a family will be voluntary.

Provision 2. The funds loaned to families for medical care will be placed in the hands of a trustee. Such trustee will pay for medical services rendered by physicians within the limitations fixed by this Understanding, provided that funds will not be pooled and unused funds will be refunded to the client.

Provision 3. This Understanding will be presented to the membership of the County Medical Society. Those Doctors of Medicine who are willing to render services

to these clients under the terms of this agreement will volunteer to do so, and the officers of the Medical Society will furnish their names to the local supervisor of the Farm Security Administration. The local supervisor in turn will supply a list of such Doctors of Medicine to the clients.

Each client is to be advised that he has the liberty of choosing the physician he will call for medical services.

The client will be advised to call the physician of his choice from the list compiled. The physician will render such services as in his opinion are necessary. At the end of each month the physician will furnish the local supervisor an itemized statement of the services and the charge for each item.

The schedule of charges for services to these clients shall be on the basis of the usual charge for similar services rendered persons of moderate means in the same community.

In the event a question is raised by the local supervisor, the trustee or a client, concerning the statement rendered by any physician, it shall be referred to a committee appointed by the President of the Medical Society. The committee shall ascertain the facts concerning the services rendered and charges made. If the recommendation of the committee is not satisfactory, the physicians or client may appeal to the Medical Economics Committee of the State Medical Society or to a committee designated by the Council of the State Medical Society.

Provision 4. It is understood that the medical services provided by this agreement shall embrace such services as would be performed by a family physician in the home of the client or in the office of the physician. It is not intended that this plan shall cover hospitalization or major surgical procedures. The physician will render service for a period of one year although funds may be exhausted before the expiration of that time.

In the event that clients make excessive demands on physicians for unnecessary services, such fact shall be reported to the local supervisor who will consider this fact in judging the client's eligibility for further benefits of any character from the Farm Security Administration.

Provision 5. The County Medical Society may direct the trustee to pool and set aside a designated sum for hospitalization or surgical emergencies of the families participating in this program.

A description of the operation of this type of agreement is as follows:³⁹

In attempting to obtain medical services within the reach of the income of these clients the FSA enters into a verbal agreement with those members of the county medical society

39. Journal of Iowa State Medical Society 28: 108 (March) 1938.

who desire to care for these patients. Each client selects the doctor of his choice. The FSA then gives to this physician a complete résumé of the financial status of the client, together with a statement of the amount of cash which he will have for the year. The patient and the physician then discuss the matter, and come to an agreement as to the amount of money which will probably be needed to care for his medical needs during the next twelve months.

This estimate is then given to the FSA representative, who together with the client, makes arrangements for the money needed. This money is secured by the client, either by sale of live stock, or if necessary through an additional loan. The money is put in the hands of a bonded trustee, picked by the medical society. Whenever the doctor is called by this client, he charges fees according to the schedule made by his county society. This bill is turned over to the trustee, paid in full, and charged against the account of the client-patient. At the end of the year, any balance is turned back to the client. This is not a prepayment scheme, but a budgeting of funds for possible medical needs. It assures the client of services, and the doctor of adequate remuneration based on the ability of the client to pay. The fact that any balance is returned to the client will reduce materially the tendency to request unnecessary services.

There is, however, one clause in the agreement which appears extremely undesirable. If the estimated fund proves inadequate, the doctor must agree to care for the family for the remainder of the year without pay. Thus there is ample opportunity for excess demands for services in every case where the funds are exhausted before the end of the year. The doctor's only safeguard is placing his estimate as high as is possible within the limit of the patient's income. He can also help, by his advice, in keeping the services down to a minimum consistent with good care. The FSA plan does not include major surgery, which will have to be provided for from other funds, and therefore, the chances of going over the estimate are greatly reduced.

Another form of this type of individual arrangement between the client and the Farm Security Administration is based on a postpayment plan whereby a client has the assurance that he can borrow funds if he is unable to pay for emergency medical needs. The Farm Security Administration does not guarantee the payment of medical bills but agrees to loan necessary funds to the client when the circumstances seem to warrant a loan. The physicians who render services base their charges on a reduced fee schedule; the necessary funds

are obtained by the client from the local Farm Security Administration supervisor. Under this arrangement the farmer undertakes to pay his physician's bill regardless of whether the payment is from his farm income or from an additional loan secured through the Farm Security Administration. The recommendations of a state medical society to its constituent county society for the inauguration of such a postpayment plan were as follows:

1. In conference with the local director of the F.S.A. such county director shall be apprized of the minimum schedule and percentage reduction therefrom under which the respective county societies rendered service to clients of the Federal Emergency Relief Administration.

2. It is then recommended that the respective county medical societies shall agree to render services under the F.E.R.A. schedule to clients of the F.S.A. in Wisconsin, with the provision that there shall be free choice of physician.

3. The State F.S.A. officials, through recommendations from their county directors, will endeavor to make necessary grants in accordance with past procedure, to cover service needed or rendered on this "cost of service basis" for their clients.

4. The local directors, after an understanding with the respective county medical societies has been entered upon, will apprise their clients of the nature of this understanding and will use all means within their power to see that funds made available to the clients by the F.S.A. checks to cover sickness care on the F.E.R.A. schedule are actually devoted to the payment of the account incurred.

5. It is further recommended that the constituent county medical societies, when entering upon such arrangements, will endeavor to secure similar "cost of service" rates from hospitals for such clients as may need hospitalization.

6. Although the recommendations of the committee are properly flexible that arrangements may be perfected according to local conditions, the committee does recommend that where the old F.E.R.A. auditing committees are still in force, or feasible, statements for services rendered shall be mailed to the individual clients by the physicians rendering service only after they have gone through such auditing committee. The purpose of this recommendation is to prevent any misunderstandings and to have an auditing committee thoroughly familiar with the local situation in its broad aspects, that it, by frequent conference with the local F.S.A. director, may see that every actual need of the client is filled and at the same time the actual costs involved are made available to the physicians rendering the service.

7. It is further understood that the local county directors of the F.S.A. having in mind the hardship on physicians in rendering service involving unnecessary travel, will encourage clients by all proper means to avoid neglect that necessitates home country calls involving time and expenditure far in excess of the F. E. R. A. mileage schedule and frequently great hardship upon the physician.

8. The local county director of the F.S.A. will provide the physicians in his territory, when arrangements with the county society have been perfected, with a list of F.S.A. clients, and advise the client who sees the physician properly to identify himself to the end that there may be no question as to those entitled to this proper consideration.

9. Finally, the committee recommends that in event some county society does not see fit to use an auditing committee, it will at least provide a committee to which both the local director of the F.S.A. and members of the society may turn for advice and for aid in ironing out any misunderstanding or abuse of these arrangements perfected in the interest of the furthering of public health.

Before making these recommendations, your committee had before it for study and consideration many other types of arrangements, some of which are in actual use in other states. All of these properly were discarded for reasons which could be cited at great length, but which citations seem unnecessary to this report. The committee concludes by the simple statement that: (1) This method seems to be that best suited to the conditions under which the service will be rendered in; (2) providing medical service with the least possible amount of subsequent paper organization, and (3) providing all necessary service with suitable assurance to the client and without any intermediary whatever between the physician and his patient.

Still another variation of this second type of plan consists of the pooling of a small amount, such as \$1.50 or \$2.00 per family annually, as an emergency fund with the remainder of the amount loaned kept separate for each family. The emergency fund is used for unusual situations or for hospitalization.

CONTRACT ASSOCIATION PLANS

The third type of plan provides for the organization of a county association to hire one or more physicians on a salary or per capita payment basis to provide necessary services for Farm Security Administration

clients. Each county association collects a fixed monthly fee per family, usually \$2 to \$3, and in turn secures a contract or an agreement with one or more physicians to provide the medical service. The physicians are paid a monthly salary from \$100 to \$225 or a per capita payment of 25 cents to 50 cents less than the charge to the family. The 25 cents or 50 cents per family is used to pay for administrative expenses of the association. A description of one of these associations is as follows:

..... COMMUNITY COOPERATIVE
MEDICAL ASSOCIATION

One hundred and twelve rural rehabilitation clients have organized the Community Cooperative Medical Association in order to provide services of a physician and medicine for themselves on an annual basis.

Each client obtained an individual loan of \$30 from the Resettlement Administration to participate in the service.

The president, vice president and secretary-treasurer of the association comprise the board of directors, who retain a competent physician to provide medical service; \$3,300 for physician's salary and medicine is authorized.

Membership privileges include:

- (a) An annual physical examination.
- (b) Such medical care in home and office as is usually given by a general practitioner, including preventive service for the more prevalent and common diseases (diphtheria, smallpox, typhoid fever, scarlet fever).
- (c) Medicine for the treatment of ordinary diseases in an amount not to exceed \$10 in value for each family. The physician will be reimbursed if he furnished this, or the secretary-treasurer may purchase medicine.
- (d) An additional \$5 fee shall be required for each obstetric case.
- (e) Excessive night calls shall not be required.
- (f) In case of a dispute between the doctor and a member, the county supervisor shall arbitrate.

Loans made for participation in the medical service are repaid from income as shown on regular farm and home plans. All client-members live within a six mile radius.

This division has made the following suggestions to the regional director with respect to this application for guidance in the further development of this type of project:

1. We are also of the opinion that, instead of the flat amount (such as \$30 per family regardless of the size of the family) there should be a minimum charge of not less than \$1.50 per month per family, and a maximum charge of not to exceed \$5 per month per family, with a small fee for additional members over and above a specified number. A family of say three or four members should not be charged the same as a family of ten or twelve. The additional fee might be as small as 15 cents or 20 cents or as high as 50 cents for each individual member, but in no event should the total amount charged to each family exceed the maximum referred to.

2. There may be some instances in which the medical associations would be justified in contracting with a group of doctors, in case they are available, in order that members of the association will have some choice in the selection of the doctor. There may be times when one doctor is unable to serve the needs of the entire group. In such instances, it would be all the more important to be able to employ the services of several doctors.

3. The contract with the doctor, or doctors, should specify clearly the amount paid either monthly or annually.

Such arrangements do not allow the client free choice of physician or do not remunerate the physician according to the services performed and have apparently proved not as satisfactory as other arrangements inasmuch as counties with this type of arrangement are now inaugurating either the first or the second type of arrangement.

STATE AGREEMENTS

An example of the form of the agreement entered into by the Farm Security Administration and state medical societies follows:

AGREEMENT WITH THE STATE MEDICAL ASSOCIATION FOR MEDICAL CARE OF FARM SECURITY ADMINISTRATION CLIENTS

Provision 1: That the Farm Security Administration loan for medical care of these clients per family per year, a sum based upon the ability of the family to pay as determined by the expected net cash income according to the farm plan.

Provision 2: That these funds be placed in the hands of a trustee in each county, or administrative district, whose duty it will be to pay for medical services within the limitations fixed by this agreement.

Provision 3: This agreement will be presented to the membership of each local society. Those doctors who are willing to render services to these clients under the terms of this agreement will volunteer to do so, and the officers of the local society will furnish their names to the local administrator. The local administrator, in turn, will supply a list of such doctors to the clients in the county or district concerned.

Each client is to be advised that he has the liberty of choosing the doctor he will call for medical services.

The client will be advised to call the doctor of his choice from the list compiled. The doctor will render such services as, in his opinion, are necessary. At the end of each month the doctor will furnish the local administrator an itemized statement of the services rendered and the charge for each item.

The schedule of charges for services to these clients shall be on the basis of the usual charge for similar services rendered people of moderate means in the same community.

In the event a question is raised by an administrator concerning the statement rendered by any doctor, it shall be referred to a committee appointed by the president of a local medical society. The committee shall ascertain the facts concerning the services rendered and charges made and the recommendations of the committee shall be final insofar as the doctor is concerned.

In case the local committee can not make adjustments satisfactory to all parties concerned, the case may be referred to the Board of Trustees of the State Medical Association.

Provision 4: It is understood that the medical services provided for under this agreement shall embrace such services as would be performed by a family physician in the home of the client or in the office of the physician. It is not intended that this plan shall cover hospitalization or major surgical procedure.

In the event that clients make excessive demands on doctors for unnecessary services, such fact shall be reported to the local administrator who will consider this fact in judging the client's eligibility for further benefits of any character from the Farm Security Administration.

It is understood that the Board of Trustees and officers of the State Medical Association do not assume the power of making binding agreements with any agency concerning the matter of fees for medical services rendered by any physician in the State.

It is our belief, however, that the entire profession should enter wholeheartedly into this co-operative effort in the hope that these families may be rehabilitated, and become financially independent citizens of their respective communities, requiring no aid from anyone.

It is our opinion that the principles involved in the above plan do no violence whatever to any principle in our code of ethics. It is, therefore, recommended for adoption by each and every component society in the State.

The agreement with the state medical society essentially authorizes the Farm Security Administration to approach county medical societies and to work out with these medical societies such plans as are mutually acceptable. A letter of authorization in agreement with the state medical societies is as follows:

In accordance with a resolution passed at the meeting of the Executive Committee of the State Medical Society held on October 11, 1938, at the domicile of the Society, I have been authorized to write a letter to you, as Medical Director of the Farm Security Administration, for your use in approaching the various county societies when attempting to formulate plans in the counties for the proposed medical care of Farm Security Administration families in

We have received from you a letter dated October 11, 1938, with enclosures on "Medical Care Program for Farm Security Administration Families" and "Memorandum of Understanding Between the Physicians of County and the Farm Security Administration." We notice that in these plans two of the basic principles involved have been satisfied. First, (b) That the family shall have free choice of physicians. Second, provision is made that before the plan is operative in a given county that the county medical society submit the proposed plan to the Secretary of the State Medical Society for review. This is to be done promptly (within ten days after acceptance by the county society).

In view of the above facts you, as Medical Director of the Farm Security Administration and/or any of your representatives, are hereby authorized to approach the county medical societies in the furtherance of the proposed medical care plans for Farm Security Administration families in

As indicated in this letter, some of the state medical societies require that the plans for each county be approved by a committee of the state medical society before being placed in operation.

A report of the Farm Security Administration for 1940 gives the following data concerning the medical care plans existing at that time.

FARM CLIENTS

Although county medical plans vary in detail, according to local conditions and preferences, they follow a general pattern. They all provide for the use of existing local facilities, and fees are based upon the ability of the families to pay—a principle long recognized by the medical associations. Every plan is founded upon three basic principles: (1) Each family has a free choice of its physician from among the participating doctors; (2) fees are paid by every participating family at the beginning of the operating period, and are held by a bonded trustee; (3) fees are based upon the families' ability to pay, as indicated by their farm-management plans and records.

Under a typical medical-care plan, all of the Farm Security Administration borrowers in the county who wish to participate pay a fixed sum each year for medical care. For the first year, this sum usually is included in the rehabilitation loan. These payments are pooled, in the hands of the county trustee, to serve as a kind of voluntary health insurance.

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Benefits covered in the plan usually include: (1) Ordinary medical care, including examination, diagnosis, and treatment in the home or in the office of the physician; (2) obstetrical care; (3) ordinary drugs; (4) emergency surgery; (5) emergency hospitalization.

Some counties have added dental services either as a part of the regular medical care program or under a separate plan. In Arkansas 40 counties have separate dental plans under which a family obtains emergency dental treatment, simple fillings, extractions, prophylaxis, and cleaning at a cost of \$4 a year for a man and wife and 50 cents for each child.

The amount paid for medical care varies according to extent of benefits, size of average farm incomes in the locality, and size of family. A typical payment schedule for medical care in a low-income county is \$18 annually for man and wife plus \$1 for each child, the maximum payment being \$26 per family.

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During the past fiscal year counties in which medical care plans had been organized increased by 245. To date, more than 80,000 families have joined such plans in 634 counties in 31 states. Medical care programs also have been organized on 56 resettlement projects, and similar arrangements are now being set up on several others. In 23 of these programs, both project families and families of rehabilitation borrowers in the county have combined to use the same medical care plan.

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In May 1938 the Administration, with the cooperation of the California Medical Association, the State Department of Health and the State Relief Administration, formed the Agri-

cultural Workers' Health and Medical Association, incorporated under state laws. Each of the agencies is represented on the board of directors of this nonprofit association.

MEDICAL CARE FOR MIGRANTS

(The information which follows is taken largely from a report by Dr. R. G. Leland, Director of Bureau of Medical Economics of the American Medical Association, entitled "Medical Care for Migratory Workers," published in THE JOURNAL of the American Medical Association, 114:45-55 [Jan. 6] 1940.)

The wave of migration from depressed and drouth-stricken regions to the Pacific states and to Arizona created conditions which gave rise to special arrangements to provide medical services for such migrants. The Farm Security Administration formed a corporation known as the Agricultural Workers Health and Medical Association to "engage in providing medical and dental care to migratory agricultural workers for whom local, county and state medical facilities are not available due to local residence regulations."

The Board of Directors of the Association consists of seven members, four of which are designated by the Farm Security Administration, one physician designated by the California Department of Public Health and two physicians designated by the California Medical Association. The workers and their families are either referred to physicians who have agreed to participate in the Association's program with a reduced fee schedule or clinics that have been established to provide service. Druggists have also agreed to accept a reduced price schedule.

Funds are furnished by the Farm Security Administration, which during the period from March 28, 1938 to May 31, 1941, had expended or made commitments of \$2,634,226.40. According to the report of the Association for May 1941, covering three years operation, 13,389 patients have received clinical services, 104,327 had been referred to physicians and 24,481 had been sent to hospitals.

EXPERIENCE GAINED

Noticeable preference has been shown by the administrators of the Farm Security Administration for the first type of arrangement whereby a trustee or a corporation receives a monthly or annual prepaid sum from clients and in turn pays physicians according to an agreed fee schedule or on a pro rata basis if the funds prove insufficient. In regard to the objection that to participate in such an arrangement each client must obtain an annual loan from \$12 to \$30 at 5 per cent interest and yet may require no medical care during the year, it is stated that most of the families do receive some small amount of medical care and feel that the security of being able to obtain medical care when needed is well worth the investment. It is likewise stated that such a plan provides an arrangement for preventive care as well as for actual clinic work. In reply to the criticism that these plans will encourage clients to abuse their privileges and to request unnecessary medical services it is stated that experience shows that this abuse has not materialized, that except for the initial period when families are likely to call physicians unnecessarily, there is no tendency to abuse the privileges of the plan.

The experience with these plans has shown clearly that one uniform plan cannot be operated satisfactorily throughout the United States in communities which differ so widely in local conditions. The success or failure of a particular plan appears to depend on the degree of local professional supervision over medical care. The necessity for flexibility of all arrangements also seems to be emphasized.

Especially provocative of dissension has been the uncertainty as to what services are included in the scope of the plan. Some plans indicate that emergency services only are to be provided, but what constitutes an "emergency" in the actual operation of the plan is indefinite.

Low rate of payment and uncertainty of the amount of services required place on the physician the responsibility for guaranteeing the necessary services and furnishing additional services without pay.

Another problem that has raised some discussion is whether or not the requirements for becoming a Farm Security Administration client are suitable eligibility requirements for membership in a medical care plan that obtains special concessions from physicians. Clients of the Farm Security Administration seem to be considered self-supporting, although many of them would undoubtedly be medically indigent in case of illness. Good medical practice demands that sick persons be given good medical care regardless of their economic status. It becomes necessary, therefore, for medical societies to consider well whether the plans proposed for Farm Security clients or for any other group of the population permit the physician to maintain standards of good medical practice.

It appears to be the policy of the Farm Security Administration to provide an opportunity for medical societies to examine the Administration's proposals for medical services to its clients before placing the plan in actual operation. Medical societies are warranted in studying these plans with the same sympathetic attitude that they have toward any other persons who need medical care. The actual operation of any specific Farm Security Administration plans will, of course, depend on acceptance by the practicing physicians in each community in which the program is proposed. These physicians may properly look to state and county medical societies for an expression of acceptance or rejection of the principles involved.

CHAPTER V

EXPERIMENTS IN MEDICAL CARE PLANS

The plans discussed in Chapter IV are concerned, for the most part, with medical care for the indigent and those who are sometimes referred to as medically indigent. These plans require the cooperation of organized medicine, individual physicians and public or private relief agencies. They have provided helpful experience in administration and have contributed something to the morbidity statistics essential to successful organization of plans for the low income classes.

County medical societies since 1930, have also experimented with the distribution of various other types of medical service. Although more persons have been served by these plans, and the ones previously described, than by all of those widely advertised types of contract medicine under such titles as "group prepayment plans" and "cooperative medicine," little publicity has been given to experiments under medical control. Medical societies place foremost the objective set forth in the Constitution and By-Laws of the American Medical Association, viz., "to promote the science and art of medicine and the betterment of public health." Financial and administrative features are put in their proper place as instruments through which medical service is supplied. Public funds are not used to conduct these experiments. One state medical society has spent as much as a hundred thousand dollars from its own funds in preliminary investigation and organization expenses before undertaking a plan. Physicians, trained in the science of medicine, consider such plans as experiments and believe it is probable that the experimental stage will be a long one. After almost sixty years of experimenting with compulsory sickness insurance in Germany and for many years in several other nations, that method of distributing medical care

is still so highly experimental that changes follow one another in rapid succession and no such system can rightly claim to have accomplished its original objectives.

If medical society experiments in this field are not satisfactory, they can be discontinued without cost to the public and always after fulfilling any promises made to beneficiaries. Such voluntary plans establish no bureaucracy of public officials, no political or private source of profits and physicians understand that a preliminary period of testing in social experiments is as essential as it is in physical experiments in laboratories.

POSTPAYMENT PLANS

The earlier experiments were concerned largely with postpayment or installment arrangements. These methods helped persons with low incomes to reduce greatly their burden of payments, since no interest or carrying charges were required and the costs of administration were borne by the county medical societies or by the cooperating physicians, dentists and hospitals. These bureaus determined whether the patient's financial resources warranted free services or reduced charges, or whether customary fees would be no burden. Such bureaus, controlled by county medical and dental societies, could not only arrange for an equitable reduction of charges by the physician, dentist or hospital, but also combine all outstanding or current bills and adjust installments to fit the family budget.

One of the first of these was established by the Wayne County Medical Society of Detroit in February 1934, under the financial control of the Board of Trustees of that society. Operating policies were decided by an advisory board consisting of representatives from the Wayne County Medical Society, the Detroit District Dental Society, the Detroit branch of the Michigan Nurses Association, the Detroit Retail Druggists Association, and the hospital executives. When a patient applied for assistance in obtaining

medical service, he was referred to the doctor of his choice after the financial investigation had been made. In the first two years of its existence, this bureau served 3,065 patients, about one half of whom were referred from physicians, one third from industry and the remainder from charitable organizations. Because hospitals were compelled to make cash expenditures in the care of the patient and did not have sufficient capital to carry accounts over a long period, they early expressed dissatisfaction over the methods of payment for their services despite the fact that they received the first \$25 collected and a proportional amount of succeeding collections until their bills were met.

The Medical-Dental Service Bureau, now known as the Health Security Administration of the District of Columbia, operated on much the same type of plan and acted as a "filter system" to determine the economic status of persons deserving free medical service. During its first five years of operation this organization served 150,000 persons, and "more than \$3,500,000 worth of care has flowed through these channels to the needy sick."⁴⁰

In the years 1937, 1938 and 1939 there were issued 121,787 clinic passes by the Health Security Administration to people unable to purchase care from a private physician. Authorized by these passes, 840,713 visits were made to private hospital health centers. In few communities can the medical profession be sure that such a vast amount of care is given where it is needed, without danger of exploitation or diversion to recipients well able but unwilling to pay for the services of a private doctor.

In the same length of time, the Administration authorized hospitalization of 24,280 patients requiring bed care in its affiliated hospitals. Here, again the city's physicians made a huge gift to the medically indigent. These patients received 277,837½ adult and child and 46,166 newborn days' care in hospitals, each day entailing consultations by staff physicians and interns. To this vast number of persons, surgeons gave the skill in delicate operations; internists gave their knowledge to readjust malfunctioning bodies, and obstetricians delivered

40. Garrett, Ross: Health Security Administration—How It Functions, Medical Annals of the District of Columbia 9: 220-223 (June) 1940.

4,487 infants under the safely aseptic conditions of modern delivery rooms. All this was done without professional fee entirely upon the certification by the Administration that the recipients were eligible for medical care.

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The plan was put into effect in the fall of 1939 and has worked to the entire satisfaction of the doctors, the Medical Society and the patients. It has succeeded in building a closer bond of interest between physician and patient, which has been to the advantage of both in prolonged treatment. The physician works under conditions similar to those in his own office, and has expert assistance in handling his patients. He also has the advantage of being able to draw upon a special fund, set up for Self-Help Exchange patients and administered by the Health Security Administration, to provide special drugs, dentures and other items prescribed.

Since the beginning of 1936 there has been marked decrease in the infant and maternal death rate in the District of Columbia. In that year the infant mortality rate was 72 per 1,000 live births, the maternal rate 69. Last year both reached a low of 48. These figures gain interest when compared with the Administration's statistics showing the increase of prenatal and postnatal visits made to private hospital centers and the number of hospital deliveries arranged in the Administration's affiliated private hospitals.

During 1939, 15,250 clinic visits were made for prenatal and postnatal care, an increase of 2,000 over the previous year. Days' care for newborn infants rose from 15,275 in 1938 to nearly 17,500 in 1939. Maternal days' care in hospitals showed a corresponding increase.

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The Sedgwick County Medical Society (Wichita, Kans.) prepared a brochure describing three types of arrangements for medical care that have been developed for different groups in the vicinity of Wichita, Kans. The text of this brochure as reported in the Medical Bulletin of the Sedgwick County Medical Society for April 1940, follows:

SEDGWICK COUNTY PLAN FOR MEDICAL CARE

(Wichita, Kans., 120,000 population)

The Sedgwick County plan of medical care is divided into three categories: (1) indigent, (2) borderline or low income group and (3) average and above average citizens.

I. INDIGENT

Determination of status: This group includes those who are dependent upon the county for general assistance or who are declared indigent for medical purposes only.

Determination of eligibility for free medical care is accomplished through the county social service department, which makes investigations of families applying for general aid or medical aid. This is done by means of personal interviews with applicants by case workers.

Those determined eligible are so listed and given cards which entitle them to admission to the downtown clinic. A seventy-two bed hospital is maintained by the county and patients first must pass through the downtown clinic before being hospitalized, unless the case is an emergency, in which instance they are admitted to the county hospital.

County staff: A full-time physician is employed by the county as superintendent of the hospital and clinic. Working with him are three full-time resident physicians who assist at the clinic and hospital and in making residence calls. In addition, two interns from the three private hospitals rotate on service at the county hospital. A staff of nurses and technicians also is employed by the county.

Medical Society: The Sedgwick County Medical Society provides a rotating staff of some seventy physicians in private practice who attend special clinics at the hospital and clinic. These physicians serve on rotating services of three month periods and include specialists in: general surgery; general medicine; orthopedic surgery; eye, ear, nose and throat; urology; proctology; cardiovascular; dermatology and syphilology; pediatrics; neuropsychiatry; obstetrics and gynecology; radiology, and pathology.

These physicians receive no pay for their services, but the county pays a monthly remuneration (\$500) to the medical society which is used in maintaining a library and office and for scientific and educational functions of the society.

Case load: The following figures are for the year 1938:

COUNTY CLINIC

Total dental patients.....	3,798
Miscellaneous patients	47,554
Total clinic patients.....*	51,352
Dental extractions	2,539
Dental fillings	826
Dental vincent's	103
Dental examinations	1,801
Doctors' day calls.....	1,707
Nurses' calls	2,418
Laboratory examinations	11,773
Prescriptions filled	34,702

COUNTY HOSPITAL

Operations (major)	262
Operations (minor)	610
Emergency room	3,243
Laboratory examinations	10,196
X-ray plates	3,031
Obstetrical cases	245
Doctors' night calls.....	566
Number of patients under care.....	1,793
Hospital days	21,821
Average cost* per hospital day.....	\$2.56

* This figure indicates the number of cases seen, not the number of individual patients.

II. BORDER-LINE CASES (LOW-INCOME GROUP)
MEDICAL SERVICE BUREAU

What it is: The Medical Service Bureau was formed in March 1927 to assist the low-income group to obtain medical care from private physicians. Persons in this group are not eligible for free care at the county clinic as they are not dependent upon the county for public assistance. Forty per cent of these persons are dependent upon WPA wages for a livelihood. The income in this group averages \$55 to \$60 per month. The bureau is maintained by the medical society and the Wichita Community Chest. The medical society furnishes office space, equipment, etc., and the community chest pays the salary of the supervisor who is an experienced case worker.

How patients are referred: Persons are referred to the bureau by physicians, school nurses, county and welfare agencies, the general public, and many come who know about it personally.

The supervisor of the bureau interviews the applicants and determines their financial status by going over their budgets for food, clothing, shelter, etc., and helps them to arrive at a figure they can afford to pay for medical or surgical service.

The applicant selects the physician of his choice if he already does not have a family physician, and the information obtained by the supervisor is sent to the selected physician. Arrangements for fee, service, etc., remain entirely a matter between the physician and patient.

The bureau, in brief, determines whether the applicant can pay for private medical service at a reduced fee and obtains a true picture of the patient's background for the physician.

If the family happens to be large and the service needed is beyond their ability to pay, the case is then turned to the county, and the applicant is treated as a medical indigent for that purpose, and service rendered free.

In the three years of its operation 3,000 applicants have been interviewed by the Medical Service Bureau.

The bureau assists both the border-line patient and the physician in the problem of medical care. The physician is saved much time in obtaining a true financial picture of the patient, and the patient is assisted in budgeting for medical service at a cost compatible with his budget. We believe the bureau aids this group of persons in retaining or regaining a certain amount of individual pride in paying for service rendered according to their ability.

The following types of service were provided during the period Jan. 1 to Dec. 1, 1939:

Glasses	175	Examination	119
Tonsillectomies	87	Venereal	*313
Dermatology	6	Obstetrics	40
Medicine (examinations, etc.)	149	Surgery	33
X-ray	158	Dental	37
		Orthopedics	6

* Venereal patients attending the county clinic must present a signed statement from their family doctor, or if they have none, from the Medical Service Bureau, stating they are unable to pay for treatment. Many of the venereal patients are referred back to the county.

III. AVERAGE AND ABOVE AVERAGE

This class of patient maintains a direct relation with the physician of his choice. Methods and arrangements for medical care are solely a matter of concern to the patient and the physician.

Through the trident plan Wichita feels it is offering medical care to all the people. The treatment in effect is the same for all persons, but the methods of obtaining that treatment, of necessity, differ for the three classes of population.

It should be noted that the cost of administration for a medical-dental service bureau, which is estimated to be about 10 per cent, is borne by the participating physicians, dentists and hospitals. Deductions of 10 per cent are made from the instalment payments to the physicians, dentists and hospitals and no interest, carrying charges or credit rating costs are added to the patient's bill. Some of the bureaus obtain the cooperation of pharmacists and provide members with drugs at cost plus 10 per cent.

While it is true that the medical-dental service bureaus are postpayment plans and, in effect, mortgage the future income of persons who incur medical, dental and hospital bills, they do not exact any payments from the patient that are not used in his behalf for services rendered; they do not charge the patient for administrative expenses; they make possible a real reduction in bills for those who are deserving; and they can arrange for every medical, dental and hospital service for all classes of patients.

Similar postpayment plans were arranged by some twenty to thirty county medical societies. Some of these arrangements have been abandoned and others are still operating, though for the most part on a reduced scale.

CENTRAL ADMITTING BUREAUS

A hospital or clinic routing arrangement for patients has often preceded or accompanied the organization of medical-dental service bureaus. The function of these "central admitting bureaus" or "clinic admitting plans" is to assist persons who need and desire medical or hospital care to obtain such services promptly and economically from appropriate sources.'

Such a bureau issues admission cards entitling the holder to free hospital and clinic services if the person's income status so warrants. The usual procedure of the bureau is to determine the applicants' ability to pay and then to refer all applicants to private physicians who agree to provide services and to charge the patient in accordance with the bureau's recommendation for reduced fees. If the physician prefers, he can sign the patient's card, thereby entitling him to free medical services in a clinic. The central admitting bureau likewise determines which hospital inpatients are entitled to assistance with funds from community chests, from individual philanthropists, or from governmental sources.

The central admitting bureau plan received widespread attention beginning in 1932 when the County Institutions Commission of Alameda County, California, was organized to investigate and direct all applicants for medical services to be paid for by the county. Similar admission bureaus were started in other counties in California and by 1935 central admitting bureaus were established in Midwestern and eastern cities.

The central admitting bureau is primarily a hospital or clinic routing plan to assist applicants to obtain appropriate medical services and to minimize the abuse of free medical facilities, while the medical-dental service bureau assists persons with moderate incomes to arrange for the payment of medical, dental and hospital bills on a postpayment basis. Through these two agencies, medical societies in cooperation with other professional groups in the community are earnestly endeavoring to assist persons with low incomes to obtain medical, dental and hospital services in a manner that will be equitable for all concerned. The primary motive is to make available the services essential for the well-being of the individual. These arrangements also seek to avoid any waste in community funds for the care of the sick. A correlated objective is to prevent the pauperizing of persons who cannot pay full medical costs, but who can make partial payments.

CREDIT AND COLLECTION BUREAUS

One of the most significant developments in medical economics during recent years has been the organization of credit and collection bureaus by county, medical societies or by groups of physicians. While these bureaus are primarily organized to provide a credit rating and collection service for member physicians, they frequently arrange for the postpayment of medical bills similar to medical-dental service bureaus and some have organized plans to assist patients in financing medical bills.

Practically all the professionally controlled collection bureaus have a credit rating service as well as a collection service. In addition to these functions a bureau sometimes offers individual physicians valuable assistance in developing proper bookkeeping systems. The bureaus may also cooperate with physicians and patients in working out instalment payment plans, according to the patient's ability to pay. In such cases the bureau may provide the physician with pertinent data on the patient's financial status, so that the physician and patient determine the actual amount of the periodic postpayments to be made.

FINANCING ARRANGEMENTS FOR MEDICAL CARE

Professionally controlled bureaus of this type have developed arrangements, usually with the cooperation of their local banks, to discount physician's accounts and to obtain an agreement from the patients to make a small monthly payment for a given period. The financing charges are discounted from the amount paid the physician, so that no additional charges are passed on to the patient. Such an arrangement may be helpful if a physician is in need of cash, but it should be remembered that the physician is paying for the privilege of receiving immediate payment of his bill at the time it is discounted through the bureau.

Commercial companies which offer to finance medical accounts are also active in this field. A detailed discussion of their financing methods is contained in the report "Collecting Medical Fees" and is available to those who desire such information. Finance plans for medical accounts are similar to other financing arrangements. The finance company does not appear to bear any risk and collects interest and a service charge for its services. The physician who desires to use such financing services is required to give adequate security for any advance or payment he receives through discounting a bill with the finance company. In addition,

the physician is, in many instances, ultimately responsible for the face value of the bill although he received an amount equal only to the face value of the account less interest and service charges.

Such finance plans do not lower the cost of medical care but, on the contrary, offer abundant opportunity to pass on to the patient the interest and service costs, thus materially increasing the medical costs to those persons who are often least able to pay. Physicians should carefully investigate finance plans before entering into contracts for discounting medical accounts.

PREPAYMENT MEDICAL CARE PLANS

The depression years brought a widespread propaganda for prepayment plans for medical care. Press, platform and public agencies advocated some type of insurance arrangement for the distribution of medical services. Because organized medicine objected to those methods that permitted lay interference with medical care, limited the choice of physicians or were based on such meager financial arrangements that good medical service was impossible, it was charged by newspaper and magazine writers that the medical profession opposed all prepayment plans. In truth, the House of Delegates of the American Medical Association repeatedly encouraged state and county medical societies to experiment with prepayment plans, and the number of persons supplied with medical service through medical society plans was soon many times that furnished in other plans so extravagantly propagandized.

The House of Delegates, in 1934, prescribed principles for protection of the public in the organization and operation of any such plans.⁴¹ No attempt has been made to develop a model plan. No such model would be suitable for all sections of the United States. A plan fitted to the industrial states would be wholly impracticable in purely rural and agricultural regions.

41. Pages 13-14.

The House of Delegates adopted only general principles which offer opportunity and encouragement for the widest possible experimentation while at the same time safeguarding the interests of the public.

THE ELASTIC ELEMENT

One fact usually overlooked in discussing all kinds of prepayment plans, especially of compulsory sickness insurance, is that morbidity is always a very uncertain element. A system of life or fire insurance can be arranged with a much more mathematically accurate basis; the elements in the system can be clearly defined. Fire and death are facts concerning which there is usually no dispute and the incidence of which can be calculated with a close approach to accuracy. Illness is uncertain in its incidence, indefinite in its scope and character, variable in form and changeable in time. Diagnosis and treatment are variable according to individuals and types of illness. Any system of prepayment medical service must be sufficiently flexible to meet the variable demands which are likely to be placed upon it. Somewhere within the structure there must be provision for adjustments. If there is no elasticity in the income available, and if payments to physicians are provided through fixed salaries, the flexibility must then fall on the quality of the medical service. Prepayment is itself an element which changes the amount of morbidity treated and the extent of medical service required.

European writers on sickness insurance freely admit the necessity of limiting the medical service until it is rather thin and the physician's income until it is too scant to enable the physicians to keep up-to-date on current medical progress. Otherwise, the service cannot be kept within the financial limits set by insurance premiums. Advocates of compulsory sickness insurance and types of contract medicine in this country deny or avoid all mention of this fact. They do not warn the prospective patients that the squeeze will fall on the

quality of the medical service. This is, nevertheless, so fundamentally true that any plan promising "complete medical service" for fixed payments must sooner or later maintain financial solvency by reducing the quality or the quantity of the medical service and the payments made to physicians. The patients can not easily detect deterioration in the quality of medical service; but of necessity diagnosis may become superficial, incompetent specialists may be hired or expensive types of treatment may be curtailed and the patient will usually be none the wiser.

That this elastic factor is inherent in the human elements of the situation is almost invariably overlooked by lay advocates of prepayment plans. They criticize provisions for payment of a small sum for the first services in any year or illness or the fixing of a maximum sum to be expended for any one subscriber within the year as attempts to restrict the service given. But unlimited service for a fixed premium is impossible unless the premium is beyond the ability of the low income group to pay. Several systems of compulsory sickness insurance provide legally for a complete medical service, but Dr. Walter Pryll, long an officer in the German compulsory sickness insurance system (one of those systems which promises a complete service) and later a member of the staff of the International Labour Office in the department dealing with sickness insurance of which he is an enthusiastic advocate, says:

Nor can the legislative authorities be guided solely by economic considerations when drawing up the regulations concerning benefits. Financial limits may be imposed, beyond which they cannot go. They may have to reject many ideas that are acceptable from the point of view of economy and agree to others that are economically unsound simply because of the relative strength of the various political parties in the Government at the time.

It is no more possible to denounce or to argue away the fact that in any prepayment plan, the medical service must be cut to fit the premiums that low income

classes can afford to pay, even when supplemented by taxation, than it is to think that similar ridicule and denunciation can abolish the fact that a comparatively equal medical service to varying income classes can be supplied without some variation of the "sliding scale."

State and county medical societies experimenting with prepayment plans frankly face these facts and are endeavoring to meet them honestly. They have introduced some elastic elements into the structure of their plans that they believe will enable them to maintain the quality of the service. A unit system of payment for services introduces a variable in the physician's income, and a "deductible clause" puts a portion of the burden on those receiving the service. Somewhere in every prepayment structure such elements of flexibility must be introduced if solvency of the organization which arranges for the services and quality of these services are to be maintained. Not all of these devices may be wholly satisfactory, but almost any of them are far more desirable than the concealed use of variable limits placed on diagnosis and treatment as the elastic element.

INDUSTRIAL CONTRACT PLANS

Contract plans for the provision of medical services to the employees of a single industrial plant have so long been characteristic of some localities and types of industries as to influence any pattern of prepayment services. Such industries as mining, lumbering and construction work are often developed in localities lacking a sufficient number and variety of medical facilities. Organized medicine recognized the necessity of providing and maintaining the best possible quality of medical service under the circumstances. For this reason the Principles of Medical Ethics provide that "Contract practice *per se* is not unethical." Each contract must be judged on its own merits.

Medical services provided by contract vary widely in almost all their features. In some the medical service is very superficial. Others seek to supply as good a

medical service as resources will permit. There are at present many types of contract service in operation in the United States.⁴² Such plans are formed by groups of employees who make regular payments into a fund which is used to supply the members with medical and hospital services or by groups of physicians who organize to give medical care. Some of these organizations have been in operation many years.

EMPLOYEE'S RELIEF ASSOCIATION, SHEET AND
TIN DIVISION,
CARNEGIE ILLINOIS STEEL CORPORATION
GARY, INDIANA

The Employee's Relief Association was formed in 1923 as a mutual benefit association of employees to give financial assistance to members in the event of sickness or death. The purpose of the Association was to eliminate the necessity for "passing the hat" to help a fellow employee or his dependents who experience such misfortunes.

Membership in the Association is open to any white person employed in the mill who passes a physical examination and is free from chronic diseases. The enrolment fee is \$1 and the dues are \$1 per month.

A cash benefit of \$2 per day is paid to any member who is unable to work because of injury or illness, starting with the fourth day of the disability and continuing for each additional day of disability but not for more than 13 weeks for any one disability. If the disability is due to chronic illness, or the result of intemperance or immoral conduct, or is self-inflicted no benefits are paid.

A death benefit of \$500 is paid the beneficiary upon the death of a member in good standing for 2 years, \$300 is paid upon the death of a member in good standing less than 2 years but more than 90 days; \$50 is paid to members at the death of husband or wife, and \$25 is paid to a member at the death of a child under 18 years of age.

Since July 1, 1937, for an additional 25 cents per month, members may receive hospital benefits of \$4 per day for 37 days of hospitalization in a year, and \$22 for extra services

42. (a) Brundage, D. K.: A Survey of Work of Employees' Mutual Benefit Associations, Public Health Reports 46:2102 (Sept. 4) 1931. (b) Williams, Pierce: The Purchase of Medical Care Through Fixed Periodic Payment, New York, National Bureau of Economic Research, Inc., 1932. (c) What Employers Are Doing for Employees, National Industrial Conference Board, Inc., New York, 1936. (d) Sayers, R. R.; Kroeger, Gertrud, and Gafafer, W. M.: General Aspects and Functions of the Sick Benefit Organization, Public Health Reports 52:1563 (Nov. 5) 1937.

during the first week, but only for services ordinarily provided by the hospital. No hospitalization benefits are allowed for obstetric cases, venereal diseases, or for illness due to intoxication or self-inflicted injuries. Hospital bills, within the limits established, which are incurred by members at recognized hospitals will be paid directly to the hospital.

The Association is administered by a Board of Trustees which has the power to settle all claims and disputes. The constitution and by-laws which govern the payment of disability, death and hospitalization benefits can be changed only by vote of two-thirds of all members. As of February, 1938, 4,231 members were enrolled in the Association and assets in cash or government bonds were reported to be more than \$48,000.

Another type of mutual benefit association with more extensive benefits is summarized as follows:

SPAULDING EMPLOYEES' MUTUAL BENEFIT ASSOCIATION ⁴³

BINGHAMTON, N. Y.

The Spaulding Employees' Mutual Benefit Association was organized in 1930 for the purpose of paying cash benefits and providing medical care and hospitalization during sickness. The Association is divided into plant divisions and although membership is voluntary two-thirds of the eligible employees in a plant must be members to maintain a division of the Association in that plant.

A Board of Trustees appointed by the company (Spaulding Bakeries, Inc.) is in charge of the administration of each plant division.

Any employee in good health may become a member, no age or salary limit. The dues vary according to the wages as follows:

Weekly Wage	Weekly Dues
\$15 or less.....	20 cents
16 to \$25.99.....	25 cents
26 to 35.99.....	35 cents
36 and over.....	45 cents

The funds of each plant division are administered separately. The company contributes about \$2 a month for each employee, as well as room and clerical assistance, but it is contemplated that the company's contribution will decrease as each plant division builds up a reserve fund.

⁴³ See the Journal of the American Medical Association for June 10, 1933, October 13, 1934, and June 6, 1936, for articles by Dr. Bloom, Medical Director of the Spaulding Employees' Mutual Benefit Association, describing the operation and experience of this plan.

Upon application to the trustees, a member may receive benefits for medical care as follows: \$3 for house calls and \$2 for office visits up to a maximum of \$50 in any one year; designated cash benefits for surgical procedures such as a \$100 limit for major operations, and a \$50 limit for tonsillectomies, with the fee schedule of the county medical society accepted for other surgical services and for x-ray and laboratory services. A hospitalization benefit of \$3 per day, not to exceed 30 days (i.e., \$90) is also provided. Members have free choice of any physician or hospital in the locality. A cash income of \$7.50 to \$20 a week after a waiting period of two weeks is also paid each member, depending on his salary. These cash benefits are limited to ten weeks. (No member can receive benefits in excess of \$350 in any one year.) This program provides the employees with considerable financial assistance in the event of any sickness or accident excepting for maternity cases. The five year average of medical costs has been \$25.47 per employee per year. Dependents are included for \$1 per family with the expenditure limited to \$50 a family for any one year. The three year average annual cost for dependent medical service has been \$7.71 per dependent.

A supervisory committee of three physicians, one appointed by the medical society, passes on bills whenever there is a question of exorbitant charges, padding, or unnecessary services.

Some industrial medical care plans are financed entirely by the employer. In others, check-offs are made from the payrolls and the cost of the plan is shared by employer and employees. A sample of each such arrangement is described below:

ENDICOTT-JOHNSON CORPORATION WORKERS MEDICAL SERVICE

JOHNSON CITY, N. Y.

A complete medical service is furnished by the Endicott-Johnson Corporation, manufacturers of shoes and tanners of leather, to its employees and their families. Employees do not contribute to the cost of medical care. The corporation has plants in three cities—Binghamton, Johnson City and Endicott—and it maintains a medical center in each city. The plan was established in 1918 and has been operating in its present form since 1928.

An employee or a member of his family who is not employed in some other establishment, may apply for medical care at any of the three medical centers. The patient is allowed a choice of staff physicians within the limits of any one physician's case load. The physician a member chooses becomes his regular doctor. Hospitalization is provided when necessary at the local

hospitals. The corporation pays standard rates for services rendered in the hospital for employees or members of their families.

In 1934, the corporation employed a staff of over one hundred persons, which included forty physicians, five dentists, five dental hygienists, four physical therapists, twenty-six trained nurses, five bacteriologists, five pharmacists and a number of technicians, office clerks and assistants to care for approximately 19,000 employees and their dependents. In that year the employed physicians made 133,580 house and hospital calls and received 183,168 ambulatory patients at the clinics. The patients receive complete medical care including dentistry, nursing and hospitalization, and all types of illnesses and diseases are included. Specialists and consultants among the private practitioners in the locality are called in whenever a medical service doctor believes it necessary.

The entire cost of this service is paid by the Endicott-Johnson Corporation and the medical service organization is administered directly by the corporation.

MUTUAL AID SOCIETY OF THE CON-
SOLIDATED EDISON COMPANY
NEW YORK

The original Consolidated Gas Company of Manhattan undertook to provide medical care for its employees in 1902. The present plan was developed in 1935 and is intended to cover all the 40,000 to 50,000 employees of the Consolidated Edison and affiliated companies.

The employees are organized into a voluntary Mutual Aid Society and the financial affairs of the society are controlled by the company. The company deducts five-ninths of 1 per cent from the employees' weekly salaries and the company contributes additional funds so that an annual fund of \$1,100,000 is established to pay for the medical care required by the members during each year.

Membership in the Mutual Aid Society is limited to employees earning less than \$46 per week. Weekly wages range from \$17 to \$45, the average is \$32.40. Further limitations are that an employee without any dependents cannot earn more than \$900 a year to be eligible; for a married employee the maximum is \$1,260 a year with an allowance of \$200 more for each dependent.

The Society contracts with a limited number of physicians to furnish home and office care at less than the minimum fees established by the workman's compensation law. It also has agreements with certain hospitals to provide unlimited hospital services in wards at \$4 per day. The physicians and surgeons who perform medical services for members in the hospital are paid on a fee basis, but according to a minimum fee schedule far below the regular established rates.

The Society has ruled that no physician shall receive more than \$1,200 a year from payments for services rendered its members. If these physicians are hired by the year and subject to call at any time by members of the Society, they have little opportunity to increase their income from private practice. An income of \$1,200 a year is too low for a physician to support himself and his family, and certainly too low to permit him to develop himself for progress in his profession.

The members of the Society do not have free choice of physician or hospital. Their choice is limited to the physicians and hospitals who have agreed to provide services at reduced fees.

There is no definite data on the actual operation of the plan.

Some employee associations are financed largely by the employees but are supplemented in part by the employer to provide members and their dependents with extensive medical services in an association-owned "clinic" or hospital. This type of plan includes the few mutual benefit associations which undertake to provide medical services "in kind" through salaried physicians and association-owned hospitals. A digest of the medical plans operated by some of the divisions of one large industry are as follows:

THE INDUSTRIAL MEDICAL SERVICE OF
THE STANDARD OIL COMPANY OF
NEW JERSEY AND AFFILI-
ATED COMPANIES

Neglect of employee absenteeism from preventable sickness or accident is not regarded as sound business by many large corporations. The widespread activities of the 23 year old medical department of the Standard Oil Company of New Jersey exemplify to what extent preventive industrial medicine has been accepted as indispensable by enlightened management.⁴⁴ The company operates in the United States, Europe, the East and West Indies and South America. It requires medical personnel and facilities, as indicated in table 1.

The services of medical examiners who operate on a fee basis are needed mainly to investigate the physical qualifications of candidates for employment in areas where concentrations of employees are insufficient to justify the appointment of full time physicians and to provide for direct medical or surgical service for industrial accidents or occupational disease. In the tropics

⁴⁴ The Medical Bulletin of the Standard Oil Company (New Jersey) and Affiliated Companies, vol. 5, no. 1, June 1941.

thirty-two hospitals are maintained to accommodate the medical, surgical and obstetric requirements of employees and their families. Elsewhere employees must consult their own family physicians for any form of treatment. Altogether this industrial medical service touches in some manner the physical welfare of 186,344 people engaged in the production, transportation and sale of petroleum products.

Under this system an administrative formula has been developed which works well in any location. Local adjustments are necessary to meet the requirements of climate terrain, racial strains, unusual working conditions or specific occupational exposures. As in all soundly conducted industrial medical departments, principal reliance rests on placement and periodic health examinations, prophylaxis, sanitation, and the maintenance and proper interpretation of medical records and statistics. From its own statement, the company bases its evaluation of medical trends and results on every case of lost time disability lasting one or more calendar days. This is a rare and

Medical and Other Facilities

Full time physicians.....	109
Part time physicians.....	28
Dentists.....	2
Registered nurses.....	101
Other medical personnel.....	400
Medical examiners (fee basis).....	1,010
Hospitals.....	32
Hospital beds.....	1,041

increasingly valuable depository of clinical information. The regular analysis of these records ought to be made widely available to the general profession as well as to industrial physicians. The company statisticians have determined that the average days of disability for each one of their own employees in the United States is six and thirty-one one-hundredths calendar days, considerably under the usually recorded figure of eight plus days for all American industry. As might be expected, industrial injury rates have been regularly decreasing in this same group of employees. Sickness disability, however, has regularly increased for the past five years or more. One reason has been the increased incidence of common colds and influenza, a situation noted even in the group of employees working in the tropics. There are other more obscure causes, related to liberalization of sickness benefit plans, labor unrest and general apprehension resulting from world disturbances. Another curious and unexplained statistical result is the higher incidence of appendicitis in our own Southwest. An epitomized statistical summary is itemized in table 2. The column headed "Noneffective Rates" refers to the average daily number of

disabled employees per thousand. This method of estimating economic loss resulting from sickness and injury is considered to be more useful than frequency rates alone.

A good share of investigation is directed at problems in sanitation and tropical medicine, especially malaria and amebiasis. Additional observations are being made on the effect of influenza vaccine on volunteers. A systematic study is in progress of 800 employees with hypertension on whom accurate medical records have been maintained for twenty years.

The general company policy throughout the entire domestic organization, says the anniversary number of the *Medical Bulletin*, June 1941, of the Standard Oil Company of New Jersey, is that "diagnostic facilities only are available and employees are urged to consult their own family physicians for any form of treatment." Under this plan there was in 1940 "an average Lost-Time rate of 5.19 days per employee." This includes all time lost with no such "waiting period" deducted as is found

Frequency of Sickness and Injuries

	Number of Employees	Frequency Rates per 1,000 Employees per Annum					
		Total	Sickness	Non-industrial Injuries	Industrial Injuries	Non-fetive Rates	Death Rates
United States...	30,815	574.62	543.24	22.20	9.18	17.29	3.60
Europe.....	3,924	333.84	295.36	18.60	19.88	14.84	2.29
Tropics.....	37,083	479.08	412.99	22.62	43.47	11.59	2.54
Total.....	71,822	512.14	462.45	22.22	27.47	14.21	2.98

in most such statistics. (It is less than half the rate for industrial employees insured under compulsory sickness insurance in Germany and Great Britain.)

In the producing field department a prepayment medical and hospitalization plan has recently been inaugurated by the Carter Oil Company. Although this plan is underwritten by an outside insurance company, it is supervised by the medical department of the firm. This plan provides a cash benefit according to the following schedules:

Private Room: A maximum allowance of \$150 for hospital room for one disability, not to exceed \$5 a day.

Doctor's Fee: Up to \$3 per visit and up to \$45 a year. Employee entitled to home, office or hospital calls; dependents entitled to hospital calls only. Absence from work not necessary. Free choice of doctors.

Surgeon's Fees: Not to exceed \$75 surgeon's fee for major operation, and \$25 surgeon's fee in minor operation.

(Tonsillectomies come under minor operations.)

(The surgeon's fees include postoperative visits but do not include the hospital fees, which are \$10 for operating room, \$10 anesthetic and \$5 laboratory fee. These fees are paid in addition to the surgeon's fee.)

Operating room: Not to exceed \$10.

Anesthetic: Not to exceed \$10.

Laboratory fee: Not to exceed \$5 (excluding teeth).

Premium: \$2 a month per employee.

The plan is entirely voluntary and in the beginning, April 1, 1939, the employees were "rather cautious about participating." This resulted in adverse selection, and a drive to encourage enrolment was put on, and "it is expected that, by April 1, 1941, 75 per cent or more of the employees will have participated."

STANOCOLA EMPLOYEES' MEDICAL AND
HOSPITAL ASSOCIATION, INC.

BATON ROUGE, LA.

The white employees of the Standard Oil Company of Louisiana formed an association in 1924 to provide medical services and hospitalization for themselves and their families.

In 1930 the association was incorporated under the non-trading laws of the state of Louisiana with the objective of "providing the attendance of physicians and other medical attention and any and all kinds of medical, surgical and hospital treatment to the members hereof and their dependents." Also, by virtue of its charter the corporation is obliged to "not engage in trade or in obtaining financial gain or profit for its members, and any revenues that it may receive in excess of the amount necessary to carry on its purposes shall be devoted to charity."

Administration.—The affairs of the association are conducted by a board of eleven directors. Eight are elected by departmental groups within the company, and three are elected by members at large. The directors are chiefly officers of the company and foremen of the various departments.

The only paid official of the association is the secretary-treasurer who is also an employee of the Standard Oil Company. He is responsible for the collection of all monies, for payments to meet expenses, and for an accounting of the affairs of the association. In addition to a salaried staff of eleven physicians the conduct of the clinic operated by the association requires the services of four nurses, one laboratory technician, one x-ray technician, two reception and registration clerks, one maid and one porter.

Membership Requirements.—White employees who have been employed for more than one year are eligible for membership. Dependents and relatives of these employees as well as a small group of former employees, annuitants, and widows of deceased employees are also included as members.

Benefits.—The members are entitled to the services of the medical staff at the clinic, in their homes, and in the hospitals. Diagnostic services at the clinic, including x-ray, laboratory tests, and physical therapy, are also available to members. Hospitalization and private duty nursing in the home or in a hospital are allowed up to \$250. Members are entitled to ward room accommodations.

Limitations.—Workmen's compensation cases are excluded as are "unusual or intricate" surgery and mental and tuberculosis cases. Mileage of 50 cents one way is charged for home calls beyond seven miles. There is also some restriction on drugs and a reduction in price on some others. Special laboratory and x-ray fees in the hospital must be paid by the patient. Obstetrical conditions are not hospitalized unless involving surgical intervention or other abnormal experiences.

Costs.—Monthly dues are \$3 with possible assessment of \$3 not more than three times a year. Dependents are included.

Payments to Physicians.—Salaries are reported to range from \$6,000 to \$9,000 annually, with two weeks vacation. There appears to be a rapid turnover in the staff of physicians.

SICKNESS BENEFIT PLAN OF THE INTERNATIONAL LADIES' GARMENT WORKERS' UNION

One example of a labor organization's plan to assist its members to obtain medical care is found in the arrangement developed by the International Ladies' Garment Workers' Union of New York City.

The International Ladies' Garment Workers' Union was organized in 1900. After 1913, the pressers' Local #35, and later other locals in the International Ladies' Garment Workers' Union, established sick benefit funds and special tuberculosis benefits for the members. It was not until after 1935, when the membership of the union increased in size, that the payment of sick benefits became a regular practice among a large number of the locals of the International Ladies' Garment Workers' Union.

UNION HEALTH CENTER

The Union Health Center was established in 1913, primarily to examine and certify members claiming sick benefits, and to make examinations of workers applying for membership in the various locals of the Union. Later, hours were designated when members could visit the Union Health Center for general examination and medical care. Thereafter the treatment of ambulatory patients became a very important function of the Health Center.

The Union Health Center is officially owned by the Union Sanitarium Association, Inc., and is licensed as a medical dispensary by the New York State Board of Social Welfare. The Union Health Center is managed by a Board of 15 Directors who represent the locals and branches of the International Ladies' Garment Workers' Union.

In 1920, the clinics were moved from 31 Union Square to 131 East 17th Street, where the Union had purchased, reconstructed, and equipped a building especially for the purpose. At this time the name "Union Health Center" was adopted. In

its early period, the Union Health Center did not receive sufficient income from the fees it charged to cover its expenses, and up to 1927, the local unions made up the deficit. Between 1927 and 1933, the annual deficit continued to rise, and the locals were unable to contribute enough to make up the difference. At that time the Rosenwald Fund came to the assistance of the Union Health Center with a grant of \$20,000, of which \$15,000 was used to wipe out the deficit, and \$5,000 was used to purchase additional equipment.

In 1935, the International Ladies' Garment Workers' Union passed a resolution to tax each member \$1.00 a year for the support of the Union Health Center and the Unity House. In that year the Union Health Center was moved to 275 Seventh Avenue. The New York garment industry has become centralized in the area around Thirtieth Street and Seventh Avenue, and this new location placed the Center near the shops. The hours for visits at the Center are also arranged for the convenience of the workers.

In 1939, the International Ladies' Garment Workers' Union had about 235,000 organized workers in 141 locals throughout the United States. Twenty-Six of these locals, with a membership of about 140,000, are located in the New York City's Garment Workers' Center. The principal purpose for which the Union Health Center was formed, according to Dr. Leo Price, Assistant Director of the Center, was to offer the poorly paid garment workers an opportunity to obtain a higher quality medical service than was ordinarily obtained by persons in their income class. The Union Health Center also acts as a health educational department for the union members to inform them concerning the value of proper health protection and early medical treatment. Its chief functions are to give immediate medical care to ambulatory patients in order to prevent workers with minor ailments from losing time from work, and to discover early symptoms of more serious illness so that workers will not go without medical treatment until the illness causes complete disability. The Center also provides physical examinations for members applying for sickness benefits and for workers applying for membership in the Union.

When the Union Health Center was licensed in 1930 by the New York State Department of Social Welfare, its objects and purposes were stated as follows: ⁴⁵

1. To furnish ambulant medical care to members of the industry who, because of their low-earning capacity, are unable to pay for good medical care from a private physician.
2. To examine all candidates for membership in the Union.
3. To supervise the medical aspects of the sick benefits system.
4. To act as the health education department of the Union.

45. Health Program of the International Ladies' Garment Workers' Union, Leo Price, M.D., Assistant Director, Union Health Center, Monthly Labor Review, October 1939, Bureau of Labor Statistics U. S. Department of Labor.

The Union Health Center does not provide medical service in the patient's home, and it does not treat injuries or illnesses which are provided for under the Workmen's Compensation Law. Patients are charged a fee for treatment or examination at the Center which usually ranges from \$0.50 to \$1.00, although in special cases the charge may be higher. If workers are destitute, medical services are provided free. The Social Service Department connected with the Union Health Center assists patients requiring service not provided at the Center by directing them to other sources of medical care. The Union's relief committee advises members in obtaining financial assistance.

At the present time, about 90 physicians are associated with the Union Health Center on a part time basis. Many of these are just on call for services when the seasonal demand requires additional physicians. The Medical Director is the only full time physician employed at the Center. The physicians are paid according to the time they spend at the Center. For a session of 1½ to 3 hours service, a physician is paid \$5 to \$10. The Center also makes arrangements with other physicians who are specialists in their field for consultation or services. Consequently, the union members are able to avail themselves of all the medical skill in the locality, instead of the services of a few full time physicians employed at the Center.

SICKNESS INSURANCE BENEFITS

In 1939 there were 15 locals with an estimated membership of 118,896 which had sickness and tuberculosis insurance benefits plans. In addition, 3 locals with an estimated membership of 17,000 had a tuberculosis insurance plan only.

The sickness insurance plans of the locals are compulsory for all members who qualify after a physical examination. The rules of most of the sickness insurance plans provide that each member shall have two physical examinations a year in order to discover incipient diseases or physical defects early, and thus avoid, in some cases, long periods of disability. Union members not accepted in the sickness benefit plan have the same status and privileges in the union as those that are, except they are not required to pay the sickness benefit premiums, nor are they eligible to receive cash benefits, during periods of sickness. They have, however, the same opportunity to obtain medical services at the Union Health Center as the members of the insurance plans. The Director of the Union Health Center and the physicians associated with it have complete control of all medical phases of the sickness benefits plans.

The sickness benefit premiums range from \$1.00 a year in locals which provide tuberculosis benefits only, to \$6.80 a year in one local which provides tuberculosis and other sickness benefits and also financial assistance when necessary. The most common rate is \$4.20 a year. Sickness benefits vary from \$7

to \$10 a week for 10 weeks in a calendar year. Partial sickness benefits of \$3.50 to \$5 a week will be paid for a maximum of 20 weeks in a given year. Tuberculosis benefits are limited to \$350 a year. The benefits for financial assistance vary from \$25 to \$50 a case, depending on the member's status in the union and his need.

Since 1935, all members of the International Ladies' Garment Workers' Union have paid a fee of \$1.00 a year for the support of the Union Health Center. Consequently, members of local sickness benefit plans pay on the average, \$4.20 a year for their local cash benefit plan, and \$1.00 a year for the maintenance of the Union Health Center. Part of the \$4.20 is paid to the Center for administering the sickness benefit plans. In general, a member is eligible to receive the cash benefits, two free physical examinations a year and limited medical treatment at the Center at special rates, or if he is destitute, without charge.

The International Ladies' Garment Workers' Union does not attempt to provide the members with full medical care and it recognizes the dangers of a plan to provide medical care to its members through contracts with a few physicians for premium rates as low as those provided in the locals' sickness benefit plans.

UNIVERSITY HEALTH SERVICES

Many colleges and universities maintain student health services. These health services appear to follow two general policies of organization and administration. One type is maintained solely as a consultation service to provide students with advice as to their health needs and to supervise and control the environmental conditions which might affect health adversely. The other type is organized and administered with a sufficient staff and facilities to provide any medical and hospital care needed by the students. Many of them undertake to provide extensive medical service for faculty members and employees as well as for students. A survey of a number of such student health services leads to the conclusion that some of them spend too much effort in providing curative medical services to the detriment of the more important function of health education for students.⁴⁶

46. University and College Student Health Services, Bureau of Medical Economics, American Medical Association, Chicago, 1936.

LIMITED GROUP PREPAYMENT PLANS

Several prepayment plans for medical service have been organized by groups of physicians. These groups are supposed to be composed of a sufficient variety of specialists and equipment to provide a complete medical service. Such groups enter into contracts with employers or with groups of employees, members of unions or other organizations and sometimes with individuals; for a specified monthly or annual premium medical services are given by the group of physicians. Such plans are variously designated as "medical centers," "health associations," "group medical practice," "cooperative medicine" or "clinics."⁴⁷ An outline of one such plan is given:

THE ROSS-LOOS CLINIC⁴⁸

LOS ANGELES, CALIF.

The Ross-Loos Medical Group, also known as the Ross-Loos Clinic, was started in 1929 when Dr. Donald E. Ross and Dr. H. Clifford Loos, both surgeons in private practice in Los Angeles, agreed to contract with the Los Angeles County Employees Association (Bureau of Water Power) to provide members of the association with medical and hospital services on a monthly prepayment basis.

A headquarters building was rented and remodeled to provide examination rooms, laboratory and x-ray rooms, etc., for the Medical Group. A contract was made with a hospital which agreed to provide members with hospital service including drugs, dressings, laboratory services, etc.

Medical services were furnished on the basis of the payment of \$1.50 per month, later raised to \$2 per month for each subscriber. For this monthly sum the Medical Group agreed to provide the subscriber with medical services including the attention of either a general practitioner or a specialist in the headquarter offices, in the hospital or in the subscriber's

47. Group Medical Practice, Bureau of Medical Economics, American Medical Association, Chicago, 1940.

48. Data from published articles describing the Ross-Loos Clinic such as: Mills, Alden B., and Guild, C. St. C.: *The Voluntary Health Insurance Offered by the Ross-Loos Clinic of Los Angeles*, Chicago, University of Chicago Press, 1933; Higgins, H. U. M.: *The Ross-Loos Clinic*, Chicago, Civil Service Assembly, 1936; *Judicial Council Action in Ross-Loos Case*, J. A. M. A. **106**: 300 (Jan. 25) 1936; Carlson, Avis D.: *The Doctors Face Revolt*, *Harper's Monthly Magazine*, September, 1938; Martin, L., and S.: *Doctors Versus Health*, Ken, May 19, 1938; Address by H. Clifford Loos, *Better Medical Care for Rural America*, American Farm Bureau, Federation, Department of Information, 58 East Washington Street, Chicago, Dec. 7, 1935.

home if he should be unable to come to the clinic. Subscribers were also to receive laboratory, x-ray services, physical therapy, ambulance, drugs and dressings, and hospitalization in a ward bed. The subscriber must pay additional amounts for certain services, such as dental services, special drugs and appliances such as crutches, eyeglasses, wheel chairs, etc. A mileage charge is made for calls beyond a certain limit.

The dependents of subscribers were provided with services similar to those indicated above with the exception that a charge was made for hospitalization, drugs, dressings, x-ray films, ambulance service, and the services of a specialist called in consultation. In 1935, as a result of a tendency on the part of the dependents to tax the resources of the clinic because of free services, the contracts were voided at the close of the year, and new contracts were submitted which provided a fee schedule for services to be provided to dependents. These fees for dependents include charges such as \$1 for home calls, \$5 for tissue examinations, and \$25 for major operations.

The latest available information concerning the financial experience of the Ross-Loos Medical Group is for the two-year period 1933-1934. The costs per subscriber per month for services from the Medical Group were reported as follows:

Compensation for doctors.....	\$0.95
Nurses salaries.....	.17
X-rays .....	.05
Hospitalization .....	.20
Laboratory .....	.04
General overhead .....	.76
	<hr/>
Total cost.....	\$2.17

Since the monthly premium per subscriber was \$2, a deficit of 17 cents per subscriber per month was incurred. Consequently, as a straight insurance proposition, the \$2 premium per member per month was inadequate. The deficit was apparently made up by income from sources such as fees for services to dependents; extra charges to subscribers; income from soda fountains, magazine and candy sales; sub-rentals, etc. The income from such sources amounted to 51 cents per subscriber per month which offset the deficit of 17 cents leaving a profit to the Medical Group of 34 cents per subscriber per month.

Dr. Loos himself has stated, "It is evident therefore were it not for the fact that a charge was made for dependents and further that dependents availed themselves of the service offered, for which they pay, the plan could not financially continue with subscribers only." During this two-year period, 1933-1934, the receipts from soda fountain, magazine, and candy sales amounted to \$18,471.68. Apparently it is necessary for the Ross-Loos

Medical Group to rely on fees from dependents who are not included on the monthly prepayment insurance basis. Likewise, receipts from the sale of items such as chocolate sundaes, magazines, and candy bars are an essential part of the financial structure of this medical care plan. The Medical Group also contracts with hospitals at a reported rate of \$2.75 per day for services which are valued by the Medical Group at \$7.30 per day. There is no indication that the Medical Group contributes to the care of indigent patients in a degree proportionate to other physicians in the county.

The profits of the Medical Group were divided as follows: 27½ per cent for Drs. Ross and Loos and 72½ per cent apportioned among the rest of the doctors who are on salary. The capital investment in the headquarters office amounts to more than \$75,000 and the branch offices to \$14,000, making a total capital investment of \$89,000, exclusive of automobiles. A Board of Advisors consisting of Drs. Ross and Loos, a business manager, and five of the staff physicians elected by the staff itself is the administrative body of the Medical Group.

These private medical group or mutual contract plans vary widely in the type of service they give. Where they have been organized by groups of competent physicians originally associated to deliver a high grade care such plans have maintained good standards of medical service. They are, however, subject to a type of competition which is not considered to be an incentive to improvement in medical service. Some such groups are organized by lay promoters and patronage is secured by advertising and solicitation. In these organizations professional control of medical procedures is almost, if not entirely, absent, although such control, throughout the ages, has been the greatest force in preserving and advancing standards of medical service. However high the medical standards of the first of such schemes in any community, its success invites the competition of others with successively lower standards. These new organizations compete for patronage on a price basis by lowering the premiums and by reducing the quality of their service. This is not an imaginary situation. In one state there were 143 such organizations promoted as medical service plans which defrauded thousands of persons who thought they were purchasing low cost

medical services. The promoters acted as medical brokers. In some instances they contracted with "clinics" or private groups of physicians and hospitals for the services promised to the prospective patients. In some cases no medical contracts were made, and when it was found that the enrolled members failed to obtain the medical services promised, a grand jury investigation followed and the officers of some of the schemes received fines or jail sentences.⁴⁹ When contract plans are organized and operated outside the influence and guidance of professional ethics and supervision, it is difficult to avoid degeneration of medical standards.

MUNICIPAL EMPLOYEES PLAN

Arrangements for prepaid medical services may be classified broadly according to the groups responsible for organizing the plans. These groups are referred to as producer groups and consumer groups. The producer groups comprise those organizations which are formed, administered and maintained by physicians or medical societies. Consumer groups are formed and maintained by groups of employees who assume the greater part of the responsibility of determining the provisions of the plan and the details of administration.

An example of a consumers group plan designed for the municipal employees and the Board of Education employees of the city of San Francisco and employees of the County of San Francisco is given here in some detail.

HEALTH SERVICE SYSTEM OF SAN FRANCISCO

Managers of the Health Service System for municipal employees and the employees of the Board of Education of San Francisco have issued a first annual report covering fifteen months of operation of a plan covering 15,000 persons. The information which follows is taken from that report.

⁴⁹ *New Forms of Medical Practice*, Bureau of Medical Economics, American Medical Association, Chicago, 1934.

The membership was made up of 9,809 employees, 3,124 adult dependents and 1,817 minor dependents. This was an average monthly membership during a period when there was a steady increase in members. The premium for each employee and adult dependent was \$2.50 a month. Minor dependents under 18 years of age were charged \$1.50 a month, and each additional minor dependent \$1 a month.

The percentage distribution of expenditures given in the first table was made from the total of the combined funds.

Of the total of \$355,232.77 disbursed for medical care, approximately 68 per cent went for doctor service, 23 per cent for hospitalization and 9 per cent for x-ray, clinical laboratory examinations, ambulance and physical therapy.

Nearly a quarter of a million dollars was paid to doctors during the first year for the treatment of 10,696 individuals. This is 73 per cent of the entire membership. Sixty-seven per

Percentage Distribution of Expenditures

Doctors.....	57.9
Hospitals.....	19.5
X-ray laboratories.....	3.8
Clinical laboratories.....	2.2
Ambulance.....	0.4
Physical therapy.....	1.3
Medical overhead.....	5.3
Nonmedical overhead.....	7.9
Equipment and alterations.....	0.5
Unexpended balance.....	1.2
	100.0

cent of the employees had the service of a doctor by the end of September 1939, and that percentage went up to 75 by the end of the calendar year. It was recognized that there was considerable abuse of the system. Nine hundred and eighty-six local doctors and ninety-four out of town doctors participated in the Health Service.

The chief complaint of the doctors has been that the monthly value of the unit of service was too low.

Thirteen hospitals received a total of \$81,422.80 for the hospitalization of 1,500 persons during the twelve months ended Sept. 30, 1939. The average cost per case was \$54.28.

Payment to the hospitals is made at the flat rate of \$7.20 a day, regardless of the amount of service used. In some so-called "come and go" cases, in which the patient is confined only part of the day, the full daily rate is not charged.

This entitles the patient to a ward bed, meals, general nursing care, floor supply of drugs and dressings, x-ray and clinical laboratory examinations, use of operating room, administration

of anesthetic and various other services. A patient may select a private or semiprivate room by paying to the hospital the difference between the regular ward rate and the rate for any other room he may choose. Many patients chose the higher priced accommodations.

This year's experience has shown that the cost of providing hospital benefits was 46 cents per subscriber monthly, exclusive of overhead.

In November 1939 several changes were made in the plan. The rate of contribution for all minor dependents was raised to \$1.50 a month and the following changes in the service were adopted to affect dependents only:

1. Treatment was limited to one year for any one condition, illness or injury.

Payment to Doctors and Value of Unit by Months

October 1938—September 1939		
Month and Year	Paid to Doctors	Value of Unit
October 1938.....	\$13,452.00	\$1.00
November 1938.....	17,603.50	1.00
December 1938.....	38,063.00	1.00
January 1939.....	17,940.75	0.50
February 1939.....	18,874.87	0.65
March 1939.....	17,801.04	0.50
April 1939.....	18,948.17	0.54
May 1939.....	19,543.34	0.57
June 1939.....	19,630.78	0.57
July 1939.....	19,174.62	0.66
August 1939.....	20,273.08	0.65
September 1939.....	20,451.42	0.67
Total.....	\$241,756.57	\$0.66

2. The rate for minor dependents was increased to \$1.50 a month regardless of the number enrolled by the employee.

3. In the future all dependents must have a medical examination before being admitted to the System and any pathologic condition existing at that time will have to be corrected before the person is admitted; or the person may be admitted but the Health Service will not be responsible for the bills for treatment of that condition.

4. No minor dependent will be admitted until attaining the age of 1 year.

The number of office visits for either dependents or employees for which the Service will be responsible has been limited to five a month. This was a counter proposal to the one made by the doctors' committee that the patient be required to pay for the first two office visits and the first two home visits.

Henceforth, all subscribers are to be restricted to the service of one doctor a month except with the consent of the medical director. This was to prevent patients from shopping around for the same condition. Refractions were also eliminated from the benefits beginning with Nov. 13, 1939. The fee schedule was revised to permit the general practitioner to receive more remuneration for his services.

The administration costs were 13.2 per cent, and it is believed that this can be reduced in the future. Demands of osteopaths and chiropractors and practitioners of drugless therapy for a right to practice under the plan are in course of litigation.

The average cost per employee member monthly for medical services is \$1.87, adult dependents \$2.28, and for minor dependents \$2.05.

The first few months of operation disclosed some defects and difficulties that have required careful consideration but at the time of preparing this report no information was available to show what modification, if any, had been adopted.

In an analysis of the annual report by the San Francisco County Medical Society, the following recommendations were made:⁵⁰

1. Adoption of a more equitable fee schedule. (Such a fee schedule has been prepared and submitted to the medical director for the Health Service Board.)
2. Revision of the hospitalization contract in order to clearly exclude medical services therefrom, and to comply with the charter provision in regard to uniform rates of compensation for physicians.
3. Revision of medical benefits to include irradiation therapy for suitable conditions.
4. Gradual or eventual adjustment of premiums to benefits, or of benefits to premiums, so that the amount of medical service provided to municipal employees will ultimately be defrayed by the amount of funds which they make available.

WHOLESALE BUYING GROUPS

In a few cities organizations have been formed which undertake to collect dues on the promise to induce

⁵⁰ Municipal Employees' Health Service System, Annual Report for 1939, The Bulletin of the San Francisco County Medical Society, May 1940.

physicians to provide their services at a discount. It is not clear just what service is provided either to patients, physicians or the public by any such organizations.

Descriptions of three of these arrangements follows:

THE PEOPLES MEDICAL LEAGUE, INC.

FAMILY HEALTH SERVICE LEAGUE, INC.

THE NEW YORK MEDICAL SERVICE
COMPANY, INC.

NEW YORK, N. Y.

These three organizations are essentially "buying clubs" organized and incorporated by laymen. The corporations act as agents for members, endeavoring to secure a 40 to 50 per cent reduction of regular fees from physicians for medical services. The annual dues collected are used to pay the operating expenses of the corporations and the salary of the officers. No part of the collections is used to pay for medical services. The corporations assume no obligations for bill collecting or for any service except to provide the members with a list of physicians who have agreed to provide free physical examinations and medical services at reduced fees.

The annual membership dues are \$2 for a single person, and range from \$3 to \$7.50 for married couples with dependents. Membership is not restricted by age limits or conditions of health although it is stated that these organizations are primarily for single persons whose income is \$25 a week or less, and for families whose weekly income does not exceed \$50.

A member receives a free physical examination and a certificate which entitles him to obtain medical service from any physician who has agreed to supply medical services for members at the reduced fees. Participating physicians receive no remuneration from the corporations for performing free examinations or for agreeing to the concession in fees.

A member must choose any physician with whom the corporation has an agreement in order to receive the free physical examination and the benefit of reduced fees. A member may employ his own physician if the latter agrees with the corporation that he will perform the services at the special reduced rates.

Such organizations do not appear to provide any service that the individual patient cannot obtain directly from his own physician.

Some community health associations, organized on a bona fide philanthropic basis, have been in operation for a number of years. These plans do not contract for medical services nor interfere with the patient in his method of obtaining medical services. Two examples of this type of community health association are as follows:

THOMPSON BENEFIT ASSOCIATIONS FOR HOSPITAL AND NURSING SERVICE

BRATTLEBORO, VT. (Pop. 9,816)

The purpose of these associations is to make it possible for members to be partly protected from the uncertain cost of sickness. For this protection the members pay annual specified sums of money. The Thompson Trust Fund was established in 1869 with the provisions that the trustees use part of the income from the fund for the relief of unemployed women in Brattleboro. The trustees have organized and directed the Benefit Associations as a means of providing this relief. The two associations are separate, and a person may belong to one or both. The trustees of the Thompson Trust Fund contributed \$1,000 to the fund of the Nurses Benefit Association and \$1,500 to the fund of the Hospital Association when the associations were formed.

The Nurses Benefit Association instituted in 1926 by the trustees of the Thompson Trust Fund offers nursing services in the home and special nursing services in the hospital for specified annual premiums of \$2.00 for single persons, \$3.00 for married couples and 50c for each child under sixteen years. Arrangements are made with the nurses to provide their services to the members at one-third or one-half of their regular charges. Benefits are not to exceed \$200 in any one case. Benefits do not cover chronic illnesses or cases where the service is desired for a convenience only.

In 1927 the Hospital Benefit Association was organized. The administration of this Association is in charge of a committee appointed by the directors of the Brattleboro Memorial Hospital with the approval of the trustees of the Thompson Trust Fund. Any person or family in the community in good health is eligible to become a member of this Association. The yearly premium was \$5.00 for a single person, \$7.50 for married couples and \$1.00 for each child under 16 years of age. The directors, with the approval of the trustees, have the right of accepting or rejecting applications.

In return for the annual premium the members are assured of cash benefits above \$30.00 but not to exceed \$300 in case of an operation at the Brattleboro Memorial Hospital includ-

ing the costs of surgical fees, nurses fees and room charges. Nonsurgical cases with the exception of obstetrics and chronic cases are provided with one-half payments within the limits of \$30 to \$300, but physicians' fees are not included. The directors of the Brattleboro Hospital may at their discretion advise that the surgical services be secured at other hospitals and payments within the limits set up will be paid. The directors also have the final decision as to the necessity of the service, the amount of benefit a member is entitled to and as to the emergency nature of the case.

No benefits are paid for treatment of chronic illnesses or cases where convenience or rest is the chief motive for demanding services. Benefits do not include costs covered by other insurance or by damage claims, but payments may be advanced by the association until a settlement is made. The provision that the first \$30.00 for hospitalization and surgical services shall be paid by the patient is to eliminate the temptation of members to demand medical care for minor illnesses which ordinarily require no hospitalization.

During the first years (1927 to 1932) the plan was in operation, the income from premiums was insufficient by several thousand dollars to pay the benefits. The Thompson Trust Fund, however, made up all deficits.

In 1932 the premiums were raised and three types of maximum benefits were provided. The new rates and benefits are as follows:

SINGLE PERSONS	
<i>Annual Premiums</i>	<i>Maximum Cash Benefits</i>
\$ 5.00	\$150
6.66	200
10.00	300
MARRIED COUPLES	
\$ 7.80	\$150
10.40	200
15.50	300
ADULT DEPENDENTS	
\$ 3.90	\$150
5.80	200
7.80	300

For a child up to 15 years old a member must pay \$2.00 a year, and for a dependent 15 to 21 years old, \$5.00 a year.

This increase in the annual rates brought the income over \$1,000 above the benefits paid out in 1933. For the year ending Sept. 1, 1933, the membership payments amounted to approximately \$7,900, and the total benefits paid out in that period was \$6,800.

In 1935 the membership had increased to about 3,000 (1,000 in 1932) and in addition to this about 1,000 students in a neighboring academy were carried for the school year under a special arrangement.

In a few rural communities groups of residents have organized health associations to guarantee a physician an annual income as an inducement to locate in the community, which could not otherwise support a physician. A number of these associations have been reported to be in operation but a recent survey of rural medical services⁵¹ found that most of the plans were either no longer in operation or were not conducting successful programs. While there is little objection to the theory of such plans, they do not seem to succeed in actual practice. After a short time of operation the members tend to grow tired of contributing to the physician's salary and feel that once he is located in the community he should be able to support himself on a fee-for-service basis. A description of a rural health association which received considerable attention is as follows:

ECONOMY MUTUAL HEALTH ASSOCIATION

ECONOMY, IND.

In April 1936, a university student and a minister in Economy, Ind., proposed to collect \$15 annually from each of 200 families to guarantee an income of \$3,000 a year for a physician to come into the community of Economy. The medical benefits to be provided under the plan were not very definite but all the members of a family were to receive medical attention, both preventive and curative, as well as surgery, from the physician who would accept the proposal. The physician could make extra charges for special medicines, x-rays, obstetrical conditions, and other special services. According to a report in May 1937, 80 families agreed to pay \$1.25 per month, payable quarterly in advance to the physician.

Prior to this proposal there was a resident physician in Economy who saw fit to leave, but offered to return if the plan was organized. There are also two physicians within a radius of 5 miles and 13 physicians within a radius of 10 miles of the town of Economy.

51. Rural Medical Services, Bureau of Medical Economics, American Medical Association, Chicago, 1937.

The plan was reported in operation, but in November 1937, the following statement appeared in the Journal of the Indiana State Medical Association:

Word was received from the Economy Mutual Health Association that their physician has left and they desire a new one. The Committee [Medical Economics] felt that it would be difficult to obtain a reputable physician to enter into the type of contract practice attempted by this association.

Subsidies and bonuses are also sometimes offered by local authorities or private individuals in rural communities to induce physicians to locate in the community.

Union and Fraternal Arrangements.—Most of the unions or fraternal orders which are organized on a national basis provide sickness and accident benefits for members. The organizations to arrange for the handling of the payments under such plans have, for the most part, developed into insurance associations of the fraternal or assessment type. Improvements in the fraternal insurance laws have virtually transformed these associations into insurance companies with a reserve basis somewhat comparable to regularly organized legal reserve companies. The membership certificates in these plans are essentially insurance contracts and provide the members with cash benefits for the loss of time due to sickness or accident. Frequently, however, the local branch or lodge enters into contractual relations with physicians and hospitals in the community to provide medical services and hospitalization for members. A digest of fraternal lodge arrangements is as follows:

LODGE PRACTICE

The purpose of a fraternal order is to improve the welfare of each member through mutual assistance. To carry out this purpose practically all fraternal orders, through local lodges, engage in various welfare projects, including that of providing medical service for its members.

In general, there are two types of fraternal orders in regard to their activities in providing members and their families with medical services: (1) Orders which organize insurance asso-

ciations under Fraternal Insurance Laws to insure members against death, disability or sickness; (2) Orders which do not organize insurance associations. Both types of fraternal orders may make arrangements to provide medical services directly to members and their families. The lodge or fraternal order either collects special dues from its members to cover the costs of the services or benefits, or it includes the cost in the regular dues.

In event of illness or disability both types of fraternal orders, which have promised medical care to their members, provide such service by employing one or more local physicians on a salary or per capita fee basis. In addition to the services of a physician, the fraternal orders which operate insurance associations pay their members cash benefits for loss of time because of disability or illness. In either case the dues are so small that it is necessary for the physician's salary or fees to be limited in comparison with the services he is expected to provide.

Under the customary arrangements, the local lodge agrees to pay the physician \$2.00 or \$2.50 per member per year, and in return the physician agrees to reduce fees by one-half for all office and home calls required by the member and his dependents, the other half to be paid by the individual member. Sometimes the physician agrees to give all office and all home calls free. The physician who accepts such a lodge appointment usually makes little pretense of giving complete medical service for the member and his family, but accepts the appointments for the purpose of providing extra services for members and their dependents at private fees. Although the medical services offered exclude major operations, obstetrical cases, x-ray services and treatment of venereal diseases, the physician finds it difficult to refuse to provide additional services without charge. The members also tend to impose on the physician for minor ailments because they feel they have paid for medical services and, therefore, should have the benefit of any service desired.

A lodge or fraternal order will frequently use the medical service provision as one of its "strongest talking points" in membership campaigns. It then uses its large membership as the main reason why physicians should provide medical care to its members on a low annual salary basis, or at reduced rates. Another deplorable situation which arises in contract practice for lodge members is that the members expect and demand full medical care in return for insignificant payments of \$2.00 to \$2.50 a year. The small dues usually makes it necessary to employ only one physician to provide medical care to a large group of members so that it is impossible for the physician to render proper medical attention to them all. In one instance a single physician was supposed to care for several thousand persons through his contract with a fraternal lodge at \$2.50 per year for each member.

As a result most lodge practice arrangements violate the principles of medical ethics by denying the member free choice of physician, by providing insufficient remuneration for the physician to perform services of desirable quality, and by misleading members into believing that they are entitled to services which actually they cannot obtain.

Lodge practice plans generally provide members with a very meager service and are considered as one of the most unsatisfactory types of contract practice plans.

MEDICAL SOCIETY PLANS

It has already been noted (pages 13-21) that the American Medical Association has for several years encouraged experiments in the distribution of medical care. In 1938 the House of Delegates further clarified its position by adopting the following: ⁵²

Since it is contemplated in the resolutions passed by the Board of Trustees that some state and county medical societies may find it necessary to develop preferable procedures for supplying the needs where medical services are insufficient or unavailable, it is urged that these medical societies be guided in the development of these procedures by the ten principles adopted by the House of Delegates in 1934. The application of these ten principles to specific suggestions or proposals for the organization of medical services may be facilitated by utilizing the method of direct cash payments to individual members. Your committee unanimously concurs in the suggestion and recommends that the American Medical Association adopt the principle that in any place or arrangement for the provision of medical services the benefits shall be paid in cash directly to the individual member. Thus, the direct control of medical services may be avoided. Cash benefits only will not disturb or alter the relations of patients, physicians and hospitals.

Likewise, at the Special Session of the House of Delegates in September 1938, it was suggested that: ⁵³

In addition to insurance for hospitalization your committee believes it is practicable to develop cash indemnity insurance plans to cover, in whole or in part, the costs of emergency or prolonged illness. Agencies set up to provide such insurance should comply with state statutes and regulations to insure their

52. Proceedings of the House of Delegates, J. A. M. A. 111:59 (July 2) 1938.

53. J. A. M. A. 111:1215-1217 (Sept. 24) 1938.

soundness and financial responsibility and have the approval of the county and state medical societies under which they operate.

* * * * *

Your committee repeats its conviction that voluntary indemnity insurance may assist many income groups to finance their sickness costs without subsidy. Further development of group hospitalization and establishment of insurance plans on the indemnity principle to cover the cost of illness will assist in solution of these problems.

A few county medical societies had already experimented with prepayment plans. One of these was the Medical Service Bureau of Fulton County, Georgia, which applied to the state of Georgia in October 1933 for a corporate charter, not for profit. On the payment of the following premiums, this organization agreed to arrange for medical service, with the exception of hospitalization, drugs and nursing:

	Initiation Fee	Monthly Dues
First member.....	\$1.00	\$1.50
Second member.....	1.00	1.00
Third member.....	.50	.75
Fourth and each additional member.....	.50	.50

Members were given full freedom to choose their own physician among all those who agreed to give service under the plan. The organization was financed in the beginning by a \$500 loan from the county medical society and \$1,200 in loans from physicians. The Board of Directors consists of five physicians who must be members of the Fulton County Medical Society, but who are elected by the physician members of the Medical Service Bureau. A fee schedule of approximately 50 per cent of the prevailing medical charges in the community was established as a guide with the understanding that the physicians were to be paid a prorata of the income. The Bureau began functioning in April 1934, and had over 1,000 members in March 1938. The inability of the Bureau to pay the full amount of bills rendered, the free service given in the

municipal hospital and the competition of contract and corporate medical care plans in industry have caused a slow growth of the plan.

The most extensive development of prepayment plans by county medical societies has taken place in Washington and Oregon largely because of a peculiarity of the workmen's compensation laws in those states. In most other jurisdictions the laws provide that the cost of compensation shall be paid entirely by the employer and the collection of any money for this purpose from employees is forbidden. In Washington and Oregon the laws specifically provide for a deduction from employees' wages to pay for medical services.⁵⁴ The Supreme Court of Washington has characterized the compensation act as follows: ⁵⁵

"To resume, ours is not an employer's liability act. It is not even an ordinary compensation act. It is an industrial insurance statute. Its administrative body is entitled the Industrial Insurance Commission. All the features of an insurance act are present. Not only are all remedies between master and servant abolished, and, in the words of the statute, all phases of them withdrawn from private controversy, but the employee is no longer to look to the master even for the scheduled and mandatory compensation. He must look only to a fund fed by various employers. When the employer, for his part, pays his share into this fund, all obligation on his part to anybody is ended. . . .

"Under our statute the workman is the soldier of organized industry accepting a kind of pension in exchange for absolute insurance on his master's premises."

Thus the Washington law was interpreted to mean that employers can use the funds collected under the state law to pay for contract medical service. In Oregon numerous so-called "hospital associations" arose as private corporations organized to contract with employers for the provision of medical services for employees entitled to compensation. The corporations

54. Medical Relations Under Workmen's Compensation, Bureau of Medical Economics, American Medical Association, Chicago, 1935.

55. Opinion Supreme Court of Washington, Stertz et al vs. Industrial Insurance Commission, Report Department of Labor and Industries, 1924, p. 18.

contracted with physicians, hospitals, nurses, druggists and ambulance firms to provide these services.

All of the evils characteristic of contract medical practice developed. The Department of Labor and Industries described cases where amputations were performed unnecessarily due to neglect and inefficient service.⁵⁶ A member of the Industrial Insurance Commission of Washington described other abuses as follows:

"There are hospitals in this state which have heretofore indulged in the practice described by Chairman Pratt of aiding and abetting in coerced settlement, giving a man a drink of whisky and a railroad ticket to a distant point, thereby being relieved of further responsibility for hospital care and stopping inroads on the hospital's potatoes due to the man's returning health.

"One corporation in southwest Washington arranged with the hospital to have all medical and hospital treatment given its stipulated average of 130 men for the sum of \$300 a year. The company then deducted regularly \$1 per month or \$1,560, leaving a net balance on the books of \$1,260 for its enterprise!"

The effects of this system upon the medical profession of the entire state as well as upon the workers subject to its operation cried out so loudly for relief that the county medical societies undertook to act as the contracting agencies for medical care under the law. It is difficult to conceive of a more inept environment in which to attempt a prepayment medical care experiment since it has long been noted that every system of medical care, including especially compulsory sickness insurance, is forced to utilize patterns existing at the time of its formation. This is true of practically all social evolution. Each new institution must be built upon the foundation and out of the materials existing at the time the new one is created. This pattern of contract medicine had established extremely low standards of medical service, wholly insufficient payment to physicians and others supplying the service and a domination by lay financial interests.

56. (a) Bulletin Department of Labor and Industries of the State of Washington, September 1921. (b) Peacock, Alexander H.: Free Choice of Physicians Northwest Medicine 30: 467-468 (Oct.) 1931. (c) Baum, W. W.: The Oregon Plan Northwest Medicine 39: 3 (Jan.) 1940.

COUNTY MEDICAL SOCIETY PLANS

Out of the elements forming the pattern of contract medicine just described, the state and county medical societies of Washington and Oregon set about organizing and administering plans of prepayment medical service that would so far as this pattern permitted assure good medical service. The first Medical Service Bureau was that of King County, (Seattle) Washington. To meet the competition of the "hospital associations" it was necessary to accept contracts with employers at premium rates that could not possibly provide good medical service without large sacrifices from the physicians. The "unit system" was adopted as a method of introducing the flexible element. This system provides that the value of each service shall be stated not in monetary terms but in numbers of units. The physician's bill describes the services given which entitle him to payment for a certain number of units. At each payment period the total number of units reported from all participating physicians is divided into the fund available and the quotient represents the monetary value of the unit for that period.

The need of some sort of uniformity in county medical society plans soon became evident. This was especially necessary as the scope of coverage of the plans was extended. In the beginning service was furnished almost exclusively to wage earners who were covered by the compensation law. The Oregon Hospital Associations had, in their competition for business, extended the coverage first to services not included in the compensation law, then to dependents and in some cases to the general public. There was a legal fee schedule for injuries covered by the compensation law that could not be changed.

The latest reports available indicate that there are 14 county medical societies in Washington operating prepayment medical plans with an estimated coverage

of approximately 100,000 persons. In the beginning the premiums, which were necessarily limited to meet the competition of private contractors, were too low to pay the costs of the medical service called for by most of the contracts; in spite of the low premiums the physicians involved did all they could to maintain a high quality of service. As the superiority of the services given by the Medical Service Bureaus became evident, it was possible to raise the premiums without losing contracts. Nearly every medical service bureau reports some such change since its formation.

All the medical service bureau contracts provide for free choice of physician and hospital from among those physicians and hospitals that agree to enter into the arrangement. In most places where medical service bureaus have been organized, a high percentage of the medical society members have agreed to participate in the plan. Although benefits were intended for employees covered by the workmen's compensation law, in many instances private contractors included executives as a means of selling the contract to the employer. The medical service bureaus are gradually eliminating from their contract coverage those individuals with high incomes, the acceptance of whom originally was really in the nature of a bribe to secure the contract.

The Medical Service Bureaus have in some instances become the agents for the distribution of medical care under public relief and also in connection with the Social Security law. When a recent referendum in Washington adopted an old age pension law containing a provision for supplying medical care for all such pensioners to be paid for from tax funds, the state negotiated with the Medical Service Bureaus to supply this service for an estimated 80,000 persons.

The situation in Oregon, to some extent, resembles that in Washington. A Committee on the Study of Contract Practice of the Oregon State Medical Society

reported in 1937⁵⁷ that "almost 100,000 individuals in Oregon are now covered by some form of prepaid medical care." This care was to a large degree furnished through lay hospital associations which were said at that time "to have an income somewhere in the neighborhood of \$1,000,000 annually. Their cost of administration amounts to approximately 25 per cent of the income." The Oregon State Medical Society investigated all phases of the problem and studied numerous plans to meet the situation.

The first of the Medical Service Bureaus or Associations to be organized by physicians in Oregon to provide prepaid medical, surgical and hospital care to low wage industrial and commercial groups was started in Salem in 1931. At the beginning of 1940 ten of these Bureaus or Associations were in operation serving 16 counties with 30,000 employees enrolled as subscribers. Plans are under way to extend this movement to other counties. The premiums paid by the subscriber are approximately \$2 per month with some variation depending upon the kinds of service offered. A reduced fee schedule was authorized by the state medical society for these Bureaus. Payments to physicians were necessarily made "on a percentage of the stated schedule in accordance with the funds available at the close of the quarter."⁵⁸ A Bureau of Medical Economics was established in the state medical society headquarters to act as a center of information to the various bureaus and to assist them in carrying out the policies adopted by the state medical society. It was estimated that 250,000 people within the state were eligible to receive medical care under the proposed plans. In a paper presented before the Pacific Coast Medical Executives Conference,

57. Report of the Committee on the Study of Contract Practice to the 63rd Annual Session of the House of Delegates of the Oregon State Medical Society, Oct. 9, 1937 (mimeographed).

58. Method of Payment and Fee Schedule to Be Applied in Providing Medical Care to Low-Wage Industrial Groups, Adopted by the Executive Committee of the Council, Jan. 24, 1940 (mimeographed).

Seattle, Washington, December 10, 1939, the principal features of the plan were described as follows:

Contracts offered to employees under the plan include furnishing of drugs and hospital services. It is hoped in the near future to be able to divorce these and to limit the contracts to furnishing of medical service only. Contracts written under the plan differ in certain details, due to various local requirements, but all offer essentially the following services: (1) all necessary medical and surgical treatment, limited to a period of one year for any one disease; (2) complete hospital service (ward), limited to six months in any one case; (3) all necessary medicines, medical and surgical supplies; (4) dental service for acute conditions and extraction of teeth necessary in treatment of general disease.

Fees paid by subscribers under these contracts vary in different industries and localities, ranging from \$1.50 to \$2 per month. The plan is designed to benefit the low-wage group and the Bureau has recommended that a maximum income level of \$1,000 per year for single persons and \$1,600 for married persons be adopted as an objective, with each local organization being permitted to fix lower income levels if it so desires.

* * * * *

In granting approval to a local organization and admitting it to membership in the Bureau, it is required to observe the ten principles adopted by the House of Delegates of the American Medical Association.⁵⁹

DALLAS COUNTY MEDICAL PLAN

DALLAS, TEXAS

The Dallas County Medical Plan is a non-profit prepayment medical service plan for low income groups. The plan which is sponsored by the Dallas County Medical Society began operation on July 1, 1940 under the administration of a board of directors made up of seven physicians representing the Dallas County Medical Society, and three laymen representing the hospitals and the public.

PARTICIPATION OF PHYSICIANS

All members of the Dallas County Medical Society are eligible to participate in the plan.

ENROLLMENT OF SUBSCRIBERS

Employed persons under 65 years of age are eligible to enroll in groups of twenty or more if 60 per cent of the group apply. Income limitations are \$2,000 for an individual subscriber, and \$2,500 for a subscriber with a family.

59. Pages 13-14.

SUBSCRIBERS' BENEFITS

Medical and surgical care in the home, office or hospital can be arranged with any physician registered with the plan. Consultation services and x-ray, laboratory and anesthesia service are also included. Obstetrical service is provided after the subscriber has been enrolled for twelve consecutive months. Medical services necessary to establish a diagnosis only are provided for tuberculosis, gonorrhoea, syphilis and nervous or mental conditions.

No medical services are provided for alcoholism, drug addiction and self-inflicted injuries, or for conditions which are compensable under the United States Employees Compensation Act, the Texas Workman's Compensation Act, or any other special legislations which cover industrial accidents or illnesses.

HOSPITAL SERVICES

Hospital services are not provided but the subscriber may obtain a separate contract for prepaid hospital service from the group hospitalization plan in operation in that area. The two plans cooperate in the enrollment of employed groups desiring both medical and hospital service contracts.

SUBSCRIPTION RATES

Originally \$1.50 a month with a \$5 deductible clause. The subscriber must pay the first five dollars incurred for medical services in a subscription year. The subscriber is entitled to a maximum of \$325 worth of medical service in each year. In a report from the Dallas County Medical Plan, Aug. 1, 1941, it stated that new groups would be enrolled at a monthly rate of \$2 for each person, but the required payment by the subscriber of the first \$5 for medical services would be eliminated.

On July 1, 1941, after one year of operation, the Dallas County Medical Plan had 1,100 subscribers and 450 physicians of the 512 members of the Dallas County Medical Society were registered with the plan.

The gross income for the first year from the subscription fees was \$14,625.50. Out of this, \$9,842 was paid to physicians for medical services rendered to 536 of the subscribers. The administration expenses were \$754.54, leaving a reserve of \$4,028.96 for the first year. During the first six months of operation, most of the administration expenses were borne by the physicians in order to build up a reserve fund.

MEDICAL SERVICE FOR FEDERAL
HOUSING PROJECT TENANTS

An experiment to provide the low-income tenants of the Vladeck Houses in the Corlears Hook section of

New York City with prepaid medical care was put in operation by the Medical Society of the County of New York in November 1940 after considerable study.⁶⁰

An association, called the Corlears Hook Medical Association, was formed to carry out the experiment. The association is directed by a board made up as follows:

- Two representatives from the Medical Society of the County of New York
- Two representatives from the Beth Israel Hospital
- Two representatives from the Gouverneur Hospital
- Two representatives from the neighborhood physicians
- One representative from the Henry Street Settlement
- One representative from the Henry Street Visiting Nurse Service
- One representative from the Lower East Side Association of Agencies
- Two representatives from the enrolled tenant members.

Membership in the Corlears Hook Medical Association is open to families living in Vladeck City or Vladeck Federal Houses whose family incomes fall below the following figures:

\$ 900	a year for individual
1,260	a year for a family of two
1,485	a year for a family of three
1,710	a year for a family of four
1,935	a year for a family of five
2,160	a year for a family of six
2,385	a year for a family of seven

The membership fee in the association is 25 cents a month for an individual, 50 cents a month for a husband and wife, 75 cents a month for a husband, wife and one child and \$1 a month for husband, wife and two or more children. The membership fee is turned over to the physicians chosen by the family without any deduction for collection or overhead cost. A member has free choice of any physician who subscribes to the plan. A month's notice is required for a change in choice of physicians.

Members in the association are entitled to all medical services provided by a general practitioner in private practice.

Free consultation, laboratory tests and x-ray services are available in the outpatient department of the Beth Israel and Gouverneur Hospitals as well as free hospitalization in the wards of those two hospitals, when requested by the family physician.

60. The New York Medical Week 19: 5-6 (March 23) 1940.

STATE MEDICAL SOCIETY PREPAYMENT PLANS

When a state medical society proposes to introduce so extensive a change in the arrangement and payment for medical services as is involved in a state-wide prepayment plan, a multitude of complex factors must be recognized and analyzed. Medical care is derived from a wide variety of sources, nearly all of which have their own institutional pattern. Any new method of providing medical service must consider not only which of the old medical institutions will be disturbed or modified, but also how the new plan will fit into and adjust itself to those medical institutions which it is desirable to preserve. The success of prepayment plans in providing a high quality of service has been largely proportionate to the extent to which such plans make provision to preserve the essentials of private medical practice. The most important of these essentials are the freedom of choice of physician, and control by the medical profession of the quality and method of delivery of the service.

Any alteration in the organization of medical service should insure continuous cooperation with public health departments on an accepted program of preventive medicine. Hospital service constitutes an important part of medical care. General hospitals have developed prepayment service plans which may easily supplement similar prepayment arrangements for general medical care. The two should, however, operate with separate contracts. Clinics and outpatient departments, especially in the care of the indigent, have become too important an element in the provision of medical service to be disregarded even though at times they may seem to have exceeded the limits of their proper function.

No prepayment plan can cover all sections of the population. Institutional care is clearly beyond its scope, and special arrangements must be made if it is to care for the indigent or the medically indigent.

There are sharp differences of opinion as to the income limits that should be set. If the income limit is placed high enough to include those who can well afford to pay for their medical care on the fee for service principle, this will be so destructive of the independent practice of medicine as to work an injury to the standards of medical care upon which the well being of the entire community depends. It is equally true that too low an income limit makes it impossible to provide a really good medical service. If physicians are not paid enough to enable them to keep up with the progress of medicine, the service is certain to deteriorate. This is but another illustration of the fact so continuously overlooked by many writers on this subject that no method has yet been proposed of providing a uniformly good medical service to different income groups without some modification of the sliding scale of fees.

By the summer of 1941, there were 20 state medical societies that had taken some steps towards the introduction of a medical service plan to operate over the entire state. In Washington and Oregon, as has already been described, while there is some state-wide supervision, the initiative remains with the county medical societies which have organized medical service bureaus. In others such as Rhode Island, West Virginia and Arizona the plans seem still to be in the process of study and formation. In Colorado the latest reports indicate that although a plan has been carefully developed it is held in abeyance. The State Medical Society of Wisconsin has conducted extensive investigations and several limited experiments, but, because such investigations and experiments have failed to show any extensive demand for prepayment plans, has not yet endorsed any particular state-wide experiment. In Minnesota the Committee on Sickness Insurance in June 1940, after careful investigation, recommended that "no state-wide

plan for sickness insurance be set in motion for the time being." The Missouri State Medical Association has developed a complete plan for hospitalization and medical services. The hospitalization scheme has been in operation for some time, but so far little has been done concerning a prepayment plan for medical services. In Texas a medical service plan has been in operation in Dallas County on an experimental basis for over a year, and it is now proposed to extend it to other counties. Medical service arrangements in New Jersey and Pennsylvania have not been in operation long enough to permit any conclusions as to results.

CALIFORNIA PHYSICIANS' SERVICE

The organization of California Physicians' Service is the outgrowth of several years of study, experiment, attempted legislation and a multitude of proposed plans. The preliminary work included a much discussed study of medical conditions in California for which the California Medical Association expended about \$50,000. There was a great amount of public controversy before legislative committees, in nearly all California periodicals and in the 1939 California legislature of a plan for compulsory sickness insurance, which received the energetic support of the current administration.

The plan is administered by a nonprofit corporation based on three classes of members: administrative, professional and beneficiary. There are seventy-five administrative members, the majority of whom are members of the California Medical Association but include a number of non-medical members who have been elected by not less than two-thirds of the administrative members who represent districts and who also elect the board of trustees of the plan.

Professional members include any person licensed to practice medicine under the laws of the state of California who carries malpractice insurance and signs an application blank agreeing to serve under the rules and by-laws and pays a \$5 registration fee, which constitutes a part of the working capital. The California Medical Association lent the service \$15,000 to meet initial organization expenses and later made additional loans totaling \$27,000.

The service was incorporated on January 2, 1939, and began actual operation about July 1, 1939. The administrative members elected a board of nine trustees, including eight physicians and one layman, who receive no salary. The board of trustees

elected a medical director, who must be a physician not engaged in private practice. The state is divided into twenty-one districts, each having an assistant medical director operating under the supervision of the general medical director. These medical directors are not to supervise medical care but only to safeguard the use of money from the fund in order that it may furnish adequate service to beneficiary members. Certain medical procedures and operations require the approval of the assistant medical director before they can be undertaken.

The beneficiary members must be under 65 years of age and belong to families with incomes of not more than \$3,000 annually. Persons with more than \$3,000 annual income have been admitted with a provision that the physician will be permitted to make a special charge for services in addition to that provided for in the fee schedule. Members are accepted only in groups of five or more, generally as employees of a single industry. In small groups, eleven and under, 100 per cent participation is required, and in larger groups at least 50 per cent must enroll. Proposals are also under consideration for the inclusion of individual members at a rate somewhat above the group rate. The established rate is \$2.50 a month per person for full coverage, as described later, and \$2 a month when a member agrees to pay for the first two visits in any illness. Of these payments, 80 cents a month is set aside to pay for hospital insurance, which is carried by an independent but, to some extent, affiliated nonprofit hospital association.

Medical services include home and hospital calls and surgical services. Obstetric service is furnished after two years' continuous membership but does not include hospital care. All kinds of laboratory examinations, including x-ray and radium therapy and anesthetics, are provided. Unlimited specialist care is furnished usually after the endorsement of the medical director without regard to the amount. Drugs and appliances are not included. Illness arising from insanity, mental disease, alcoholism, drug addiction, self-inflicted injuries, dental services and injuries covered by workmen's compensation or other insurance are also excluded. The beneficiary member has complete freedom of choice among all physicians who have become professional members. All professional members vote on equal terms on all matters subject to vote, whether members of the California Medical Association or not.

Payments to the physicians are made on the "unit system." The fee schedule items are not expressed in monetary units but in units of service, the cash value of which depends on the income received. A single unit is an ordinary "repeat" office call, and all other items are multiples of this. For example, a fracture of the clavicle with four weeks' care is thirty units.

The amputation of a finger or a toe is six units. A similar unit scale applies to payments for laboratory and x-ray service. It was recognized by the administrative members of California Physicians' Service at the annual meeting that:⁶¹

There are a great many procedures which are so variable in extent that no unit value has been placed upon them here. Whenever such procedures are performed, the units to be charged for them may be agreed upon by consultation with the Medical Director, pending the time that accumulated experience can include them in the formal schedule.

California Physicians' Service

Month	Beneficiary Membership	No. of Patients Served	Collections from Beneficiary		Unit Value
			No. of Doctors Serving Patients	Members (from Which Professional Bills Are Paid)	
Aug. and Sept, 1939..	1,220	.....	.....	\$2,823.83	\$1.75
October 1939.....	2,270	.....	.....	3,721.98	1.60
November 1939.....	3,700	.....	.....	6,068.15	1.60
December 1939.....	5,742	.....	.....	9,416.86	1.60
January 1940.....	7,000	.....	.....	11,496.60	1.50
February 1940.....	8,437	.....	.....	13,311.00	1.30
March 1940.....	9,322	1,488	868	15,910.44	1.30
April 1940.....	10,868	1,685	1,053	18,137.49	1.25
May 1940.....	11,949	1,964	1,057	20,110.80	1.25
June 1940.....	14,065	1,993	1,109	23,207.10	1.35
July 1940.....	15,608	2,219	1,199	25,868.85	1.35
August 1940.....	16,650	.....	.....	27,409.45	1.35
September 1940.....	17,398	.....	.....	.....	.....
March 1941.....	22,948	.....	.....	.....	.....
May 1941.....	25,378	.....	.....	.....	.....

The unit system makes the income of physicians the flexible element and thereby insures that the quality and quantity of the service will not be subject to financial limitations unknown to the patient. The physician's bill describes the separate services given and these are then calculated according to the fee schedule expressed in units. The income for any period (it is computed monthly at present) is then divided by the total number of units supplied to all patients during that period, and the result is the value of the unit in cash according to which the physician is paid.

61. California Physicians' Service, California & West. Med. 51: 337 (Nov.) 1939.

The accompanying table shows growth of membership by months, the number of patients served, the number of doctors serving patients, revenue and the unit value.

Several additional fields of activity are being explored. Officials of several schools have already approached California Physicians' Service with the suggestion that the service take over the medical care of their student bodies. Owing to the fact that the incomes of many of the families of students in educational institutions exceed \$3,000 annually, it is necessary to make special arrangements. The house of delegates has granted permission to make such contracts with schools subject to the approval of the county medical societies in which the schools are located. Negotiations are under way with relief authorities for arrangements for medical care of persons receiving public assistance.

The 1941 meeting of the House of Delegates of the California Medical Association adopted the following resolution with the object of establishing machinery by which to bring the County Medical Societies in more direct connection with the trustees of California Medical Service.⁶²

Resolved, That the House of Delegates instruct the Council of the California Medical Association to request each component county society of the California Medical Association to immediately appoint a committee to be known as a coordinating committee, to confer upon appropriate occasion with the Board of Trustees of the California Physicians' Service.

The size of these committees shall consist of not less than three members or more than five members, and their appointment shall be for one year.

Each component county society shall report the names of these committee members to the Council of the California Medical Association and the Board of Trustees of the California Physicians' Service.

The function of these committees shall be to contact the Board of Trustees of the California Physicians' Service for the purpose of bringing to their attention the various reactions to the plan from their respective committee areas, and to offer such assistance as may be useful to or necessary for the furtherance of the plan as it stands, or to offer such suggestions as may be considered pertinent to the modification of the plan, as instructed by their respective committee areas. It is further suggested that these committees report to their component county societies monthly, such report to embody the current policies and functions of the California Physicians' Service. The names of the members of these committees shall be published in each issue of CALIFORNIA AND WESTERN MEDICINE.

62. *California & Western Medicine* 53: 333 (June, 1941).

Another resolution adopted at same meeting expressed this opinion:

Resolved, That the House of Delegates reaffirm its confidence in the conduct of the affairs of the California Physicians' Service and leave to the Board of Trustees and Administrative members the details of its policy and administration.

MICHIGAN MEDICAL SERVICE

The Michigan State Medical Society undertook the organization of a state-wide prepayment plan only after long study and much investigation. For nearly ten years medical care plans were studied and many experiments, especially in the care of the indigent, were tried. State-wide surveys cost the state medical society about \$30,000 in cash, besides a great amount of voluntary work. At one time compulsory sickness insurance was given very serious consideration and, indeed, looked upon with so much approval that two representatives of the society were sent to Great Britain to study the system there. In the end, however, the idea of a compulsory plan was rejected and, at a special meeting of the House of Delegates in January 1939, a prepayment medical service plan administered and controlled by the profession was sponsored. This action was confirmed at a regular meeting of the House of Delegates, September 18, 1939.

An enabling act (Michigan Public Act 108 of 1939) was passed by the legislature. The advice of the state insurance commission and of actuaries and attorneys insured legality and financial soundness. The Council of the Michigan State Medical Society then developed the nonprofit corporate structure of the Michigan Medical Service. This involved the advancement of \$7,800 in organizational expenses plus \$10,000 of working capital. A surplus is now being gradually accumulated from which to pay this debt.

Control of administration is vested in members of the corporation, who elect a Board of Directors of 35 members, two-thirds of whom must be physicians and the remainder from various lay groups. No compensation is paid any director.

Medical advisory boards have been established in each of the councilor districts of the state society. Members of these boards are selected by the county medical societies on the basis of 1 board member for each hundred doctors of medicine, or major fraction thereof, in the county medical society. It is proposed to have members of these boards meet annually to consider such problems as may have arisen in their various districts. To these boards are referred all problems involving the rendering of medical services and the approval of payment for services.

On the recommendation of the insurance department the Michigan Medical Service was organized on a state-wide basis.

It was felt that such an organization would result in lower administration costs, uniform subscription rates and greater financial stability through centralization of reserves.

In recognition of the closely affiliated fields of activity of hospitals in the furnishing of medical service, an agreement was drawn up between the Michigan Medical Service and the previously existing Michigan Hospital Service. This provides that certain phases of administration will be conducted by the Hospital Service on behalf of the Medical Service. These include information, educational and acquisitional services. The necessary accounting work together with billing and collection is also conducted by the Hospital Service. This does not include the disbursement of payments to physicians or the general accounts and statistical reports of the Medical Service. This arrangement makes for greater economy and, consequently, lower costs of administration.

Two types of service are offered, a Medical Service Plan and a Surgical Benefit Plan. The first provides the services of physicians in the home, office and hospital. In order that the premiums may be kept low, the first \$5 incurred for medical services in any one subscription year must be paid by the subscriber to the Medical Service. The total benefits in any one year are limited to \$325 for an individual, \$550 for a husband and wife and \$875 for a family. This service, which with a few exceptions includes all of the medical care that is apt to be needed by any individual or a family, costs \$2 a month for an individual, \$3.50 for a husband and wife and \$4.50 for an entire family including all children under 19 years of age.

The Surgical Benefit is intended to cover such catastrophic diseases as require surgical action. It provides the following benefits, but only while the subscriber is a bed patient in a hospital: surgical, diagnostic x-ray and maternity services after 12 consecutive months in the plan. The monthly rate for these services is 50 cents for an individual (more if 15 per cent of group are females), \$1.25 for a husband and wife and \$2 for a family including all children under 19 years of age. At least 50 per cent of a group of eligible employees must become subscribers, with a minimum of 25. The Surgical Benefit Plan has no age limit, but an age limit of 65 is fixed for the Medical Service Plan.

The Michigan experience, at present, would seem to indicate that combined hospital and surgical service has a much greater appeal to the public than a comprehensive medical service.

Enrollment is by groups, generally according to employment in a single firm. During the first year 330 groups were enrolled; 285 of these chose the Surgical Benefit Plan and 45 the Medical Service Plan. The response of physicians has been extremely satisfactory. In some counties there has been a 100

per cent enrollment, and the average for the state is more than 80 per cent. The steady increase in enrollment is shown by the following table:

Enrollment

Month	Medical Service Plan	Surgical Benefit Plan	Total Enroll- ment
March 1940.....	1,360	58,758	60,118
October 1940.....	4,346	86,050	90,396
January 1941.....	5,227	115,747	120,974
February 1941.....	5,893	125,234	131,127
March 1941.....	7,960	60,593	68,553
April 1941.....	8,420	69,274	77,694
May 1941.....	8,333	76,577	84,910
June 1941.....	6,216	181,731	187,947
July 1941.....	6,216	187,371	193,587

The discontinuance of 75,000 employees of one automobile company, which was anxious to secure national coverage, caused the drop in enrollment under the Surgical Plan on March 1, 1941, but other firms more than replaced this loss within a few months. The subscribers are fairly well distributed throughout the state, so that doctors in practically every county have patients who are subscribers. About one-fourth of the subscribers are enrolled as individuals, one-fourth under husband and wife certificates and one-half as families. During the first year services were provided for 9,200 subscribers, and payments to doctors for these services amounted to \$300,000.

A sample study of 1,301 patients under the Surgical Benefit Certificate indicates that 23.8 per cent received services for abdominal surgical procedures (6 per cent for hernias, 15.3 per cent for appendectomies, 1.2 per cent for cholecystectomies, 1.3 per cent for all other abdominal procedures); 25.1 per cent for nose and throat surgical procedures (18.3 per cent for tonsillectomies, 4.7 per cent for submucous resections, 2.1 per cent for all other nose and throat surgical procedures); 29.2 per cent for radiology services (10 per cent for chest x-ray films, 5.5 per cent for gastrointestinal series x-ray films, 13.7 per cent for all other radiology services), and 21.9 per cent for all other surgical procedures. This study covered primary surgical services only. Frequently the patient required two or more operations at the same time.

A sample study of 357 patients under the Medical Service Certificate indicates that 70.5 per cent required office or home visits or general examinations (48.7 per cent office visits, 10 per cent home visits, 9.5 per cent general physical examinations and 2.3 per cent all other visits and examinations); 9.5 per cent required eye, ear, nose and throat services (5.04 per cent tonsillectomies, 3.36 per cent refractions, 1.12 per cent all other

eye, ear, nose and throat procedures); 8 per cent required radiologic services, and 12 per cent required gynecologic, urologic, pathologic and other services.

The average payment on behalf of a patient under the Surgical Benefit Plan has been \$47.11; under the Medical Service Plan, \$16.27, or an average of \$37.65 per patient. The monthly payment to individual doctors has ranged from a low of \$2 for an office visit to a high of \$762.

The financial experience from March 1 to December 31, 1940, is as follows:

Earned Income.....	\$359,699.66	100.0%
Medical Services:		
Paid	\$172,115.00	
Reserve for pending and unreported services.	81,188.00	253,303.00
		70.5%
	<hr/>	
	\$106,396.66	
Operating expenses.....	72,119.45	20.0%
	<hr/>	
	\$ 34,277.21	
Other Income.....	520.66	
	<hr/>	
Net Income.....	\$ 34,797.87	

In each month, the full schedule of benefits, equivalent to prevailing charges now made by doctors in Michigan for patients in the income group enrolled in Michigan Medical Service, has been paid for all services.

NEW YORK PLANS

Prepayment plans in New York state are organized under a special law authorizing "nonprofit medical indemnity or hospital service corporations." This law provides that "medical expense indemnity shall consist of reimbursement for medical care provided through duly licensed physicians, for nursing service and of furnishing necessary appliances, drugs, medicine and supplies." While a hospital service corporation and a medical expense indemnity corporation may issue a combined contract providing for medical expense and indemnity, neither one of the corporations can issue a combined contract. Before any corporation can be

established it must obtain a permit from the superintendent of insurance and also the consent of the State Department of Social Welfare. For the first year of operation 20 per cent, for the second year 15 per cent, and thereafter not more than 10 per cent of the aggregate amount of payments received from subscribers during any one year may be used for solicitation. The State Department of Social Welfare in its certificate of consent provides that at least one-third of the board of directors shall be persons other than physicians and at least one-third shall be physicians duly licensed to practice in the state of New York. Since there is no provision for state-wide operation of a single plan, a number of plans have been started, some of which are described:

PLANS IN NEW YORK CITY

Owing to the fact that the enabling act of the New York legislature did not provide for a state-wide medical indemnity plan or for limitation of the number of plans that might be set up in any one locality, six plans have been proposed in the city of New York:

- Medical Expense Fund of New York, Inc.
- Group Health Cooperative, Inc.
- American Plan for Medical and Surgical Care, Inc.
- Medical Guild Foundation, Inc.
- Association for Prepaid Medical Care, Inc.
- Associated Health Foundation, Inc.

As a result there has been considerable difference of opinion as to which of these plans should receive support. No attempt will be made to describe all of these plans. One of them offers practically unlimited medical care on a per capita yearly fee basis. Some do not have any income limits or deductible clauses, and have such low requirements for enrollment as to raise a question as to their ability to fulfill the promises held out to subscribers. Until these plans have been in operation for a sufficiently long time to test some of

these features, it is practically impossible to draw any conclusions even as to their experimental value. The Westchester County Medical Society did make a careful analysis of the plans.⁶³ The Comitia Minora approved the Medical Expense Fund of New York, Inc., and the action of the Comitia Minora was approved by the Medical Society of the County of Kings.⁶⁴ Similar approval was given by the Medical Society of the County of New York.⁶⁵ The Medical Society of the County of Orange also approved of the Medical Expense Fund.⁶⁶ However, these actions do not prohibit endorsements by these organizations of other plans within the same territory.

MEDICAL EXPENSE FUND OF NEW YORK, INC.

The Medical Expense Fund of New York, Inc., was organized by physicians in the following counties of New York: Bronx, Columbia, Delaware, Dutchess, Greene, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Sullivan, Ulster and Westchester. The plan was incorporated in October, 1939, according to the provisions of the Piper Hampton bill, article IX-C of the insurance laws of the State of New York.

The Medical Expense Fund of New York, Inc., is directed by a Board of Trustees consisting of twenty-four members, at least eight of whom shall be other than physicians. The members of the Board of Trustees are chosen to represent the various counties included in this plan. The trustees are elected by and are responsible to the administrative members of the plan. A general advisory board consisting of representatives of the Associated Hospital Service of New York, the Hospital Superintendents' Association and other health agencies and the public at large is appointed by the Board of Trustees.

The management of the plan is directed by an administrative board consisting of five members appointed by the Board of

63. (a) Medical Expense and Voluntary Health Insurance, Westchester Medical Bulletin 9:7, 11-14 (Jan.) 1941. (b) Report of Committee on Medical Economics to Medical Society of the County of Westchester on Medical Expense and Voluntary Health Insurance Corporations, Westchester Medical Bulletin 9:7-8 (Feb.) 1941.

64. Proceedings of the Society, Bulletin of the Medical Society of the County of Kings 19:187 (Dec.) 1940.

65. Gateway to Action, New York Medical Week 20:4 (April 26) 1941.

66. Medical Expense Fund, Bulletin of the Medical Society of the County of Orange 2: (July-Aug.) 1940.

Trustees. Any physician licensed in the state of New York is eligible for professional membership in the plan, and a registration fee of \$5 is required of each member. Officers and trustees of the plan and those physicians who are residents in a county in which the Medical Expense Fund of New York, Inc., operates, and who are also members of the House of Delegates of the Medical Society of the state of New York, are eligible for administrative membership with voting privilege.

Premiums are graded according to income as shown in the following table:

Beneficiary Membership Eligibility Table—Premium Rates and Deductible Sums

Series	Monthly Income		Annual Premium When Enrolled Individually	Annual Premium When Enrolled by Groups	Maximum Indemnity in a Contract Year	Deductible Sums
	With Dependents	Without Dependents				
A	Over \$175	Over \$125	\$17	\$15.00	\$500	\$10.00
B	\$175 to 140	\$125 to 100	15	12.60	500	10.00
C	\$140 to 100	\$100 to 75	12	10.80	500	7.50
D	Under \$100	Under \$75	10	9.00	500	5.00

In case of an emergency the subscriber will receive indemnities for medical expenses incurred according to the provision of the contract. The subscriber's contract also provides indemnities for payment of services of a specialist if the subscriber was referred to the specialist by the attending physician. If the subscriber chooses a specialist without first consulting his own physician, the plan will pay indemnities at the rate provided for general medical services and the subscriber must arrange to pay any additional sum himself.

The plan provides four types of subscribers' contracts, as shown in the accompanying table.

Rates for dependents are the same as for subscribers. Dependents are spouse and unmarried children under 18 years of age.

Persons may be enrolled in groups or individually. When enrolled by groups and at least 75 per cent apply, the medical examination will be waived. When less than 75 per cent of a group apply, and in case of all individual applicants, a statement from the family physician, that the applicant is not in need of immediate medical care, must be presented. Persons over 65 are not eligible for membership, nor persons whose family physician is not a professional member of the plan.

Beneficiary members are entitled to receive general medical care including home, office and hospital visits, up to \$300

indemnity in any one year, a maximum of \$300 indemnity for surgical service in a contract year, and up to \$100 in a contract year for services received from a specialist at the request of the attending physician. The contract also provides that a member may receive up to \$50 in indemnities for services from a pathologist, \$100 for diagnostic services of a radiologist and \$300 for radium or x-ray therapy from a radiologist, and \$75 for the services of an anesthesiologist. The total amount of indemnities a beneficiary member may receive in any contract year is \$500. All indemnities are payable directly to the physician who rendered the services, according to a schedule of fees established for the plan. There is a deductible clause of \$5 or \$10 depending on the income of the subscriber.

Indemnity will not be paid for services for preexisting illnesses or injuries, and there is a ten day waiting period before the contract becomes effective for illnesses, but no waiting period for injuries. Obstetric services are covered only after a ten month waiting period.

Mental disorders and illnesses or injuries due to alcoholic or drug addiction are excluded, or any occupational injuries or illness covered by workmen's compensation laws.

In April 1941, 2,500 physicians had enrolled as professional members. No license actually to begin business will be asked for until at least 5,000 subscribers are enrolled.

WESTERN NEW YORK MEDICAL PLAN

The Western New York Medical Plan, Inc., was organized late in 1939 to cover the eight counties of western New York: Alleghany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming. License to operate was issued in February 1940, the plan was offered to the public March 1, and the first contracts became effective March 15, 1940.

The board of trustees, elected by the participating physician members, consists of twenty-five members—sixteen physicians and nine laymen.

Any person under 65 years of age who has not had cancer, diabetes, osteomyelitis, chronic nephritis, tuberculosis or coronary thrombosis is eligible for membership. Subscribers reaching the age of 65 may continue membership at the discretion of the corporation. Married women must include their husbands in the contract.

Two types of contracts are provided:

1. Medical and Surgical Contract: This provides service for all kinds of medical and surgical conditions, but obstetrics and elective operations are not covered in the first year of the contract.

2. Surgical Contract: The benefits of this contract are limited to surgical cases only plus obstetrics (after first year) and an annual physical examination at the request of the subscriber. There is no limit to total benefits.

There are two classes of members:

1. Those whose annual income is less than a specified amount, as follows: (a) individuals with \$1,800 or less; (b) man and wife with combined income of \$2,500 or less; (c) subscriber and family, including all unmarried children under 18 years of age, with combined income of \$3,000 or less.

Subscribers in this class receive service without further expense (except for co-insurance provision noted later) up to the limit of benefits under the contract, which are as follows: (a) individual, \$200 of service a year; (b) man and wife, \$300 of service a year; (c) family, \$400 of service a year.

2. For those whose annual income exceeds the amounts that have been noted the contract becomes one of pure indemnity according to a definite schedule of indemnities attached to and made a part of the contract. This class of subscribers is subject to the same limitation of total benefits as is the lower income class, but only on the type 1 contract (medical and surgical). Neither class of subscriber is limited as to total benefits under type 2 contract (surgical).

The subscriber may choose his physician from the list of participating physician members. About 80 per cent of the eligible doctors in the area are members.

Emergency treatment by other than member physicians is paid for only up to one-half of the amount that would be paid a participating physician. Obstetric service is furnished only after the first year of the contract.

The general medical and surgical contract includes house and office calls, hospital calls, consultations, specialists' fees, operations, anesthesia, x-rays, physical therapy, immunization, and laboratory and pathologic examinations (when not furnished subscriber under a separate hospital service contract).

An individual subscriber must pay the physician one-half of the first \$10 for service in any contract year (total \$5) on house and office calls for medical (nonsurgical) service. Man and wife and family subscribers must pay half of the first \$20 for service in any contract year (total of \$10).

There are the customary exclusions of cases covered by workmen's compensation, elective operations during the first year of the contract, treatment of venereal diseases during the first eleven months of the contract, conditions arising from the use of drugs, functional nervous or mental diseases, injuries received through felonious conduct or intentionally inflicted, pre-existing and congenital conditions.

The amounts of subscribers' dues are given in the accompanying table.

All duly licensed physicians in the district may become members on written application, by payment of the registration fee and signing a contract. Physicians must give written notice of intention to cancel their membership contract, but such termination of membership will not become effective until thirteen months after date of notification.

Physicians who enrolled before April 1, 1940 paid \$10 as a registration fee, which is returnable as corporation funds are available. All membership fees paid after this date are not to be refunded.

All remuneration for services is on a unit basis. Seventy per cent of the premium income the first year and 75 per cent each year thereafter is set aside for the payment of doctors' bills. Payments are made quarterly, and when the value of the unit is below par for the quarter the balance becomes a contingent liability to be paid as earnings accumulate.

Subscriber's Dues

	Monthly	Quarterly	Semi-annual	Annual
Medical and Surgical Contract				
Subscriber only, no obstetrics.....	\$1.50	\$4.50	\$ 9.00	\$18.00
Man and wife, no obstetrics.....	2.25	6.75	13.50	27.00
Family group, with obstetrics.....	3.00	9.00	18.00	36.00
Surgical Contract				
Subscriber only, no obstetrics.....	0.40	1.20	2.40	4.80
Man and wife, no obstetrics.....	1.10	3.30	6.60	13.20
Family group, with obstetrics.....	1.70	5.10	10.20	20.40

Service is evaluated on the basis of an established fee schedule, most of the items of which are below the prevailing schedule for private patients. Where services are rendered subscribers in the higher income group (class 2) the doctor is paid the amount stated in the contract as indemnity and may charge the subscriber an additional fee by private arrangement.

Physicians have so far been paid 100 per cent of their bills. In the first quarter of operation, which ended June 30, 1940, only \$376 was paid in claims. For the quarter ending March 31, 1941, \$2,250.50 was paid.

MEDICAL AND SURGICAL CARE, INC.,
UTICA, N. Y.

This is the first medical expense indemnity plan approved by the New York State Department of Insurance and incorporated under the provisions of the law previously described. It was formed to provide medical service under the law to subscribers in the following counties: Oneida, Madison, Herkimer,

Lewis, Chenango, Otsego, Delaware, Montgomery, Fulton, Hamilton, Oswego, Essex, St. Lawrence, Franklin and Clinton.

This plan differs somewhat in principle from other plans inasmuch as there is no ceiling limit on incomes, but the limit of services provided annually for the individual is \$225, for man and wife \$325, and \$425 for a larger family. During the first contract year the subscriber must pay for the cost of the first two calls of each separate illness.

The rates are as follows:

	Mo.	Quar.
Gainfully employed subscriber.....	\$1.40	\$4.20
Spouse and each dependent from the ages of 16 through 18 years.....	1.15	3.45
All children between the ages of 1 and 16 years .....	.75	2.25
(This one payment covers all children under 16 years regardless of number.)		

Another type of contract, known as Plan II, provides for medical and surgical care in the hospital only with the further provision of \$25 for after-care in the home or office. This has practically the same limits for annual service and the first \$10 of medical expense per family per year is paid the first time during the year hospitalization is necessary.

The premiums under this plan are as follows:

	Mo.	Quar.
Gainfully employed subscriber.....	\$.80	\$2.40
Spouse and each dependent from the ages of 16 through 18 years.....	.75	2.25
All children of the subscriber 1 to 16 years .....	.65	1.80
(This one payment covers all children under 16 years regardless of number.)		

The schedule of fees is practically the same as those paid under workmen's compensation law, although a great many fees, for conditions not covered by compensation, have been set up on a similar scale. If necessary, physicians can be prorated on their payments.

A low cost Plan III, allowing for credits that a physician will allow toward maternity, x-ray, anesthesia, pathology, basal metabolism, electrocardiograms and eighty-three surgical procedures, has just been announced.

This rather new approach also eliminates the necessity of any ceiling of income for subscribers. A patient in a low income class would probably not be charged by the physician for any additional amount. A patient in a higher income group would

receive a credit for the amount shown in the schedule and the physician could bill an additional amount to make the fee equal to what would be normal.

The rates are as follows:

	Mo.
Gainfully employed subscriber.....	\$.48
Husband and wife .....	.99
Husband and wife and all children between the ages of 1 and 16 years.....	1.38

The plans have been sold chiefly in the city of Utica with a population of only 100,000, yet more than 4,000 people have enrolled in the Medical and Surgical Care Plans, I and II, during the first year of operation.

The Medical Plan is closely associated with the Hospital Plan, Inc., at Utica, N. Y., with an enrollment of over 75,000 subscribers. Enrollments for both Hospital and Medical Plans are handled by the same office.

The Medical and Surgical Care Plan went into operation in April of 1940 and has been able to meet all payments without drawing upon lines of credit that have been available. The membership on April 1, 1941 was 4,237, and earned reserves in excess of all liabilities totaled \$7,430.32.

MEDICAL SERVICE ADMINISTRATION OF NEW JERSEY

Few state medical societies have conducted more investigations and experiments in medical care than the Medical Society of New Jersey before completing the organization of a prepayment plan. Experience with the FERA and the organization of a state-wide plan of medical care in 1939 and thorough discussion participated in by almost every member of the Medical Society of New Jersey had prepared them for the enabling act which was signed by the governor on May 29, 1940. A license was received from the Commissioner of Banking and Insurance March 24, 1941.

The Medical Service Administration of New Jersey incorporated Oct. 27, 1939, with a Board of Governors of eight members appointed by the Board of Trustees of the Medical Society of New Jersey. This Board of Governors appoints an advisory board in each county subject to the approval of the county medical society.

The Medical Service Administration operates two plans. Under Plan I the income limits for beneficiaries are \$1,600 for a single person or the head of a family without dependents, and an additional allowance of \$400 is permitted for the first dependent and \$200 for each additional dependent. Physical examinations are required for those over 65 years of age. Married women are admitted only when the husband is also

included. A physical examination is required for groups of less than ten. The subscription rates are as follows:

Subscribers	\$1.50 per month
First dependent.....	1.25 per month
Second dependent.....	1.00 per month
Third dependent.....	.50 per month
Fourth dependent.....	.50 per month
Other dependents.....	No extra charge

Service in the office, home and hospital is given. Elective surgery is not provided during the first year. Drugs, nursing, surgical appliances and maternity care during the first contract year, except for prenatal advice, are not furnished. There are the usual exclusions of functional mental, nervous and venereal diseases, institutional tuberculosis, drug addictions and workmen's compensation cases.

Physicians are paid according to the local custom as determined by the Board of Governors depending on the amount of money available. X-ray services are limited to \$15 annually per individual.

In Plan II, for hospitalized subscribers, only employed persons under 65 years of age with an annual income of not to exceed \$2,000 are eligible. Subscribers receive all types of medical and surgical services rendered hospitalized patients by fully licensed physicians, including x-ray examinations, not exceeding \$15 during any one period of hospitalization.

The monthly subscription rates are 65 cents for males and 80 cents for females.

OHIO ENABLING ACT FOR MEDICAL SERVICE PLANS

The enabling act sponsored by the Ohio State Medical Association (House Bill 51) to prepare the way for establishment of a plan endorsed at the recent meeting of the house of delegates of that association has now become a law, effective Aug. 5, 1941.

Any corporation "desiring to establish, maintain and operate a medical care plan must obtain from the superintendent of insurance a certificate of authority or license to do so." Each such application must contain a full description of the proposed medical care plan and also evidence "that the medical care plan which the corporation proposes to operate, the articles of incorporation and any amendments thereto, and the regulations and by-laws of such corporation have each been approved by the established medical association, society or academy of each county lying wholly or partly within the territorial boundaries described in the articles of incorporation or any amendments thereto. The term 'established medical association, society or academy,' as used herein, means the medical association, society

or academy maintained in the county by a majority of the duly licensed physicians and surgeons residing therein."

This appears to permit the establishment of county plans rather than a single statewide plan. No certificate is to be issued unless written agreement to enter the plan has been obtained from at least one physician for each five hundred subscribers. It is also provided that "the relationship between a duly licensed physician and surgeon rendering professional services under such plan and such subscriber shall constitute the ordinary relationship of physician and patient; and no action based upon or arising out of such relationship shall be maintained against a corporation operating a medical care plan in compliance with the provisions of this act."

The enabling act does not enter into any further details of the type of organization that shall be formed, but the state medical association has developed a rather complete outline of those that it will approve.

At the time of preparing this report, no organizations authorized by the Ohio Act had been incorporated and no medical service plans were yet operating in Ohio.

MEDICAL SERVICE ASSOCIATION OF PENNSYLVANIA

After several years of discussion and extensive experiments with the care for the indigent and a study of all available systems of prepayment medical care, the Medical Society of the State of Pennsylvania secured an enabling act under which a prepayment plan has now been started. This law provides for nonprofit medical service corporations limited to the following income classes: individual without dependents, \$30 weekly; one dependent, \$45 weekly, and more than one dependent, \$60 weekly.

The law, which was approved June 27, 1939, provides that the plan shall be subject to the approval and supervision of the insurance department and shall make regular reports to the department of health, which is also given some supervisory powers. Payment for services is according to a fee schedule with provisions that payments to physicians shall be prorata according to income for any month when that income is insufficient to pay the entire schedule.

The plan is not yet in force over the entire state. A limited service has been put into operation in western Pennsylvania. This service provides mainly for surgical services and, under certain conditions, obstetrical services. The subscription rates for this limited service are as follows:

- 35 cents to 68 cents for individuals, depending upon the percentage of males and females in the group.
- \$1.05 for a man and wife (obstetrics not included).
- \$1.75 for a family of two or more (obstetrics included).

On the first of April 1941, 216 physicians had agreed to give service under this plan, and approximately 1,000 subscribers had been enrolled.

UTAH MEDICAL AND HOSPITAL BENEFIT ASSOCIATION

The Utah Medical and Hospital Benefit Association, Inc., was organized by the Utah State Medical Association in cooperation with various hospital administrators and lay persons under the insurance laws of the state of Utah as an assessment benefit association in the early part of 1940. The Utah Medical and Hospital Benefit Association, Inc., is a non-profit voluntary association and is subject to supervision of the commissioner of insurance of the state of Utah.

The general purpose of the association is to secure for its subscribing members medical service and hospital care and to reimburse the subscribing members for all or a portion of the cost of such medical services and hospital care according to the terms and provisions of the subscriber's contract.

The board of directors is made up of nine members, a majority of whom must be medical doctors in good standing of the Utah State Medical Association. One of the members of the board of directors who is not a member of the Utah State Medical Association must be a member of the Utah State Hospital Association. The president, first vice president and secretary of the association must be medical doctors in good standing of the Utah State Medical Association.

CONTRACTS

The Utah Medical and Hospital Benefit Association, Inc., offers two subscribers' contracts, one for partial medical and surgical reimbursement, and one for limited hospitalization expense reimbursement. It is contemplated that the benefits of the two contracts will provide complete coverage for limited reimbursement of all medical services and hospital care specified in the contracts.

The contract contains a schedule of maximum reimbursements for surgical operations and the treatment of fractures and dislocations. This schedule does not indicate the physician's fees but only the limit of reimbursement by the association to its subscribers.

If the subscriber obtains medical care for the following illnesses the association will reimburse him \$3 per physician's visit up to a maximum of \$50: pneumonia, typhoid, diabetes, not preexisting, meningitis, coronary occlusion, tularemia and undulant fever. The association will pay \$25 reimbursement for delivery in obstetric cases when both the husband and wife have been members in good standing for one year. When the medical and obstetric cases are not hospitalized, \$5 additional will be allowed for laboratory and x-ray procedure in each case.

LIMITATIONS

No subscriber or dependent may receive more than \$100 of benefits in one year and no family more than \$300 of benefits in one year. If two or more surgical operations are performed for the same accident or illness the association will reimburse the subscriber for the one for which the largest reimbursement is payable. The association will not provide reimbursement for any conditions for which the subscriber is entitled to benefits under workmen's or veterans' compensation laws.

BENEFITS OF THE HOSPITALIZATION EXPENSE CONTRACT

A subscriber or dependent is entitled to \$4 a day for twenty-one days in any one year while he is confined as a bed patient in a hospital recognized by the medical profession as a proper institution for the care of physically disabled persons and under the care of a licensed physician. In addition an amount up to the following maximum will be provided for regularly hospitalized bed patients :

- \$ 5 for ether anesthesia
- 10 for gas anesthesia
- 15 for use of the operating room
- 20 for x-ray services, excluding roentgen therapy
- 5 for special laboratory services

LIMITATIONS

Total benefits to any one subscriber or dependent shall not be more than \$150 a year for a subscriber and one dependent, not more than \$300 for a subscriber and more than one dependent and not more than \$400 in any one family.

Payment for hospitalization for herniotomy, tonsillectomy, adenoidectomy and operations on the nasal septum and sinus is allowed only after contracts have been in effect for one year; for obstetrics, only after husband and wife have been subscribers for one year. Benefits for hospitalization for removal of tonsils or adenoids shall be for one day of twenty-four hours only.

No benefits will be furnished for conditions for which subscribers or dependents are entitled to benefit under any workmen's or veteran's compensation laws, or for pulmonary tuberculosis, acute or chronic alcoholism, acute venereal diseases, mental disorders, quarantinable diseases, drug addiction, self-inflicted injuries or for conditions resulting from unlawful acts, known preexisting deformities, illnesses or abnormalities, for rest cures and for diagnostic purposes.

ENROLMENT

Any person in the state under 65 years of age in good health may apply through a group of not less than ten persons for membership in the Utah Medical and Hospital Benefit Asso-

ciation, Inc. Such a group must have taken the necessary action, indicating desire to make available subscription to these contracts, and have appointed a remitting agent to handle the collection of premium payments from subscribing members. Such groups to be acceptable must have been organized for some purpose other than the purchase of insurance. They may be church, social, professional, common employer, farm bureau or fraternal in nature. The subscriber may include all dependents under 19 years of age at somewhat lower premium rates. A registration fee of \$1 is required of each member when applying. A subscriber may purchase either the medical and surgical contract or the hospitalization expense contract or both.

Premiums

	Monthly	Quarterly	Semiannual	Annual
Medical and Surgical Reimbursement Contract				
One person.....	\$1.00	\$3.00	\$ 6.00	\$10.80
Two persons.....	1.75	5.25	10.50	18.00
Three or more persons.....	2.25	6.75	13.50	24.00
Hospitalization Expense Contract				
One person.....	1.00	3.00	6.00	10.80
Two persons.....	1.75	5.25	10.50	18.00
Three or more persons.....	2.25	6.75	13.50	24.00

SUMMARY AND TENTATIVE CONCLUSIONS

All of the plans organized and operated under medical society auspices are experimental. Each plan was not only preceded by extensive research and lengthy discussion, but is now being examined and tested at every point. Each plan is compared with every other, and changes which prove helpful in one are quickly considered by others. There are no vested interests, financial or political, to hinder this process of testing, rejection or adaptation.

A few conclusions appear to be evident, though most of these must still be considered as tentative. There does not appear to be the widespread demand for prepayment medical care that has been so widely publicized. All of the plans are growing slowly. Their development could undoubtedly be accelerated by costly high

pressure salesmanship, which would greatly increase the cost of administration and acquisition and consequently would raise the cost of medical care at the expense of the consumer. None of the plans has adopted this method. Most of them have restrictions on the percentage of income that may be devoted to acquisition. In several of the plans cooperation between hospital and medical service organizations on acquisition and administrative procedures has reduced these costs. Some plans have failed to arouse sufficient demand, even when offering superior medical care at less cost than is offered by some private schemes, to obtain sufficient enrollments to justify continuance or even beginning operation.

It would appear from the experience of Michigan that there is a demand for exclusive surgical and obstetrical benefits for those who must be hospitalized. Medical societies have often pointed out that it is not the common colds or the contagious diseases of childhood which bulk so largely in the morbidity statistics and account for much of the service that is given in private practice that create the most important financial burden. It is catastrophic diseases for which the majority of the public seems to be willing to make regular contributions in advance. It will be of interest and value to note whether the experience throughout the United States where prepayment arrangements are available, shows any preference for one or another type of contract. It is quite possible that further evolution may show that hospital insurance plus prepayment medical plans to protect the low income classes against these more serious diseases may be all that is required to meet the financial difficulties of the great majority of the population in paying for medical care. At present, the entirely indigent constitute, as they always have, a burden properly borne by the entire community through taxation,

The development of these plans seems to demonstrate the position continuously maintained by organized medicine that in any system of medical care all the features of diagnosis and treatment should be under the control of professional associations if the quality of the service is to be maintained.

CHAPTER VI

HOSPITALIZATION INSURANCE

Hospitalization insurance is offered by two types of agencies: nonprofit hospital service associations and commercial insurance companies. The commercial insurance companies became more active in the field of hospitalization insurance soon after the nonprofit hospital service associations had pioneered with their plans and had developed an appreciable demand for the hospital service type of indemnity.

DEVELOPMENTS OF NONPROFIT PREPAYMENT HOSPITALIZATION PLANS

In the latter part of the nineteenth century, advance payments for hospital benefits were collected from interested persons to provide working capital to build and to operate hospitals. At about the same period, prepayment arrangements for medical and hospital services were also common in the lumber industry, particularly in the logging camps to provide funds with which to arrange for necessary medical services for injured or sick workers.

The first of the more recently organized prepayment plans for hospital service for the general public was offered by the Grinnell Community Hospital, Grinnell, Iowa, in 1918. The annual rates were \$8 for a single person, \$12 for husband and wife, \$5 for the first child and \$2.50 for each additional child. The benefits consisted of three weeks of hospital care but no extra services were included. Other similar plans were organized between 1918 and 1929, such as those of the Hospital Service Association of Rockford, Illinois, and the Thompson Benefit Association for Hospital Service in Brattleboro, Vermont.

The arrangement initiated by the Baylor University Hospital of Dallas, Texas, in 1929, is often credited as being the pioneer of the present nonprofit hospital service plans. This hospital agreed to provide 1,500 local school teachers, who were members of a mutual benefit society, with free hospital services for 21 days for an annual premium rate of \$6. The plan seemed to show promise of success, and soon agreements were made with other employed groups in the vicinity of Dallas.⁶⁷

From 1930 through 1935, there was a rapid growth of non-profit prepayment hospital service plans throughout the United States. In 1932, a plan was initiated in Sacramento, California; in 1933, in St. Paul, Minnesota; Durham, North Carolina and Newark, New Jersey; and in 1934, in Washington, D. C., and Cleveland, Ohio. In 1935, the Associated Hospital Service of New York City was organized. This organization has the largest membership of any hospital service corporation in operation at the present time. By January 1941, there were 115 hospitalization plans operating in 39 states and the District of Columbia. Of these 115 organizations, 22 are state-wide in operation, and it appears that reorganizations and extensions now under consideration will soon increase the number of state-wide organizations.⁶⁸

It is impossible to state specifically the factors that are responsible for the rapid growth of prepayment hospital service plans, but it seems apparent that the public is interested in purchasing limited protection against the hazard of hospital bills if the premium rates are reasonable. Hospital service plans were developed at a time when public interest and activity in economic security through insurance or public assistance was evident by the passage of the Federal Social Security

67. Rorem, C. Rufus: *Non-Profit Hospital Service Plans*, Chicago, American Hospital Association, January 1940, p. 9.

68. Source Files of the Bureau of Medical Economics, American Medical Association.

Act of 1935. A number of state laws authorizing the formation of various forms of assistance programs pertaining to economic insecurity were enacted at about this time.

It may be significant also that these plans were introduced during an economic depression when hospitals were experiencing a severe loss of endowments, gifts, and paying patients, and were in desperate need of the income that was envisaged by prepayment arrangements. Moreover these hospital service plans, because of their non-profit nature, received a great deal of free publicity from the press and secured the active support of established clubs, charitable organizations and other local civic agencies.

BASIC FACTORS

Hospital service plans are basically insurance against undeterminable hospital costs, but they are designated non-profit hospital service plans or hospital service associations to indicate the characteristics which distinguish the service benefits which they offer from the cash benefits offered by the commercial insurance companies.

The premium rates and benefits of hospital service plans are based on certain factors which could not be measured accurately because of the lack of actuarial data when the plans were first started. The nature and amount of actuarial data is still insufficient to warrant complete confidence in the soundness of these plans in every particular.

Roughly, in an employed group it is expected that 10 per cent of the membership will be hospitalized for an average of ten days each year. By estimating the average charge for each patient day in the hospital, it is possible to arrive at a premium rate which will provide the plan with sufficient income to pay the hospitals the agreed charge per day and to have enough left to pay administration and enrollment costs and to

establish a small fund for unanticipated contingencies. For example, with an enrollment of 10,000 employed persons, it is assumed that each year 1,000 will require an average of ten days of hospital care, or 10,000 days. If it has been determined that a flat rate of \$5 per day for the hospital care will be acceptable to the hospitals, the plan would need to charge the subscribers a premium of about \$9 a year. Its income would then be \$90,000 a year. The expected hospital cost would be \$50,000, the administrative and enrollment expenses are estimated to be not more than 30 per cent at first, or \$27,000 leaving \$13,000 for a reserve fund or unforeseen expenses.⁶⁹

Many other factors beside these basic figures must be considered in the actual organization and operation of a hospitalization insurance plan. If benefits and premiums are based on enrollment of employed groups, as most plans are, then enrollment should follow the principles established by insurance experience. Commercial insurance companies which offer group insurance maintain very rigid enrollment procedures, and hospital service plans should follow similar procedures if they are to remain financially sound. All the other considerations fundamental to good group insurance underwriting—such as type of employment, ratio of male and female employees, age, race, the influence of malingering and the possibility of increase in demand for benefits after premiums have been paid for a number of years—must be taken into account. In general, hospital administrators, physicians, and representatives of local community agencies have, with the available information at their disposal, tried to make their hospital service plans as financially sound as possible, and have more recently endeavored to observe the known rules pertaining to insurance practice. In some cases, however, individual promoters of early hospital service

69. Group Hospitalization, Bureau of Medical Economics, American Medical Association, Chicago, 1937.

plans were more interested in building up a large enrollment than in establishing, at the beginning, the soundness and integrity that would enable the corporation or association to fulfill its agreements with both the hospitals and the subscribers.

LEGAL STATUS

In the earlier years, hospital service associations were organized as non-profit corporations under the general corporation laws of the states. The question was raised, almost at once, as to whether or not these corporations were engaged in the practice of medicine contrary to law, or whether they were insurance carriers not incorporated under the insurance laws. Many state departments of insurance ruled that the hospital service contracts were a form of insurance which required the hospital service associations to incorporate as insurance companies with the legally specified amount of capital stock, reserves, assessments and supervision. In some states where hospital service contracts were not considered insurance, the hospital service associations operated without any supervision by the insurance departments, a practice considered by many informed and interested persons, not to be in the best public interest.

In 1933, when the United Hospital Fund of New York City wished to form a hospital service association for New York City, it was advised by the New York State Superintendent of Insurance that such a contract could be offered only by a stock or mutual insurance company. Since the United Hospital Fund and other interested persons did not deem it advisable to organize as an insurance company, a special enabling act was sponsored by physicians, hospital administrators and civic leaders, and the bill was passed by the New York State legislature in 1934. The New York act gives the state superintendent of insurance and the state department of social welfare considerable supervision of the nonprofit hospital service plans organized under this act.

Other states followed New York with similar enabling legislation. At the present time, 24 states and the District of Columbia have special enabling laws, although plans are in operation in only 21 of these states. In 9 other states, attorney generals or insurance commissioners have ruled that the hospital service associations in these states are not engaged in the insurance business, and the associations in these states have been permitted to operate under the general corporation laws. It appears that in at least three states the hospital service associations are organized as mutual assessment associations under the insurance laws, and in six other states in which plans are in operation, they are organized under the general corporation laws as non-profit associations without any specific ruling on the matter.

The enabling acts passed by the various states were modeled more or less after the New York Act. As more experience was obtained, certain improvements were made in the later bills. In 1938, the Commission on Hospital Service and the Council on Hospital Service Plans of the American Hospital Association prepared a model enabling act which was believed by those who prepared the draft, to contain the best features of the various acts. This model bill follows:

PROPOSED MODEL LAW TO ENABLE THE FORMATION OF NON-
PROFIT HOSPITAL SERVICE ASSOCIATIONS UNDER
THE SUPERVISION OF THE VARIOUS STATE
DEPARTMENTS OF INSURANCE

Scope

1. Any corporation organized not for profit under the General Corporation Acts of the State of for the purpose of establishing, maintaining and operating a nonprofit hospital service corporation, whereby hospital service may be provided by a hospital or group of hospitals with which such corporation has a contract for such purpose, to such of the public as become subscribers to said corporation under a contract which entitles each subscriber to certain hospital care, shall be governed by this act and shall be exempt from all other provisions of the insurance laws of this state, unless otherwise specifically provided herein.

Incorporation

2. The articles of incorporation of every such corporation, and amendments thereto, shall be submitted to the Department of Insurance, whose approval thereof shall be endorsed thereon before the same are filed with the Secretary of State; provided, however, that if the articles of incorporation of any such corporation shall have been filed with the Secretary of State prior to the effective date of this statute, the approval thereof by the Department of Insurance shall be evidenced by a separate instrument in writing filed with the Secretary of State.

Directors

The directors of such corporation must at all times be composed of the following groups in equal numbers: (1) administrators or trustees of hospitals which have contracted with such corporation to render hospital service to the subscribers; (2) licensed physicians, exclusive of group (1); (3) general public exclusive of groups (1) and (2).

Contracts

3. Such corporations may enter into contracts for the rendering of hospital service to the subscribers only with hospitals approved by the Department of Insurance.

All contracts issued by such corporation to the subscribers shall constitute direct obligations of the hospital or hospitals with which the corporation has contracted for hospital service. The rates charged to the subscribers for hospital service and the rates of payment by such corporation to the contracting hospitals, at all times shall be subject to the approval of the Department of Insurance.

Licensure

4. A corporation subject to the provision of this act may issue contracts only when the Department of Insurance has by formal certificate or license authorized it to do so. Application for such certificate of authority or license shall be made on forms to be supplied by the Department of Insurance, containing such information as it shall deem necessary. Each application for such certificate or license shall be accompanied by copies of the following documents: (a) certificate of incorporation; (b) by-laws; (c) proposed contracts between the corporation and participating hospitals showing terms under which hospital service is to be furnished to subscribers; (d) contracts to be issued to subscribers showing a table of rates to be charged and the benefits to which they are entitled; (e) financial statement of the corporation, including the amounts of contribution paid or agreed to be paid to the corporation for working capital and the name or names of each contributor and the terms of each contribution.

The Department of Insurance shall issue a certificate of authority or license upon payment of a fee of \$..... and upon being satisfied on the following points:

(a) That the applicant is established as a bona fide non-profit hospital service corporation.

(b) That the contracts between the applicant and the participating hospitals obligate each hospital party to render service to which each subscriber may be entitled under the terms and conditions of the contract issued to the subscribers.

(c) That the rates charged and benefits to be provided are fair and reasonable.

(d) That amounts provided as working capital of the corporation are repayable only out of earned income paid and payable for operating expenses and hospital expenses, and such reserve as the Department of Insurance deems adequate.

(e) That the amount of money actually available for working capital be sufficient to carry all acquisition costs and operating expenses for a reasonable period of time from the date of the issuance of the certificate.

Reports

5. Every such corporation shall annually on or before the first day of March (or the first day of June) file in the office of the Department of Insurance a statement verified by at least two of the principal officers of said corporation showing its condition on the 31st day of December, then next preceding, which shall be in such form and shall contain such matters as the department shall prescribe.

Visitation

6. The Department of Insurance may appoint any deputy or examiner or other person who may have the power of visitation and examination into the affairs of any such corporation and free access to all of the books, papers and documents that relate to the business of the corporation, and may summon and qualify witnesses under oath to examine its officers, agents or employees or other persons in relation to the affairs, transactions and conditions of the corporation.

Expenses

7. All acquisition and administrative expenses in connection with such hospital service corporation shall at all time be subject to the approval of the Department of Insurance.

Investments

8. The funds of any corporation subject to the provisions of this act shall be invested only in securities permitted by the law of this state for the investment of assets of life insurance companies.

Disputes

9. Any dispute arising between a corporation subject to the provisions of this act and any hospital with which such corporation has a contract for hospital service may be submitted to the Department of Insurance for its decision with respect thereto. Any decision and finding of the Department of Insurance made under the provisions of this act shall not be any bar to constituted legal procedure in a court of competent jurisdiction.

Dissolution

10. Any dissolution or liquidation of a corporation subject to the provisions of this act shall be conducted under the supervision of the Department of Insurance which shall have all power with respect thereto under the provisions of law with respect to the dissolution and liquidation of insurance companies.

Taxation

11. Every corporation subject to the provision of this act is hereby declared to be a charitable and benevolent institution, and its funds and property shall be exempt from taxation.⁷⁰

STANDARDS

The hospitals that were to provide the services offered and the physicians who were responsible for the standards of medical practice in these hospitals, and who were to certify subscribers for benefits were particularly concerned with the organization and operation of prepayment plans. In a series of articles on prepayment medical and hospital service plans which appeared in *THE JOURNAL* of the American Medical Association between October 1932 and February 1933, some of the main principles for the proper development of hospitals service plans were indicated. Attention was called to the chief dangers that should be avoided, such as competition between hospitals that were members of plans and those that were not; interference with free choice of physicians; organization by profit-seeking promoters; uncertain actuarial basis; improper regard for insurance or other state laws; extension of benefits to include medical services and solicitation of subscribers by salesmen on a commission basis.

⁷⁰. *Roem*, 57 Appendix A, p. 99-102.

In 1933 the American Hospital Association endorsed the principles of prepayment plans for hospital services, and its Council on Community Relations and Administrative Practices prepared a brochure outlining certain principles in regard to hospital service associations. These principles pointed out that emphasis should be placed on public welfare and not hospital finances, control should be in the hands of a nonprofit organization representing the hospitals, contracts should not be made with business agencies seeking to control the plan, benefits should be limited to hospital charges only, free choice of hospital and physician should be maintained, and there should be a cooperation between all reputable hospitals in a community.⁷¹

County and state medical societies also adopted resolutions recommending that hospital service associations organized in the respective jurisdictions of these medical societies should adhere to the general principles adopted by the House of Delegates of the American Medical Association, and should provide for representation of the medical profession in the control of the plans.

No blanket approval of hospital service associations was given by the medical societies, but in 1934 the House of Delegates of the American Medical Association adopted ten principles to be used as a guide in organizing prepayment medical plans.⁷² The principles which were adopted by the medical and hospital associations served as an important guide to the hospital administrators and physicians who considered it desirable to develop hospitalization plans as community welfare agencies to assist persons in the low income groups to obtain needed hospital services for a small regular annual payment.

The principles adopted by the medical profession and the hospital administrators were modified and expanded

71. (a) Footnote 59, p. 150. (b) Hospital Accounting and Statistics, Chicago, American Hospital Association, 1935, pp. 18 and 72.

72. Proceedings of the House of Delegates, Annual Session 1934, American Medical Association.

in keeping with the experience gained from the operation of the hospital service associations. In 1937, the House of Delegates of the American Medical Association adopted ten principles specifically for the guidance of physicians and hospital administrators in the organization of hospital service associations. The principles were revised in 1938 to clarify further the attitude of the medical profession on some of the new problems in this field.⁷³

A more formal program of standards for hospital service plans was provided by the American Hospital Association, through its Commission on Hospital Service, which was established in 1937 with a grant from the Julius Rosenwald Fund. The main purpose of the Commission on Hospital Service is to collect information and data on hospital service plans, to act as a clearing house for hospital service associations that are in operation and to advise hospitals and communities that contemplate the organization of hospital service plans.

An approval program was developed by the Commission on Hospital Service for the associations which met the following standards:

STANDARDS FOR APPROVAL⁷⁴

1. *The corporate body should include adequate representation of hospitals, the medical profession, and the general public.* Trustees or board members of the hospital service plan should receive no remuneration for service as trustees or board members. The interests and responsibilities of participating hospitals make it desirable that a majority of the policy-making body be representatives of hospitals.

2. *No private investors should advance money in the capacity of stockholders or owners.* Initial working capital may be provided by individuals, hospitals, chests, councils or other civic agencies, but should be repayable only out of earned income, over and above operating expenses, payments to participating hospitals and legal reserve. No organization or individuals advancing initial capital should attempt to influence or direct the management of hospital service plans because of their

73. Pages 18-21.

74. Rorem, 57, pp. 25-28.

financial support. The hospital service plan should be independent of any other corporate body or professional lay group.

3. *Plans should be established only where needs of a community are not adequately served by existing nonprofit hospital service plans.* Opportunity should be given for all institutions of standing in each community to become member hospitals in a hospital service plan and subscribers should have free choice of hospital at the time of sickness.

4. The hospital service benefits of a non-profit hospital service plan should be guaranteed by the member hospitals during the life of the subscriber-contract. The ultimate economic responsibility for service to subscribers enrolled at any given time should be assumed by the member hospitals, through definite contractual agreements with the hospital service plan. All contracts involving the plan, the subscribers and the member hospitals should be equitable and consistent with respect to the rights and obligations of each party.

(a) Benefits in member hospitals should be expressed in "service contracts," which describe specifically the types and amounts of hospital services to which the subscribers are entitled.

(b) A majority of the hospitals of standing should be member-hospitals in each area where a hospital service association enrolls subscribers, and arrangements should be made for provision of service in nonmember hospitals.

(c) In case of physical impossibility to provide service in member-hospitals or others, equitable arrangements should be made for protection of the subscribers' interests.

(d) It is understood that state legislation may require modifications of the requirements.

5. *Subscription payments or dues received should be currently separated into "earned" and "unearned" income.* The earned income should be apportioned to special accounts each earmarked for special purposes, as follows:

(a) *Hospitalization:* For payments to participating hospitals. Charges against this account should include estimated payments for undischarged cases. (Desirably 60 to 80 per cent.)

(b) *Contingency Reserve:* In minimum ratios determined by law, or larger proportions designated by action of board of trustees. (Desirably 5 to 10 per cent.)

(c) *Field Service and Administration Expense:* (Not exceeding 15 to 30 per cent.) The cumulative ratio of field service and administration expense to earned subscription payments or dues should not exceed 30 per cent for the first full year, and the monthly ratio should be considerably less by the end of the year. Ultimately the ratio should not exceed 15 per cent.

In the calculation of earned income from subscription payments or dues during the given fiscal period, only those cash

receipts should be considered "earned" which apply to and are intended for the payment of hospital benefits and expenses during that period. When subscription payments or dues are received in advance of the fiscal period to which they apply, the "unearned" portion should be accurately determined and separately recorded in the accounting records.

The formulas for calculating unearned subscriptions established by the various state departments of insurance are, in general, acceptable to the commission. Where a non-profit service plan is not supervised by the State Department of Insurance the uniform procedure adopted by the Council on Hospital Service Plans is recommended. Details of this procedure can be obtained from the Commission of Hospital Service.

6. Statistics should be maintained currently as follows:

- (a) Number of subscribers (classified).
- (b) Number of hospital admissions (classified).
- (c) Number of patient days of care (classified).
- (d) Number of member-months (or member-years of protection to subscribers (classified)).

7. Initial working capital should be sufficient to carry all acquisition costs and operating expenses for a stated period (e. g., six months), after contracts first become effective, thus making earned income from subscriptions available in full for payments to hospitals during this period. Financial statements of operations and conditions should be prepared by certified public accountants at regular intervals, at least annually.

8. The requirements for annual reapproval by the commission shall be: (a) maintenance of standards of organization and policies applied at time of original approval; (b) a substantial number of enrolled subscribers having in mind the possibilities of the area served; (c) a period of successful operation, with sound administrative procedures, usually not less than six months of enrollment activities; (d) financial status and operations which adequately protect the interests of subscribers and member hospitals.

9. Payments to hospitals should be based on the costs of services provided to subscribers in hospitals of that community, district or region. This does not preclude the possibility of developing public ward-service plans for employed groups with low income, and agreements by member hospitals to provide service at rates less than the full operating costs.

10. Employees of a non-profit hospital service plan should be reimbursed by salary as opposed to a commission basis. A private sales organization should not be given responsibility for promotion or administration on the basis of a percentage of premiums. Promotion and administrative policies should be

dignified in nature, consistent with the professional ideals of the hospitals concerned, and in accord with economically sound practices as determined by actuarial and financial experience of the various plans.

11. In communities with only one hospital, the finances of a hospital service plan should be separate from the general budget of the hospital.

12. Hospital service provided through a hospital service plan should be determined by the practice of the member hospitals of the particular plan.

13. Hospital service plans should not interfere with existing relationships between physicians and hospitals or between physicians and patients.

14. A hospital service plan should meet with the general approval of the Commission on Hospital Service of the American Hospital Association.

In January 1941, 65 of the 115 hospital service associations operating in the United States had obtained approval from the Commission on Hospital Service of the American Hospital Association. These organizations are permitted to place on their literature and record forms the insignia of the American Hospital Association superimposed upon a blue cross. The Commission on Hospital Service does not guarantee the performance of the hospital service associations, nor does it exercise any legal control through its approval. The approval means that the Associations so recognized were organized and have operated in accordance with the standards established by the Commission on Hospital Service.

ORGANIZATION AND ADMINISTRATION

The general plan under which most of the hospital service associations are organized provides that they be non-profit, non-stock corporations which act as selling agencies for the member hospitals. The Boards of Directors are made up of representatives of the hospitals, medical profession and the public and receive no pay for the services they render. The hospital service associations contract with their member hospitals as to the services which will be provided by the

hospitals at a stipulated amount per hospital day. The member hospitals thereby become coinsurers with the hospital service associations for the service promised in the subscriber's contract. The hospital services available at all of the participating hospitals form a reserve of services which takes the place of the cash reserve required of commercial insurance companies. The hospital service associations are responsible for enrollment of subscribers, collection of premiums, payment to hospitals for services provided subscribers and proper bookkeeping and accounting of all income and expenses. A medical director is usually employed to certify payments on questionable claims.

BENEFITS

The benefits that are enumerated in the subscriber's contract of the different hospital service association vary considerably, but the basic benefits are similar, viz., 21 days of hospital care in a semi-private room, use of the operating room, general nursing care, routine medicine, surgical dressings, routine diagnostic laboratory services and anesthesia if given by a salaried employee of the hospital. Practically all of the plans include maternity benefits of 7 to 12 days after a waiting period of ten to twelve months. There is usually no waiting period for other benefits except for elective surgery, such as, tonsillectomies, adenoidectomies, and herniotomies in which the waiting period may range from 90 days to one year. One of the more recent developments has been the offer of contracts which provide service in wards at lower premiums. Such ward service contracts do not usually include the services of staff physicians which are customarily provided patients in public wards. The difference between ward service contracts and other contracts is in the type of room accommodation and the premium rates.

To make the hospital service contract effective at all times, most of the contracts provide for cash allowance

for emergency care in a non-member hospital. Allowances are also made if the subscriber desires more expensive accommodations than those provided in the contract. The restrictions on the choice of hospital provide that the subscriber is limited to member hospitals except in emergencies or when none of the member hospitals are able to provide the services.

ENROLLMENT

In general, hospital service contracts are sold to employed groups of five or more persons, but this procedure varies considerably. Eligible groups consist of persons who have a common employer, and groups previously formed for purposes other than insurance, such as trade or labor unions and professional societies. Usually 100 per cent of the members of small groups are required to enroll, but in groups of 25 or more only 50 to 75 per cent is required. No health examination is required, but the application blank requires information on the person's sickness experience.

Payment of premiums may be by payroll deduction if the plan is arranged through the employer, or by a remitting agent designated by the subscribers if the group is not enrolled through its employers. A subscriber who leaves the employment of the group in which he was enrolled may in some plans continue his contract through direct payment. Payments may be made monthly, quarterly, semi-monthly, or annually.

Hospital service associations have been developed largely in urban communities because of the ease and convenience of enrolling employed groups. There has been an attempt to enroll the farm population through special groups of farm organizations such as the grange, the farm union, the farm bureaus or cooperatives, or through some local agencies such as the offices of local newspapers. Progress has been slow because of the many new problems which include the individual employment characteristics of the agricultural popula-

tion, the difficulty of making regular collection of premiums, and the almost insurmountable difficulty of securing a proper spread of risks.

The first principle of hospital service plans is the group enrollment of employed persons, and the benefits and premium rates are computed on this basis. Unless rigid enrollment procedures are maintained there is apt to be unfavorable selection of risks, as well as additional acquisition and administrative costs.

Many hospital service associations have found it necessary to make changes in enrollment procedures because of the neglect of group enrollment principles. In 1939, the Associated Hospital Service of New York cancelled about 57,000 contracts which had been issued to persons on an individual basis. These subscribers were privileged to reenroll through organized groups. The Associated Hospital Service stated that a study of its experience had shown that a proper distribution of risks had not been maintained among those who had been individually enrolled.⁷⁵

SUBSCRIPTION RATES

Premium rates have not been standardized, although the most common annual rates for contracts which provide service in a semi-private room are about \$9 for a single subscriber, \$18 for husband and wife, and \$24 for a family contract which includes husband, wife and dependent minor children. Rates vary with the type of contract and the benefits provided. Where dependents are given only partial coverage the husband and wife and family contract rates are lower. The rates for contracts which provide service in a ward are usually about \$7 a year for a single subscriber, \$14 for husband wife, and \$18 for a family. A number of associations offer ward contracts at even lower rates. The prevailing patient day charge in the hospitals of the community is the most important factor in determining the subscriber's annual premium rate.

75. New York Cancels Individuals, Hospitals 13: 118 (Sept.) 1939.

PAYMENTS TO MEMBER HOSPITALS

The contract between the hospital and the hospital service association usually specifies that the association will pay the hospital a flat rate for each day a subscriber is hospitalized. The rate may be \$4, \$5, or \$6, depending on a number of factors peculiar to the geographical location. The rates are highest in the large metropolitan areas. This flat rate of payment is weighted for short stays of less than four days, so that if the flat rate is \$5 a day, the hospital may be paid \$10 for a one-day stay, \$15 for a two-day stay, and \$18 for a three-day stay. For longer periods the flat rate would be applied.

The inter-hospital contract sometimes provides that the rate of payment to hospitals may be reduced if necessary, with the approval of the state supervising body—the Department of Insurance or the Department of Social Welfare—depending on the laws of the state. During 1939, the Associated Hospital Service of New York obtained permission from the New York State Department of Social Welfare to reduce its payments to hospitals by 25 per cent for the months of April through September. The member hospitals carried the difference between the agreed amount and the new rate on their books as an contingent debit account, all of which it was possible to pay later out of the association's earned surplus.⁷⁶ This provision in the inter-hospital agency contract protects the subscriber during periods of necessary adjustment of rates, benefits, enrollment procedures and methods of certifying benefits, since the hospitals must continue to provide the service during the effective period of the subscriber's contract. Necessary changes may later be passed on to the subscribers through the changes in their contracts,

76. (a) Payments to New York Hospitals, *Hospitals* 13:96 (April) 1936. (b) Associated Hospital Service of New York Submitted Revised Contract to Member Hospitals.

stricter investigation of claims, or more careful selection of risks if the original rate of payment to the hospitals is not too high.

GROWTH OF HOSPITAL SERVICE PLANS

There are no accurate figures available on the total number of people enrolled in the 115 non-profit hospital service associations since some of the organizations do not make regular reports on enrollment. The 65 plans approved by the American Hospital Association had 6,112,483 subscribers at the beginning of 1941. These 65 plans included over 1,950 member hospitals with an estimated bed capacity of 225,000. Many of the remaining 50 plans are single hospital plans limited to a few hundred subscribers.

It appears, on the basis of experience, that the number of subscribers may continue to increase during the next few years. In January 1940, there were 60 approved plans with an estimated enrollment of 4,500,000. From January 1940 to January 1941, there was a net increase of 6 new plans which met the standards of the American Hospital Association and an increase of about 1,600,000 subscribers.⁷⁷

There appear to be natural limits to the number of persons that are eligible for membership in the employed group plans. Commercial insurance companies have profited by the newly created demand for both group and individual hospitalization insurance. In recent years commercial insurance companies have sold hospitalization insurance contracts with cash benefits to some of the largest industrial groups in the country as well as to smaller groups of 1,000 or more employees. No figures are available on the number of persons covered by insurance company contracts, but from the number of covered groups listed in the literature of various insurance companies, it appears that the insurance com-

77. Hospital Service Plans News, Hospitals 115:94-95 (Feb.) 1941.

pany subscribers in this type of group contracts may be considerably larger than the number enrolled in hospital service associations.

The chief difference between the commercial insurance company contracts and the hospital service association contracts is that the insurance companies pay limited cash benefits, whereas the hospital service associations pay limited service benefits.

Hospital service associations are usually limited by state enabling acts or by their charters to provide or make available services only. There is some variation in the interpretation of hospital service in different localities, especially with respect to certain laboratory services rendered by physicians in hospitals, but most of the plans are prohibited from including surgical or medical services in their contracts. There appears to be a demand for insurance against surgical expenses if the premium rates can be made sufficiently low to be attractive to the low income groups, and many of the larger hospital service associations believe that they are well enough established to develop plans to include surgical services to supplement their hospital service contracts.

State medical societies have for a number of years studied the possibility of developing prepayment medical and surgical service plans under Medical society sponsorship. Such plans have now been organized by the medical societies in at least eight states and are under consideration in a number of states. In California and Michigan where the prepayment plans have been in operation for more than a year, the hospital service associations and the medical service associations have developed a cooperative arrangement in the enrollment of subscribers. Where such cooperation exists, subscribers to the hospital service association may obtain for an additional premium a medical or a surgical contract through the medical service association to supple-

ment the hospital service benefits. The subscribers may pay the total premium to one organization, but the accounts are handled separately. In this manner, employed persons may obtain protection against medical, surgical and hospital expenses through non-profit, non-stock associations, directed and controlled by the medical profession and hospital organizations in which all the money beyond a certain percentage for administrative expenses and reserves is used to pay for the services required by the subscribers. Expansion in the field of voluntary prepayment medical service plans will depend largely on the possibility of accumulating basic data that can be used to establish sound, equitable rates and benefits and the ability of the sponsors of such arrangements to maintain the quality of medical service and to avoid non-medical control of medical procedures.

MEDICAL AND HOSPITAL WARD SERVICES

There has been increased inclination on the part of several group hospital service corporations to develop special ward contracts in their prepayment plans.

The inclusion in group hospitalization plans of ward services at lower rates creates new problems with regard to the medical services required by these ward patient subscribers. Much depends on the definition of "ward services" used in these plans. The provisions in the hospital service plans which offer ward service contracts differ from those which offer semiprivate room service chiefly in the rates and the accommodations the subscriber may receive while in a hospital. This newer development on the part of group hospitalization organizations represents a further deviation from the principles pertaining to group hospitalization adopted by the House of Delegates and should be given serious consideration as a possible move on the part of the group hospitalization organizations to provide their subscribers with general medical services.

A modification of the ward hospitalization plan is found in a new non-profit medical indemnity arrangement developed in New York City.

Community Medical Care, Inc., received a permit from the New York State Department of Insurance on June 4, 1941. According to an announcement, this new contributory plan will provide hospital ward service and all the medical service needed for satisfactory clinical treatment for workers with limited incomes and their dependents.

It is proposed that this new plan will offer ward hospital service for \$6 per annum for individuals and \$13.50 for families. Additional payments of the same amount to the Community Medical Care, Inc., will cover medical fees. The rates for combined hospital and all necessary medical care during the subscriber's hospital stay will therefore be \$12 per annum for individuals and \$27 per annum for families including all children under 18 years.

It is stated that this plan will be limited to single persons with incomes of \$1,200 or less, but subscriptions providing maternity care as well as general medical and surgical service will be available to husbands and wives with combined incomes of \$1,680 and to families including children with incomes of \$2,100 or less.

COMMERCIAL INSURANCE COMPANIES

The rapid growth of non-profit hospital service associations has led commercial insurance companies to become more interested in hospitalization insurance. The contracts offered by the commercial insurance companies are reimbursement contracts under which the policyholders are paid cash benefits for the financial losses they suffer through hospital confinement. The hospital expense policies provide that the insured will be paid a cash benefit of a stated amount, depending on the premium paid, for each day he is confined in a hospital under the care of a physician. There is such a large

number of insurance companies, each offering a number of hospital expense insurance policies that it is not practical to attempt here to discuss the different provisions in detail. In general, the insurance companies can be divided into two classes; those which offer hospitalization insurance on a group basis only, and those which offer policies for individuals.

Many legal reserve stock and mutual life and casualty insurance companies offer a complete insurance program to employed groups either through the employer or directly to the employed groups. A complete insurance program may include life, accident and health, accidental death and dismemberment, hospital and surgical expense insurance protection. A limited program may include any combination of these. To obtain group hospitalization contracts from insurance companies, these companies usually require that there be at least 50 persons in the employed group and not less than 75 per cent of the group shall enroll. The requirement that the total premium charge be paid through the employer or a representative of the group in a lump sum, at stated intervals, is one of the basic principles of group insurance. The hospital expense policies may provide that cash payment directly to the insured will be made for 31 or more days of hospital care for any one disability, whereas, the benefits of hospital service association contracts are usually limited to 21 days of hospitalization for each year. Cash reimbursement is also provided by insurance company contracts for diagnostic laboratory services and use of the operating room up to a maximum of five times the amount of the daily benefit. The insurance companies' policies in some cases also stipulate a maximum amount of benefit that will be paid out in a contract year. The premium rates are computed according to the rate of daily benefit desired, the type of employment and the age and sex of the members of the group. Premiums for insurance company contracts

compare favorably with the rates for contracts of the non-profit hospital service plans. Some insurance companies offer more liberal benefits at lower rates than non-profit hospitalization associations depending upon the particular group. In general the insurance companies' rates and benefits are more flexible and can be more easily adjusted to fit the needs of a group.

If surgical benefits are included with group hospitalization an addition premium is required. The indemnities or cash benefits that will be paid for surgical procedures are stated in the policy and are maximum benefits but do not represent the total physician's fees for services. Reimbursement is limited to avoid encouraging policyholders to claim unnecessary hospital and medical service in order to receive insurance benefits greater than the premiums. All benefits are in cash and are paid upon proper claim directly to the insured. The policies do not provide for any contract with hospitals or physicians, although they usually require that the policyholder obtain hospital service in a legally constituted hospital under the direction of a licensed physician.

HOSPITAL AND MEDICAL EXPENSE INSURANCE FOR INDIVIDUALS

In addition to the insurance companies which offer group hospital and surgical expense policies, there are a number of well-established casualty insurance companies which offer hospital and surgical expense insurance to individuals or families not enrolled in groups or not eligible for group insurance.

The benefits in the individual hospital and surgical expense policies are quite similar to those sold to groups, although the premium rates are considerably higher and vary according to the age and sex of the applicant, and the benefits desired. In most instances the individual policies for women do not provide benefits for

maternity cases since the insurance companies have experienced an unfavorable selection of risks on this type of benefit when sold on an individual basis. Premium rates for individual hospital expense policies are usually about \$12 a year for men and \$15 a year for women. The premium for surgical benefits is usually about \$6 a year.

A number of relatively new mutual insurance companies and benefit associations, usually organized on an assessment basis, have attempted to enter the field of accident, health and hospitalization insurance with low rate contracts. The benefits provided in many of these contracts are paid in services, or the contract provides that the charges for hospital or medical service sustained by the insured will be paid by the insurance company directly to the physicians or hospitals. Frequently, the contract is written in such a manner that the insurance company or benefit association will control the type and amount of services the policyholder may receive. Such control appears to be advantageous to the insurance company from the financial standpoint if no maximum benefits are stated in the contract. Sound actuarial principles require that the premium rates be sufficient to cover the benefits offered; and if the maximum benefits are not stated, it then becomes necessary to exercise control over the amount of the services provided. Insurance companies organized on the assessment plan are able to meet this problem through their privilege to assess additional premiums if the regular premiums are not sufficient to cover the benefits and expenses. From the selling point of view, it is more desirable to restrict the benefits than to raise the premium rates; and, therefore, subscribers to low rate hospitalization insurance policies with mutual benefit associations often find that there are greater restrictions on claims than they anticipated.

LIMITATIONS

It must be borne in mind that practically all hospitalization insurance contracts are limited contracts. The restrictions are about the same for both hospital service contracts and hospital expense contracts. No services or benefits are given solely for diagnosis or for contagious or venereal diseases, tuberculosis, pre-existing illnesses, or injuries or illnesses covered by workmen's compensation laws.

The non-profit associations offer coverage to dependents which few of the insurance companies will include. The insurance company policies, however, usually provide benefits for a longer period of disability—31 to 70 days, as compared with 21 days for the hospital service associations. Although experience has shown that the average length of stay in a hospital is about 10 days, the longer the period of hospitalization the heavier the burden for the wage earner becomes, and consequently, the insurance company policies offer greater protection. The insurance companies have also enjoyed an advantage in their ability to offer surgical benefits, although this advantage is decreasing as more non-profit medical service plans are organized by the medical profession to provide surgical service on a prepayment basis to employed groups. Insurance companies endeavor to show ultimately an underwriting profit, but their acquisition costs are usually higher than for non-profit associations because of competition between companies and duplication of sales agencies. However, insurance companies utilize already organized sales agencies and personnel whereas, non-profit organizations must form their acquisition methods and agencies.

The non-profit hospital service associations for the most part, are exempt from state, county, district, municipal and school taxes. They are also exempt from federal income taxation if they can meet the requirements of "an organization for social welfare" as described in Section 101, (8) of the Revenue Act of

1936.⁷⁸ This enables the non-profit plans to use a larger part of the premiums to pay for services rendered to subscribers. Although the non-profit plans claim to be social welfare agencies, the indemnification of loss due to hospital confinement is an insurance function, and any plan must be prepared to meet the difficulties inherent in casualty insurance. Casualty insurance does not have the scientific basis of life insurance, and inexperienced management or unsound underwriting may disrupt the financial status of the program before the necessary changes can be made. Insurance companies have had more experience in the field and have large financial resources with which to cover errors in judgment or unsound underwriting principles; in this respect they appear to be well equipped to develop sound hospitalization insurance through the trial and error methods. The non-profit hospital service plans however, must be given credit for initiating the low cost hospitalization insurance movement.

Either type of hospitalization insurance is prepared to make hospitalization benefits available to eligible employed workers at reasonable costs. As part of a general social security program, the voluntary hospitalization insurance with surgical benefits has many advantages over a governmental compulsory insurance program. The lack of basic actuarial data and experience tables on changes in demand for hospital services which take place under a prepayment arrangement, make it desirable to obtain such data through experiments that are now being conducted. The provisions of the voluntary plans can be more readily changed than those of compulsory plans established by law. Under voluntary plans, as now conducted, control of the hospital and medical services remains with the hospital administrators and the medical profession. This is essential for the maintenance of the quality of the service

78. Rorem, 57, p. 33.

provided. Consequently, it is important to the subscribers to such plans that the quality of the medical care be under the direction and control of physicians, since lay administrators, concerned primarily with financial side of the program, might attempt to lower the quality of medical care or restrict the benefits in order to make a better financial showing with low premium rates.

A prepayment hospital insurance program established by the federal or state government would be more inflexible than voluntary plans and would tend to centralize the control of the services with unqualified political appointees. It is important that the organization and administration of hospitalization programs be under the direction of persons trained and experienced in insurance and especially familiar with the elements which comprise good hospital and medical care.

The limitations of the voluntary plans in regard to the number of people in the entire population eligible for coverage are not as great as those of the federal old age and survivors insurance and state unemployment insurance programs, since the small groups and also the self-employed are eligible for insurance under the voluntary plans. The unemployed and the people receiving different forms of public assistance are at present, unable to obtain insurance, but some of the hospital service associations and medical service plans are studying arrangements whereby governmental or private welfare funds can be used to pay a lump sum premium for groups that are unable to pay such premiums themselves. Such an arrangement is being studied for groups of Farm Security Administration clients also.

It appears that there are opportunities for the voluntary hospitalization insurance program to be extended to a larger proportion of the people in the low income group if those who are interested in this movement can establish and adhere to the necessary enrollment and

premium payments arrangements to fit the needs of the various groups and will, at the same time, maintain high standards of quality of the services rendered under the insurance agreements.

CHAPTER VII

PLANNING AN ORGANIZATION OF MEDICAL SERVICES

Medicine has advanced by almost continuous experimentation. Improvements in diagnosis and treatment, in surgery, drugs and appliances, in the administration of hospitals and in plans of payment for medical care are now, as they have been for centuries, being retested, rejected, restricted or extended according to their effect upon the health of the people. There is no trace of truth in the charge that the medical profession is opposed to experimentation to determine either the value of diagnostic and therapeutic procedures or the suitability of the methods by which medical services are made available.

This long period of experimentation in so many fields, with this common objective, has taught the medical profession much about experiments. It has learned that experiments should be preceded by research and study of all the elements that may enter into them. The use of new and unknown drugs on human beings is dangerous, but no more so than the trial on the public of extensive and over-propagandized schemes of the distribution of medical services. Experiments should usually start on a small scale and be extended only after results warrant such expansion. An experiment should always be treated as an experiment—to be changed or abandoned as it achieves or fails to achieve its object. It should never be continued to perpetuate jobs, profits or other vested interests, or to satisfy a craving for a change.

Existing conditions should be used as a "control" against which to compare proposed experiments. Advocates of compulsory sickness insurance avoid such comparisons. In all the flood of printed matter issued by

such advocates, countries having compulsory sickness insurance are never compared with the United States as to morbidity and mortality, preventive medical practice, the quality of medical service, medical education or other features presumably effected by differences in the organization by which medical care is made available. Merits as well as defects of present medical practice should be analyzed in such comparisons lest the good features rather than the bad be changed and the whole be made worse.

Ask these questions when testing the effects of organization experiments: Have general, maternal and infant death rates steadily declined? Is preventive medicine advancing, as measured by immunization, vaccination, and sanitation? Are standards of medical education—before and after graduation, of licensure, drugs, medical appliances and hospital management rising? These are some of the basic tests of the value of any medical service. If advance in these directions has been more rapid and continuous where there is greater professional control and less lay and political interference with medical practice, where there is free choice of physician and no financial or administrative straight-jacket restrictions on the quality and quantity of medical care available to any important section of the population than in countries where these conditions do not exist, then it seems reasonable to assume that these elements should be preserved in any experiment that may be undertaken.

There should be a definite understanding of the defects in the distribution of medical care that a new arrangement is proposed to cure. Many people in case of serious illness cannot pay the full costs of the best hospital and medical care. Neither can they pay for the best food, clothing or shelter, or for the education of which they are capable and which would make them better and more productive citizens. These very real

problems are more economic than medical. Medical care for the indigent is a burden that should be borne by all society and not by physicians alone. Physicians have always borne without complaint more than their share of this burden and they will probably continue to do so in the future. Appropriations to provide the poor with medical care have always been and are still ridiculously insufficient. It is easier to pass the responsibility for the provision of such care to the medical profession than to raise sufficient funds. No prepayment plan of arranging for medical care for the poor by voluntary or compulsory contributions from the beneficiaries themselves is practicable since this group has no money with which to pay premiums. Any such prepayment arrangement must be based on the costs of the system being met out of tax funds. State and county medical societies have been ready to cooperate with public relief and social service plans for providing medical care to those unable to pay for it. That cooperation will continue in the future, and there are many indications that if public authorities and private philanthropy will cooperate, professionally controlled prepayment medical care plans may be of great help in meeting this problem.

The population group that has incomes too small to meet health necessities in the way of food, clothing, fuel and shelter cannot be expected to budget or make prepayments for catastrophic illness. These "medically indigent" are also more of an economic than of a medical problem. Their medical care, whether contributed by physicians or subsidized by taxation must, as always, be paid for directly or indirectly out of higher incomes. No prepayment scheme or compulsory sickness insurance or any other hocus-pocus can escape some form of application of the "sliding scale."

A realistic approach to any prepayment medical plan must recognize the fact that it will aid but little, if at all,

in supplying medical care to the no income and very low income groups. It may, if properly organized, furnish a better administrative framework through which public and private funds may be utilized in paying for such care.

WHERE PROBLEM EXISTS

There is a real problem in the procurement of medical services among the 15 or 20 per cent of the members of the low income group who suffer each year from illnesses which involve the loss of considerable time and the expenditure of burdensome amounts for medical care. When the actual facts are known, it is found that the care of this comparatively small fraction of the low income groups is mainly responsible for the demand for special plans in the distribution of medical care. State and county medical societies are giving serious consideration to this group and have experimented with numerous plans to meet the problem. The success of such plans depends largely on the way in which they are coordinated with the organization of medical service for the entire community. Such experiments should not be allowed to dominate the activity of a medical society, but should be considered in their proper relation to all other health and medical activities. The medical profession cannot afford to weaken its general attack on the whole problem of the protection of the community against disease and the postponement of death by concentrating its attention on so small a section of the problem. This would be especially dangerous if it led to the neglect of such other important phases as preventive services, detection of diseases in their incipency, and continuous improvement in medical science and practice.

Nearly all of the discussion of medical service plans is focused on a method of distribution of medical services for persons with annual incomes between \$1,000

and \$2,000 per family. It must be remembered that this group is of considerable size. It includes about 40 per cent of all families. Not all of these, however, constitute a special problem. Many such persons are able to pay for their medical care in the same way that they meet other exceptional expenses.

Not all of this important section of the population within these income limits can or will wish to join a prepayment plan. Premiums must be fixed at a point within the ability of prospective subscribers to pay, but not so low that it will be impossible to deliver good medical service. Some questions arise at this point: Just how will the flexible element previously discussed be used? What services can be given and what services must be excluded for any fixed premium? How will prepayment itself change the incidence of demand for medical care? What is the moral risk, and how will it be met?

Organized medicine must not take refuge in the sort of deception of subscribers as to the quality of the service on which many compulsory systems depend for solvency. If the medical profession is to continue to merit the confidence of the public, whatever services are promised must be delivered, and the quality of the service must not be allowed to deteriorate. In all existing plans, and there appears to be no evidence of a changing policy, medical societies have assumed the preliminary costs of organization and, together with the cooperating physicians, any risk of financial loss through miscalculations of premium rates because of the paucity of actuarial data. The payment for the treatment of minor disease is often of minor importance. Economic difficulties arise when major illness falls on those who have low incomes. This seems to be one explanation of the greater enrollment in prepayment plans that provide surgical care during hospitalization than in plans offering "complete care."

PREVENTIVE MEDICAL CARE

While "preventive medicine" has become a "blessed word" with which to conjure favor for medical schemes and especially for lay promoted contract prepayment plans and compulsory sickness insurance, it is well to keep in mind that there is, thus far, little evidence that any type of prepayment or insurance arrangement gives any significant encouragement to preventive care. The theoretical argument that physicians are consulted and treatment is begun earlier when the service is already paid for sounds convincing. It seems to be true that those under prepayment insurance do make more frequent use of medical services, but there is little evidence that such preventive measures as immunization or pre-clinical examinations are more universal or that the detection and treatment of such diseases as cancer and tuberculosis are more general under insurance than in private practice. A recent thorough examination of 1,592 workers in a British industry, enrolled in the compulsory British health insurance system, showed a higher percentage of illness and physical defects needing medical care than has been found in similar studies in the United States.⁷⁹

Of the 112 men and women in whom major disorders were found, twelve were, or had recently been, under medical care at the time of the examination. Similar records showed that in the case of varicose veins, a minor disorder of the 252 men who had the condition, only seven had ever consulted their doctors about it. For the most part both major and minor disorders were neglected or unsuspected. . . . Actually 50 per cent had seen their doctors during the preceding two years, and 22 per cent between two and five years ago.

The most important elements in the successful extension of preventive medicine would seem to be the improvement of public health, especially education of the public and cooperation with the practicing physi-

79. Morris, J. N.: A Medical Examination of 1,592 Workers, *Lancet* **1**: 51 (Jan. 11) 1941. Also abstract in *J. A. M. A.* **116**: 1933-1934

cians. No prepayment system, voluntary or compulsory, should be permitted to interfere with the development of these measures.

THE FUNCTION OF MEDICAL SOCIETIES

The Principles of Medical Ethics are the only firm foundation on which to base a sound medical service. State and county medical societies are the only organizations occupying a natural geographic area and possessed of the necessary professional knowledge and the desire to maintain the Principles of Medical Ethics in the organization of medical service for a community. These features place medical societies in a strong strategic position to organize medical services and to become the center of medical activities within the territory they cover. It also places on these medical societies an obligation to participate in the maintenance of high standards of medical practice.

Special interests, seeking to set up artificial classifications of patients, find their financial administration simplified if they can group patients as employees, students, members of economic groups, lodge members, compensation cases, or as almost anything but sick human beings in a definite locality. Each enthusiastic, interested pioneer of such schemes dreams of seeing his plan grow until it supplies service to a whole community. Industrial medical service is pictured as expanding until it includes all employees and their dependents. Universities are urged to extend medical care to all the people in their communities, and lodges or unions are expected to include almost the entire population.

Any such expansion reveals inevitable contradictions, overlappings and omissions. No such universal expansion is possible. Any partial expansion along such lines results in a standardized and inferior service even to those included, and lowers the quality of care given to those necessarily excluded.

The medical society is not only the logical unit on territorial and professional grounds but it is also, by tradition and discipline, founded on the basis that "reward or financial gain should be a secondary consideration." It cannot legitimately be organized for profit. It must be devoted as much to the constant improvement of the services that the medical profession can render to humanity as to the advancement of the science and art of medicine.

CONCLUSIONS

All the elements of this problem are still so constantly changing that any conclusions must be tentative; any action must be experimental. A complete solution of the problem of the distribution of medical facilities and services to every one is not immediately possible. Progress must come through adjustment of individual medical needs to existing knowledge and resources. Financial resources are widely dispersed and are controlled by individuals, governments, societies and institutions. Medical resources are found almost entirely within the medical profession. Unified means of utilizing these medical resources places the duty of direction in the hands of the medical profession. The various county and state medical societies, in their effort to meet the demands placed on them by this duty, have undertaken experiments that may be helpful in an attempt to find a more complete solution of the ultimate goal of good medical care for every one.

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