# ORGANIZATION OF MEDICAL SERVICES

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# PLANNING AN ORGANIZATION OF MEDICAL SERVICES

The medical profession has always given first attention to the quality of medical service. This begins with the education of physicians both before and after entering practice. Medical organizations foster research, test results, and disseminate knowledge among their members. They have never given first attention to employment, poor relief, politics, or payment of medical fees. If they are ever forced to consider these things first, medical service cannot but suffer.

For centuries medicine has sought, first of all, to reduce morbidity and mortality and extend the span of healthy human life. It has never expected to "solve" completely the problems of disease. It knows that death must come to all. It has, within recent centuries, doubled the span of human life and made these added years far more livable.

A definite pattern of successful tactics in the battle against death and disease has been developed and tested. Essential elements in this pattern are research, tests, methods of treatment and training, health education, and professional ethics. These elements are so closely united in this pattern that changing or destroying any one of them may weaken the entire defending force. When such foreign elements as industrial, political or economic considerations are permitted to enter, or especially to dominate the situation, morale is destroyed and professional effort is weakened.

## PLACE OF FINANCIAL ARRANGEMENTS

It is impossible entirely to disregard "reward or financial gain." Many of the elements essential to good medical service will be destroyed if the reward is insufficient. The Principles of Medical Ethics do not err in making financial elements a "subordinate consideration." Whenever they are permitted to become a primary consideration the service declines and society soon recognizes the fall in value and meets it with a reduction in reward.

Some of the critics of present medical practice seem to make financial administration a first consideration.

The "experts" who propose new schemes of medical service spend most of their time discussing administrative and financial questions. Their title of "expert" depends on their knowledge of the "machinery," blanks, reports, statistics and organization. They give practically no attention to the quality of the medical service to be distributed. They take that quality for granted, believing that the traditions and practice of the medical profession may be depended on to maintain its high grade. This might be true did not their other proposals disrupt and destroy many of the principles on which the medical profession depends for the maintenance of that quality. It is as if a proposal to supply the people with bread was to be concerned only with market reports, crop statistics, and price without considering the quality of the bread. Yet people are far better judges of bread than of medical service and the distribution of bread might be changed without affecting its quality, while the distribution of medical service is an essential part of the service and cannot be changed without altering its quality.

When compulsory insurance forced physicians in certain European nations to neglect their professional associations in order to attend "graduate schools" teaching rules, regulations and bookkeeping rather than medical science, not only did medical education and interest in professional progress deteriorate, but the service became superficial. It is not strange that in some cases the public sensed this loss of value and that a decline in professional income followed.

### IMPORTANCE OF PREVENTION

Medical Societies continually urge measures for the prevention of disease. They rightly spend much of their energies in educating physicians, patients, and the general public in the importance of immunization and regular physical examinations. They seek to build up efficient health departments and to drive political influence from their operation. Ignorance, prejudice, politics and financial niggardliness have always been the greatest obstacles to effective functioning of public health work. When a medical society and its individual members lose touch with public health departments, both suffer.

Public education has always been one of the most important means used by the medical profession to fight

disease. It is the duty of medical associations to make use of the platform, the press, the radio, and every other legitimate method of disseminating helpful information on health. It is right and proper that medical journals and speakers at medical meetings should constantly urge greater interest and activity in preventive medicine by practicing physicians. The comprehensive campaigns organized by many societies to extend preventive medicine are among the best forms of medical society activity. It is essential that such societies cooperate with schools and civic organizations, not only to extend desirable activities, but to restrict undesirable ones. Such work by medical societies has placed the United States ahead of nearly every other nation in the general application of preventive medicine. The proof of this may be read in the statistics of the decline of such diseases as diphtheria and tuberculosis.

Organized medicine tests proposals for changes in medical practice by asking: How will they affect medical service? It is the main function of organized medicine to improve that service and its most important meetings have always been given to discussions of progress in medical practice. The entire American Medical Association with its state and county societies and its affiliated organizations with their multitude of meetings and journals, is primarily an institution for graduate education in medicine. It would be a betrayal of the social function of organized medicine if this work were neglected in order to give primary attention to administrative machinery concerned with "reward or financial gain."

### NEED OF COMPREHENSIVE PLAN

Any plan by a county medical society to supply the best "service it can render to humanity" must be a comprehensive, balanced plan. It must be an attack on all things that threaten the health of the community and include in proper proportion all activities that decrease morbidity and mortality. All conditions surrounding the practice of medicine should be studied and the proper treatment for each phase determined. In such a study the primary fact must be kept in mind that sick persons and not economic classes, diseases, employees, or students are to be protected and treated. Diagnosis and treatment must be carried out by human beings and not by laboratories, clinics, hospitals or

administrative machinery. All these other things may be necessary at times, but all are for the purpose of bringing the individual physician and the individual patient into sympathetic, confidential, personal contact.

It is often necessary to classify the population for some of the purposes of giving a complete medical service, but it must always be recognized that every such classification will result in intricate overlapping and duplication. The only elements in the whole problem that remain constant are individual patients and physicians. Everyone is born and must die, and usually requires medical service on both occasions. In passing from infancy to old age most persons are pupils, employees in many organizations, members of various institutions, and participate in a wide variety of other social relations. At all times and in all places they are apt to be sick and in need of preventive, curative, or institutional treatment. Every new classification comprises most of these divisions.

The line between preventive and curative medicine is a thin and disputed one. Some forms of prevention like education, sanitation, and food protection are necessary to nearly everybody, and under some circumstances and for certain conditions can be given en masse. There is an overlapping of public and private activities in even such comparatively simple measures as immunization for diphtheria. When cancer and tuberculosis are to be prevented, detected and treated, individual treatment becomes paramount.

## CONFUSING CLASSIFICATIONS

When we seek to classify patients according to income, lines must be drawn across nearly all the other classifications. Indigent, low wage, and high income classes have all types of disease and include all age groups. Need for medical care does not vary significantly with income. The variable element is ability to pay for that care. This is an economic, not a medical problem. It has always been met by some variation of the "sliding scale" of payment according to income. The patient may pay nothing or whatever he can afford and the remainder is contributed primarily by the physician in reduced fees and secondly by public funds or private contributions from those with larger incomes. These contributions may be collected by gifts, taxation, a variation of charges according to

income, or by compulsory or voluntary regular payments in advance by a whole class of actual or prospective patients. The principle of adjusting payments according to income remains the same in all these methods.

When patients are classified by diseases these groupings involve nearly all other classifications. Such classifications are, nevertheless, necessary in analyzing the problem of medical care for any entire population. This is because the extent and expense of treatment varies according to diseases. Some minor diseases require slight attention, while some major afflictions call for considerable expenditure of time and money if proper treatment is to be given. Some patients are best cared for at home or in a physician's office, while proper medical service can be given to others only through the use of the facilities of a hospital or other institutions. Always it is the patient and not the disease that is treated. Attention has been called to the conflicting, contradictory and confusing character of these classifications only in order to emphasize the fact that in spite of these difficulties they all may be properly used at certain times and under some conditions in organizing the medical service of the community. They can be properly used, however, only when they are recognized as means to bring the individual patient into the best possible contact for good medical service by an individual physician.

## CARE OF THE INDIGENT

Rapidly changing political and economic conditions in recent years, accompanied by almost equally rapid changes in administration of poor relief, have made any action by county medical societies in this field largely temporary and experimental. Out of all these changes and experiments, however, some principles appear to be developing. There has come to be a general recognition of the duty of the whole community to bear the burden of medical care for the indigent and to relieve the physician of some portion of this age old duty. It is also being recognized that whatever medical service is given should be of the best possible character and that this high quality can be maintained only if the patient is given a free choice of physician, and if the supervision of medical care and the maintenance of medical standards are confided to professional organi-

zations, Nearly all the medical programs proposed by social reformers, especially all governmental plans, devote their attention and resources primarily to the treatment of minor illnesses among the low income classes. No system of compulsory health insurance gives any effective attention to the chronic sick or to the indigent and most such schemes leave the care of the seriously ill largely to previously existing institutions. The outcome is that such plans actually spend most of their efforts where there is least need.

One of the reasons why attention is focused on minor illnesses is because programs of mass medical care can be most easily sold to those who have, or imagine they have, many insignificant illnesses. If a considerable section of the more poorly paid population can be made to believe that the superficial medical care supplied by some political agency contributes to their ease of mind and possibly to their more rapid recovery, they are apt to show their gratitude at the polls to the organizers of the scheme. A county medical society must be on guard against being influenced by such considerations. This class of patients can be safely left to the individual care of private practitioners. It is just this class that has been most guilty of exploiting free clinics and outpatient practice. Many county societies have found that one of the most valuable contributions that they can make to the best use of available medical services is to guard against this exploitation of available services and to direct such patients to the care of the private practitioner where they belong.

### WHERE A PROBLEM EXISTS

There is a real problem among the 15 or 20 per cent of the members of the low income class which 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 sifted from the many bushels of chaff which have accumulated around the discussion of medical problems, it is found that the care of this comparatively small fraction of the low income group is mainly responsible for the demand for special plans in the distribution of medical care. County medical societies have usually centered their efforts on 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 an entire community. Such experiments should not be allowed to dominate the activity of a county society, but should be considered in their proper relation to all other activities. The medical profession cannot afford to weaken its general attack on the whole problem of the defense of the community against disease and death by concentrating its attention on so small a section of that line. This would be especially dangerous if it led to the neglect of such more important phases as preventive service, detection of diseases in their incipiency, and continuous improvement in medical science and practice.

All of the upper income classes (above $3,000) may be assumed to constitute no important problem. They are already cared for under the traditional system of private practice, with existing facilities. The same is true for the great majority with incomes between $1,500 and $3,000 annually. Only cases of prolonged illnesses, or a series of serious illnesses in the same family, or the occurrence of such illnesses in connection with other unexpected expenditures should throw any members of this income division into the problem class.

Nearly all of the discussion of medical service plans is focused on those with incomes below $1,500. It must be remembered that this is a considerable class. It includes about 35 per cent of the nonfarming class and 72 per cent of the farmers.

Not all of these, however, constitute any special problem. A large percentage are able to pay for their medical care in the same way that they meet exceptional expenses in other lines.

Below these is the indigent class. This class is not fundamentally, and certainly not exclusively, a problem for the medical profession. The care of the indigent is a broad social problem. It is no more the problem of physicians than of any other citizens, except in the field of medical service. This is a large, and for the medical profession—especially during recent years—an extremely important field. It involves cooperation with public authorities and philanthropic organizations; and the function of the medical profession is principally to see that the quality of the medical service is maintained and that care of the indigent does not become an entering wedge for the introduction of undesirable methods of control and distribution of medical service.

Except for the indigent there is no important problem in the care of minor diseases. The economic difficulty arises at the point where major illnesses are combined with low incomes.

The problem of the care of the chronic ill is so largely economic as to be scarcely the main concern of the medical profession. The care of the chronic invalid depends on providing sufficient economic relief to provide support and medical care.

Neither do institutional cases demand any special new plans for their care. Here the function of the medical profession is to see that the care of the mentally diseased, the blind, crippled, or any others for whom institutional care is deemed necessary receive good medical service, free from political influence.

Preventive care runs across all income classes and many types of illness. Again, this is a field in which the main problem is the development and improvement of existing institutions. In this field public health, nursing and the private practice of medicine must combine their efforts. The problem is largely one of keeping clear the line of division and creating the most efficient forms of cooperation between each of these.

The medical profession in the United States is favored by some features in the present situation. It is not handicapped by some of the conditions that existed in other countries at the stage when the demand arose for new adjustments in medical practice. This country has had far less contract club practice by private societies than existed in other countries at the time when schemes of compulsory insurance and state medicine were proposed. It is now recognized that the influence of such societies in determining the character of evolution in medical practice was generally harmful. The care received by even the lowest income class in the United States is much better than it was in foreign countries at the time the demands for a change in medical practice arose; facilities for medical care are more extensive and diversified and are better distributed. It is one of the most important tasks of organized medicine to see to it that these advantages are retained and that future changes do not involve the evils that have come in other countries.

It is the function of state and county medical societies to determine and direct the organization in proper rela-

tion of all medical facilities for all members of the community. Such a program does not call for wholesale transformations but rather for such a multitude of minor adjustments as are characteristic of peaceful social progress. Such minor adjustments may always be conducted in the form of experiments which can be expanded, abandoned, or altered as conditions of good medical care for the entire community demand.

This method attacks the problem of medical care according to the tested and approved method of individual medical diagnosis and treatment. Diagnosis begins with an investigation, classification and interpretation of all the elements essential to proper understanding and treatment. Such a systematic, impartial analysis by the medical profession is the peculiar contribution of the United States to the problem of organizing a complete medical service. In no other country has organized medicine ever attempted any such thorough analysis and diagnosis prior to changes in medical practice.

### PLACE OF THE FILTER SYSTEM

One of the instruments which nearly all medical societies that have been considering this problem have found to be helpful in classifying and analyzing the problem of an equitable distribution of medical facilities is the creation of some sort of "filter" or examining system. Because of its basic character, the machinery for this phase of the work becomes the most essential feature of any organized medical service plan. Such a "filter" provides for a social, economic, and, when needed, medical examination of all patients who come within the system. These are then directed as individual patients to the treatment best suited to their personal needs and abilities.

Some such analysis must be the first step in achieving progress with any problem. It is the first step in dealing adequately with any form of relief of indigency. The early workers in organized charity assumed that the chief need was a thorough "case study" followed by assignment to the proper organization or institution for treatment. This program faltered and failed for lack of agencies to meet widespread unemployment and other causes of extensive poverty. There is no such lack in the field of medical service. There is a sufficient supply of such facilities and service nearly everywhere

and no great difficulty in procuring additional ones where necessary.

A thorough economic and medical diagnosis often removes what previously looked like insurmountable difficulties. Several localities have found that a proper distribution of medical needs may render some facilities superfluous. This appears to be the case with regard to clinics in Alameda, Dayton, Los Angeles, Battle Creek, Cleveland and some other localities. Perhaps it is still too early to be sure that clinics will be permanently abandoned in these localities, but their need has certainly been greatly lessened with better organization and utilization of other facilities.

### THE COUNTY MEDICAL SOCIETY

The Principles of Medical Ethics are the only firm foundation on which to base a sound medical service. The county medical society is the only organization, occupying the natural geographic unit, possessed of the necessary professional knowledge and the power to maintain the Principles of Medical Ethics in the organization of medical service in a community. These features place county medical societies in a strong strategic position to organize medical service and to become the center of medical activities within the territory it covers.

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 classes, 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. They picture industrial medical service expanding until it includes all employees and their dependents. They urge universities to extend medical care to all the people in their communities. They would have lodges or unions include the entire population.

The moment an attempt is made to picture such developments as a whole, the inevitable contradictions, overlappings and omissions become evident. It should be clear that no such universal expansion is possible. It should be equally clear that any partial expansion can do nothing but give a standardized and inferior service even to those included, while such a development

rapidly lowers the quality of care given to those necessarily excluded. It cannot be too frequently repeated that medical care must be given to individual patients in some locality and not to employees, students, lodge members, etc. Every attempt to organize medical service along occupational, income, or other lines, rather than for individuals according to geographic location, only multiplies the confusion in medical care and makes it difficult for the medical profession to give the best service it is capable of rendering. Experience with sickness insurance has demonstrated the necessity of abolishing all divisions except geographic ones. Nearly every such system started out by trying to follow occupational or other arbitrary lines. Today they are nearly all trying, in the interest of efficient administration, to abolish all but territorial divisions. This is true even where administrative and financial considerations are placed ahead of medical service as a criterion of success. The United States is fortunate in not having developed a more extensive system of contract practice. It would certainly be foolish to attempt to develop forms of medical practice that have been found so undesirable elsewhere.

The county medical society is not only the logical unit on territorial and professional grounds, but also because it is, 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 interests of the profession itself.

## CONCLUSIONS

All the elements of this problem are still so much in flux 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 everyone is not immediately possible. Progress must come through adjustment of individual medical needs to existing resources. Financial resources are widely dispersed and are in control of individuals, government, societies and institutions. Medical resources are controlled almost entirely by organized medicine. This unified control of the main feature in the problem places the duty of limitation and direction in the hands

of organized medicine. The various county and state medical societies, in their effort to meet the demands laid upon them by this duty, have undertaken the experiments which are described below.

The descriptions of these experiments which are given here have been revised and approved by representatives of the county medical societies that are conducting such experiments. They are offered here as suggestions for further experiment, not necessarily as examples to be followed, nor with any implication of superiority over work that may be conducted by other county medical societies.

## ALAMEDA COUNTY, CALIFORNIA

Of the 475,000 population in Alameda County, approximately 440,000 are in the five cities of Berkeley, Oakland, Alameda, San Leandro and Hayward. The remainder are largely engaged in agriculture. The American Medical Directory for 1934 lists 824 physicians in Alameda County, of whom 480 were members of the county medical society.

Medical developments have not come as the result of the sudden introduction of any plan. They have been part of an evolution the lines of which were fairly clear nearly twenty years ago. The deplorable condition of the Alameda County Infirmary and the County Hospital in 1915 led to an investigation and the creation of the County Institutions Commission of six, appointed for eight years each, with overlapping terms. There have usually been at least two physicians on this commission, and it has become the center through which most philanthropic or medical activities of a public character have been organized. The membership of the County Institutions Commission has been increased until there are now ten, four of whom have been members from the beginning.

With the approval of the Alameda County Medical Association, a clinic for medical care of the indigent sick and persons of moderate means was established in 1918 and was named the Public Health Center of Alameda County. There were several other clinics in existence at the time the County Institutions Commission was appointed, but this commission was not given charge of clinics. In 1930 several health organizations requested a county survey by the California State Board of Health. The board appointed Dr. J. W. Mountin, of the United States Public Health Service, to make such a survey. His report formed the basis of much subsequent action. In August 1932, in accordance with the report of this commission, the County Institutions Commission took charge of all clinics and immediately abolished all pay clinics.

The commission also controls the following institutions through the supervision of the county medical director, who is charged with, and directs, their manage-

ment: (1) Highland Hospital, a modern institution of 450 beds; (2) Fairmount Hospital, a convalescent hospital with 900 beds; (3) Arroyo Sanatorium, for citizens with tuberculosis, and (4) Del Vallee, a preventorium for children.

There has thus been a unified management of public institutions in close cooperation with the county medical society. This situation permitted progress with much less friction than has taken place in some localities. The county medical society, while best known for its success in conducting a specialized plan for the care of the indigent and those of low income, in cooperation with the County Institutions Commission, has made this phase of its work only a part of a comprehensive organization of all activities. The Alameda County Health Department is an integral part of the organization of medical services, working in continuous and close cooperation with all other agencies.

The county medical society has organized its members into groups, the better to conduct an immunization program. These members give immunization injections for $1 per patient, the toxoid being furnished free by the Board of Supervisors through the County Institutions Commission; the immunization is given to the indigent just the same as any medical service, in accordance with plans to be described later.

### HEALTH EDUCATION

The county medical society conducts a speakers' bureau which is charged with the work of health education. Through this bureau speakers are furnished to luncheon clubs, parent-teacher associations and other groups. As a part of similar educational work, the annual Health Institute is sponsored by this association. Close affiliation is maintained with the press by a representative of the county society. In addition to cooperation through the central body of the County Institutions Commission, the Alameda County Medical Association is officially represented in many public welfare organizations, including the Chamber of Commerce, the Tuberculosis Association and the Visiting Nurses Association.

The abolition of pay clinics in 1932 made necessary some sort of special provisions for those who can pay only a portion of the cost of medical service. Those

unable to pay anything become the responsibility of the county government.

The examining, classifying and "routing" center of the plan is formed by the County Institutions Commission. This conducts a social investigation to determine how the economic and social factors affect treatment. This information is always available to any physician treating the patient. This function of investigation and classification according to ability to pay is exercised by a nonmedical organization, although physicians, to a certain extent representative of the county medical society, are members of the County Institutions Commission.

### INSTITUTIONAL COOPERATION

Alameda County is especially well equipped with a variety of medical facilities the development of which seems to be so well balanced as to permit a satisfactory assignment for proper care of a wide variety of patients. It is possible to bring these institutions into cooperation for different services for the same person. When a patient who is able to pay in part for medical services may require a x-ray picture, for example, or special laboratory service, this can be obtained without cost from the county, although he might receive his actual treatment from his individual physician, whom he can pay whatever he is able for the services. The x-ray film or the results of the laboratory investigation is sent to the physician for his guidance.

### ECONOMIC CLASSIFICATION

When families who are not known to recognized charitable agencies request a physician, such a call is referred to a member of the Alameda County Medical Association with the understanding between the prospective patient and the doctor that he will make that original call, supply the professional services demanded by such call and charge the patient a fee that the patient will be able to pay. Physicians receiving such calls from recognized agencies render a brief report covering such social and economic information as may be obtained to a central bureau operated by the county, which makes a further investigation as to the patient's financial and social standing. A complete determination is then made as to whether the patient is entitled to charity and free medical attention. If the doctor who has been sent can work out the problem with the

patient, then he is retained by the patient, and the case becomes a part of his own private practice. If he finds that the financial and the social condition of the patient makes him properly an indigent patient he refers him to (1) the clinic or hospital operated by the county for charity cases or to (2) the county physician paid by the county to care for the indigent. Fundamentally, the basis of this plan is to keep the care of this type of person in the hands of the physicians in practice.

If the referral from the County Institutions Commission is to a physician, it is accompanied by a statement as to the income and an estimate as to the amount which the patient is able to pay. The physician having this knowledge is at liberty to make his own arrangements with the patient. Practically every member of the county medical society has agreed to cooperate. Where no preference is expressed by the patient, the social service representative selects names in alphabetical order from the lists of physicians who have agreed to accept such referrals. During the year 1933, 2,077 referrals to private physicians were made by social workers, clerks, nurses, doctors and others in the Alameda County agencies. In 1934, 2,455 patients so referred paid the physicians who attended them about $15,000.

There has been much discussion during recent years in Alameda County concerning the formation of a hospital prepayment plan which has now almost come to completion with the organization practically ready to proceed. There is at the present time a law in California which permits the formation of nonprofit hospital service corporations under the joint management of hospitals and the medical profession, without the deposit of any sum with the insurance commissioner. The law is nonoperative for the reason that the act made no provision for funds with which to administer it. Because of this fact, the Alameda County Medical Association is proceeding under the old insurance law and is incorporating as a mutual insurance company. The policy provides for payment to hospitals for hospital service and indemnifies the patient for payment of the roentgenologist and the pathologist, in conformance with the principles of ethics set down by the California Medical Association and with the law of this state in prohibiting the sale of the services of a doctor

of medicine. The organization recognizes that the practice of pathology and roentgenology, in all of their subdivisions, are the practice of medicine.

Steady development, without any important conflicts over a period of years, has created the possibility of further harmonious evolution. The existence of such a plan has made possible the addition of new institutions and forms of service and their coordination with those previously existing. So long as the whole plan is made to center around the principle that the only function of the "machinery" created is to investigate economic conditions, classify the patients according to facts found and then direct them to where the service most suitable both as to economic and to medical needs can be found, the plan should continue to develop satisfactorily.

The success that has been accomplished in connection with the work in Alameda County has been due to a spirit of confidence and mutual cooperation between the official agencies operating under the County Institutions Commission, the Alameda County Medical Association and certain other nonofficial agencies that are deeply concerned with this particular medical program.

# ATLANTA, GEORGIA

## Fulton County Medical Society

Atlanta had a population of little over 360,000 in 1934; there were 686 physicians (43 colored) in the county,[1] of whom 451 were members of the Fulton County Medical Society in December 1935. There is, therefore, one physician in every 525 population. In the state of Georgia less than 1 per cent (0.88) of the population filed income tax returns in 1931, and the average income per person for the state in 1930 was $218.

### PREVENTIVE MEDICINE

The county medical society has stressed the need of immunization through physicians speaking to parent-teacher associations and school groups. Private physicians have set aside the time from 4 to 5 p. m. every Friday as a "Health Hour" in their offices. At this time immunizations against smallpox, diphtheria and whooping cough are given at a reduced fee to those not able to pay a regular fee. The usual charge is $1 per injection. The Georgia State Board of Health immunizes those unable to pay. Periodic health examinations are urged by at least one newspaper article annually.

Practically all immunizations against smallpox are administered by the two city physicians who devote their entire time to treating the poor of the city. Immunizations against diphtheria and typhoid are administered by a physician who gives the city two hours (on salary) each day for five days a week in a clinic in the city hall. A large placard in the clinic states that such immunizations are free only to those unable to pay. The physician accepts the statement of the patient and does not investigate each one to see if he is entitled to free treatment. A colored outside clinic, paid by the city, is conducted during the summer months.

Examination for immunizations was formerly done in the schools, but this has been discontinued and the "Health Hour" substituted. Since the work in the schools was done by doctors without pay and many of those able to pay were being treated free, it was felt

1. American Medical Directory, 1934.

that such a plan was unfair to the physician. Members of the county medical society give addresses to pupils on health matters. The Department of Health maintains baby centers—mainly in poorer sections. The service is supposed to be for those unable to pay. The standards of classification as to ability to pay are indefinite and are enforced only by public opinion. The result is that if a person who is unable to pay the regular fee presents himself to the Atlanta Board of Health for immunization he receives it.

Last year 2,902 immunizations against diphtheria and 1,862 against typhoid were given by the clinic conducted by the Board of Health. Six hundred and thirty-one immunizations against diphtheria and 6,241 against typhoid were given last year in a special clinic for Negroes.

### PUBLIC EDUCATION

A speakers' bureau is maintained by the County Medical Society, and speakers are sent out to the various organizations. There is a health article each Sunday in one of the newspapers. One hundred addresses were given by doctors to parent-teacher groups and at public schools during the year; thirty-nine radio health talks, selected from the library of the American Medical Association, were also given.

### HOSPITALS

The staffs of all hospitals are composed of members of the county medical society, and this is the only representation of organized medicine in hospital organization. The members of the county medical society give their services, without costs, to charity hospitals, except when these institutions have full-time physicians employed. The hospitals receive no pay for hospitalization from patients treated in such charity hospitals.

Other hospitals have flat-fee services covering the various services, including a special number of days of hospitalization. The price varies with accommodations given and does not include medical fees. Group hospitalization is illegal in the state of Georgia.

### GRADUATE EDUCATION

The county medical society holds two monthly meetings during each year at which scientific papers are presented and discussed. The six hospitals hold monthly staff meetings; sections of the county society

hold monthly meetings; Emory University arranges a clinic week each year. There were 215 physicians who attended the 1935 clinic.

### PUBLIC RELATIONS

The county society has no direct representation in civic, social and welfare organizations. Individual physicians are members of many civic groups, and there is one physician-member of the county Board of Health. The county society was active through the Committee on Public Policy and Legislation. In the state legislature they succeeded in preventing the passage of a bill which would have permitted physiotherapeutists to practice medicine. A bill also was killed which would have permitted three year graduates to practice medicine. This committee also succeeded in eliminating an undesirable chiropractors' broadcast from a local radio station.

### PLANS FOR FINANCING MEDICAL CARE

In October 1933, after two years of study, the Fulton County Medical Society applied to the state of Georgia for a corporate charter, not for profit, which was granted to the Fulton County Medical Relief Association, now the Medical Service Bureau.

Membership in the Medical Service Bureau entitles a patient to all forms of medical examination and treatment, such as surgical and obstetrical care, x-ray pictures, laboratory examinations, care of the eyes, ears, nose and throat, consultation, office calls and home and hospital visits—in fact, everything that the physician does for the patient. Hospitalization, drugs and nursing are never furnished by the physician and are not included in this service.

There is complete freedom of choice of physician from among those physicians who have accepted the plan. Any member of the Fulton County Medical Society is entitled to have his name placed on the Roster. He retains the right to decline a call under the same conditions that he would do in private practice. Any physician, even though his name is not on the Roster of Doctors of Medical Service Bureau, if he is a member in good standing of the Fulton County Medical Society may accept patients who are members of Medical Service Bureau under the rules of the bureau. His relation to the patient is not limited or changed except that the Medical Service Bureau pays the bills.

The organization was financed in the beginning by a $500 loan from the county society and $1,200 in loans from physicians. The Board of Directors consists of five doctors who must be members of the Fulton County Medical Society. However, they are elected by the voting member-doctors of the Medical Service Bureau, which is a separate corporation. Hospitalization is not furnished.

### THOSE INCLUDED IN THE SERVICE

The following requirements govern membership in the bureau: if there are no dependents and the income does not exceed $75 per month; if there is one dependent and the income does not exceed $125 per month; if there are two dependents and the income does not exceed $135 per month; if there are three dependents and the income does not exceed $145 per month; if there are four or more dependents and the income does not exceed $150 per month.

Membership is individual, and a separate application is required for each member of a family or any other group.

The cost of membership for an individual is $1.50 per month plus an enrolment fee of $1 with application. The enrollment fee is paid only once.

In family groups the first member pays an enrolment fee of $1 and $1.50 per month. The second member of the same family pays $1 enrolment fee and $1 per month. The third member of the same family pays an enrolment fee of 50c and 75c per month. All additional members of the same family group each pay an enrolment fee of 50c and 50c per month. All dues are required to be paid in advance.

A fee schedule for all services is used, and each physician bills the Medical Service Bureau, monthly, for his services according to this fee schedule. All bills are paid in the order of receipt at the office of the Medical Service Bureau. When paid, such bills are paid in full. At the present time the physicians are receiving 70 per cent of their fees. The plan was started on a small scale and began functioning on April 2, 1934. During the month of April, thirteen people became members. The bureau has shown a slow but consistent growth, and in April 1936 there were 778 active members. The monthly income has increased in this period from $49 to $986.09.

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### COLLECTION FEES

The county medical society has no plan for the collection of general medical fees. There is a Physicians' and Dentists' Credit Bureau, but it is not controlled by the county society. It was at one time under the society control, and there is a movement at the present time to again resume this relation.

## BEXAR COUNTY MEDICAL SOCIETY

Bexar County, (San Antonio) Texas has a population of 292,533. There are 536 physicians in the county, of whom 302 are members of the county medical society.

### IMMUNIZATION AND SCHOOL CARE

Every year the county medical society, in cooperation with the parent-teacher associations, organizes a Spring "round-up" of children of preschool age for immunization and physical examinations. This work is given publicity in the daily newspapers and in classrooms. The actual immunization and examinations are held on the first days in May in various designated schools. Physicians give their services for this purpose, free of charge. If any medical treatment is required, the patient is referred to the family physician if able to pay. Indigent patients are treated at the county hospital free of charge.

### PUBLIC HEALTH EDUCATION

Occasional articles are published in local newspapers, and city health officers give weekly health talks. On special occasions other physicians use the radio for talks on health matters. Members of the county society are frequently called on to address meetings of the Chamber of Commerce and service groups. The county medical society also edits and publishes a monthly magazine, *Health and Happiness,* which is mailed to homes of the city, free of charge. This has a circulation of about 5,000.

### COOPERATION OF HOSPITALS

Members of the county medical society are on the Board of Trustees of nearly all the hospitals. In other cases the board consults with the medical staff. All the hospitals are included and accept patients insured under a group plan by a local insurance company. Special arrangements have been made by the hospitals for the care of semi-indigent patients, at reduced rates, on a written request from the Credit and Information Bureau described here.

### PUBLIC COOPERATION

Physicians and their wives are active in the Bexar County Tuberculosis Association and the Bexar County Crippled Childrens' Association. The cooperation is both through active members in these organizations as well as through the service given by the physicians. The county medical society is represented in practically all civic and welfare organizations. Among these there is such representation on the Advisory Board of the Chamber of Commerce, the Board of Directors of the Red Cross and the Board of Directors of the Crippled Children's Association and as president of the County Tuberculosis Association, president of the San Antonio Association for the Blind, president of the Lions and past president of the Rotary Club and president of the Optimists. The Legislative Committee of the Bexar County Medical Society has worked with the local Chamber of Commerce improving health conditions and has recently secured the appointment of a committee of five physicians, by the city and county administration and the school board, to act as a health board. It will advise and enforce health regulations and coordinate this work so as to prevent duplication and overlapping.

### FINANCING THE COST OF MEDICAL CARE

The county medical society maintains a Credit and Information Bureau. This bureau, in addition to supplying physician members with credit information and undertaking the collection—on a percentage basis—of delinquent accounts, also acts as a classifying and routing agency for patients in the low income class. Any patient applying to a clinic or county hospital for free treatment is first interviewed at the clinic or hospital. If any question arises at this time as to the ability of the patient to pay for medical care, he is sent to the Information Bureau of the medical society for further social and financial investigation. This investigation determines the ability to pay. If unable to pay anything, the patient is sent to a free clinic or county institution. If the patient prefers some physician, he goes to the one he has chosen, with a statement of his ability to pay, and the question of whether free treatment will be given or whether the physician will refer him to a clinic is determined between the patient and the physician.

Those patients able to pay part fees are referred to the physician of their choice together with a statement of the amount which they are able to pay. If the physician is willing to care for him for the amount so determined, he does so; if not, the patient is referred to another physician on the list. Those patients able to pay full fees are referred to the physician of their choice together with suggestions as to financial arrangements and as to time of payment as may be found necessary and desirable.

In connection with the financial investigation and arrangements for treatment, the bureau also provides means of payment for medical services on the installment plan.

### THE BUDGET PLAN

The patient signs an installment note covering the amount the bureau has determined he is able to pay. He is required to have one or two good cosigners. His employer is contacted and asked to cooperate. He makes as large a down payment as possible and pays the rest in weekly or monthly installments. The obligation to pay on such arrangements is far greater than on open account with the doctor.

The collections from these notes are paid monthly to the physicians, the bureau retaining 10 per cent of all money collected to defray overhead expenses. Where there is more than one doctor involved in the case, the payments are distributed accordingly among those participating. The patient is charged a straight interest of 7 per cent on the deferred payments. This plan is also to be used in the liquidation of past due accounts.

# CLEVELAND, OHIO

## Cuyahoga County Medical Society

The population of Cleveland in 1935 was 900,490, of whom 71,899 were Negroes. There were 1,693 physicians, included in the American Medical Directory for 1934, residing in Cleveland, of which 51 were Negroes, and there were 1,237 members of the county medical society.[2]

The organization of medical activities within Cleveland is directed by the Academy of Medicine of Cleveland, a division of the county medical society.

### PREVENTIVE MEDICINE

The Committee on Health Education has for several years cooperated with the schools in an effort to secure immunization of a large number of children during the summer months. This effort has included the cooperation of the welfare groups in publicity campaigns or house-to-house visits in which parent-teacher associations and school nurses have also participated. Members of the county medical society were asked to set aside clinic hours at least once a week at which they would charge not to exceed $1 plus the cost of materials for each dose. Little has been accomplished by these efforts, especially during the years of depression. The committee now feels that more effective work could be done by concentrating on efforts to get children immunized in the early years of their life, or at least during preschool years, and by urging the medical profession to secure immunization of the children in the families of their private practice. Cards have been furnished to physicians to be sent to their patients urging immunization of the children, but the results have been rather small. It is thought that this indifference in the public may be due to the absence of any alarming epidemic of communicable disease within recent years.

### COOPERATION OF PUBLIC HEALTH DEPARTMENTS

There has been constant and effective cooperation between the Academy of Medicine and the Division of

2. This includes about 200 interns who are included as members of the county medical society but not of the American Medical Association, and also a number of delinquent members, or those who have not paid full dues but are given the privilege of the Academy of Medicine of Cleveland.

Health of Cleveland for many years. The commissioner of health is, ex-officio, a member of the Academy Committee on Public Health and attends its meetings regularly. The academy has also been represented on the Advisory Committee to the Division of Health, which has conducted studies and made recommendations and is consulted constantly regarding any programs that arise. During the past two years the committee has shared with other civic bodies in urging the granting of adequate budgets for the Division of Health. It is felt that this activity is one of the most valuable and effective. During the last year, the director of public welfare asked the Academy of Medicine to survey the City Hospital since charges of unsatisfactory conditions had been made by the newspapers. A detailed study was made, and the findings presented showed political influence, improper financing and other conditions that constituted a distinct handicap to the institution. The academy followed this up with the support of the newspapers in a victorious fight for reorganization of the hospital management. The Public Health Committee work in the City Hospital study was incidentally one of the important factors in bringing about a reformed city administration.

The Committee on Public Health has also been instrumental in freeing the medical service in the schools from domination of the lay-controlled physical education department. It is now taking the lead in arousing the community to a consideration of the problem of venereal disease. The work of this community has been so effective that the Chamber of Commerce, which formerly had a Committee of Public Health, has abandoned this field.

### PERIODIC HEALTH EXAMINATIONS

Efforts in this direction to overcome the inertia of the medical profession or the public have been rather ineffective in recent months. Campaigns conducted a few years ago on this subject seem to have had some effect at the time. The Ohio State Medical Association has a Committee on Periodic Health Examinations which keeps the subject alive.

### PUBLIC EDUCATION ON HEALTH MATTERS

Several years ago the Academy of Medicine of Cleveland established a Health Education Foundation,

setting aside $10,000 for this purpose, the income from which is expended by the Academy Committee on Health Education. Eventually it is hoped that more funds will be accumulated.

The Committee on Health Education is using all available methods; these include lectures through a speakers' bureau, the newspapers, radio programs, demonstration talks, etc. The Speakers' Bureau has organized several hundred talks during the past year before private agencies. These include four series of lectures on social hygiene presented by a team of four doctors in different sections of the city before parent-teacher associations. The average attendance at these lectures on social hygiene has been well over 500. The Academy of Medicine of Cleveland has for several years presented to the public four Sunday afternoon health lectures each year before audiences ranging from 600 to 2,000. These are now given by local doctors in cooperation with the Holden Foundation of Western Reserve University.

The Academy of Medicine has now become a center for "spot news" for the medical profession and is visited by reporters as regularly as the city hall or any other focus of city life. The scientific lectures are open to the newspapers, and there has rarely been any undesirable publicity for the medical profession. The newspapers understand that when they desire comments on telegraph news or local events they are privileged to call the chairman of the Committee on Health Education, who is authorized to speak for publication, on behalf of the Academy of Medicine. If a member is to give a lecture to any public group he calls the Academy of Medicine and is then authorized by the Committee on Health Education to be presented to the public as a speaker under the auspices of the academy. This relieves the physician of any individual onus. The Academy of Medicine has also exercised influence to restrain certain hospital publicity programs which did not seem to be to the best interests of their own staff members. A committee of the Academy of Medicine, in cooperation with the Committee of the Hospital Council, has reached an agreement with the hospitals, newspaper and academy that no information is to be published about a private patient without the physician's consent. This applies particularly to

the public use of the physician's name. This does not prevent the mention of a physician's name when the presence of a prominent citizen in a hospital constitutes legitimate news and when the publication is such as not to constitute a breach of ethics.

An experiment with a radio-sponsored program several years ago was found unsatisfactory, and the program was dropped. During the past year one of the stations requested that the academy provide them with a health program. This was done, and there have been continuous weekly broadcasts by physicians on health subjects. The time is furnished free by a local station whose executive secretary interviews a member of the academy. The physician's name is announced without further publicity.

Recently the Committee on Health Education called together a community conference to discuss the establishment of a permanent museum of health and hygiene. The conference approved the idea and is studying ways and means.

### HEALTH WORK IN SCHOOLS

School doctors examine children at various periods in their school years and immunize those not already immunized by private physicians. This situation is not entirely satisfactory to the Academy of Medicine, but it has at present no solution to offer. The School Division of Health employs a large number of physicians on a full-time or part-time basis. The director of the division sits on the Academy Committee on Public Health. The policies of this division are usually worked out with the academy before being adopted.

For several years the academy supported the tonsil clinic conducted in outlying districts of the county by school physicians in school buildings. The academy finally took over the tonsillectomies in the schools and employed a social worker who determines the economic rating of the family and either makes arrangements for the tonsillectomy by the family physician, or if the family physician believes the income is not sufficient to meet the charge in private practice, arranges for care in Cleveland hospitals. The academy makes the arrangements with the hospitals who collect $5 for each tonsillectomy, of which $1 goes to the academy to cover the costs of social service. If the family is indigent, it does not pay the $5. The practicing physicians in

these outlying communities are satisfied with these arrangements as they are consulted and given an opportunity to care for their patients if they so desire.

### ORGANIZATION OF MEDICAL CARE

An experiment in the correlation of private practice with dispensary practice was started in July 1932. The plan was worked out in cooperation with various welfare organizations, hospitals, dispensary managements and other institutions or organizations concerned. All social agency workers agreed that any patient who had been under the care of a private physician within recent years should be referred to him. Those able to pay should be referred to a neighborhood physician. A central committee composed of representatives of the major groups involved was formed to handle the "traffic" and other problems. Referral slips made it possible to trace the results. In the year ending July 1933, 8,844 such slips were issued. An investigation showed that one third of the persons were kept as patients by the physician; one third were sent by the physician to the dispensary, and the other one third tore up the slips, went to a drug store for remedies and could not be accounted for further. A questionnaire asking for opinions on various features of the plan was sent out to all members of the Academy of Medicine. The replies indicated approval of all its features, although there was still a minority that criticized its workings. A questionnaire sent to dispensaries and other agencies concerned brought similar approval with a number of objections. The plan is being further studied by a subcommittee of the Committee on Economics.

### RELATIONS WITH HOSPITALS

The Hospital Council, in which nearly all of the hospitals are represented, is in constant contact with the Academy of Medicine. While there is no representation of the academy on the Hospital Council there are almost always members of the Hospital Council on the Council of the Academy of Medicine. Relations are most cordial and effective.

The Academy of Medicine approved the formation of a periodic payment plan for hospital care and appointed two directors to the Hospital Service Corporation which manages the plan. The annual rate is

$7.20 per person for ward service and $9 for semi-private room.

The service is sold only to employed groups of ten or more. The provisions in the subscribers contract are that he is to receive hospitalization

for not to exceed twenty-one (21) days within a period of one year next following the date of execution of this contract; (*a*) bed and board in a semi-private room (or ward); (*b*) general nursing service; (*c*) technical X-ray service (excluding professional interpretation); (*d*) operating room service, including anaesthesia, when administered by a salaried employee of the hospital; (*e*) routine laboratory service, and (*f*) ordinary drugs and dressings. It shall not, however, include ambulatory service, so called, which is defined to mean service rendered to one who is not regularly admitted to a hospital as an inpatient, and shall not include hospitalization for the treatment of the following: (*a*) psychoses (mental diseases), (*b*) maternity cases, (*c*) pulmonary tuberculosis, (*d*) diseases which cannot be admitted to a general hospital under laws, ordinances or regulations of public health authorities applicable to the Participating Hospital to which the Subscriber applies for admission, or (*e*) injuries or diseases for which hospitalization is available without cost to the Subscriber, under laws enacted by the legislature of any state or the Congress of the United States. It also shall not include the professional services of physicians and/or surgeons, except services rendered in assisting the Subscriber's attending physician by the medical house officers of the interne and resident staff, and services of the salaried pathologist or laboratory director of the Participating Hospital to which the Subscriber is admitted.

A little over 28,000 subscribers have been obtained. In the first two years of its existence the plan has paid for hospitalization of nearly 2,000 subscribers and has a cash balance of $38,000 after paying off a loan of $7,500. The academy approved this plan with the proviso that "no additional services should be added to the plan, and that the plan should never be turned over to any other group, insurance company or otherwise."

### CARE OF INDIGENT AND LOW PAY PATIENTS

In 1933 the Academy of Medicine developed a plan for rating and referring to private physicians patients in need of diagnostic procedures, which were more expensive than they felt they were able to finance in a normal manner. A social service department was created and authorized to determine financial ratings and arrangements for payment. Members of the academy agreed to accept this rating and care for them accord-

ing to the arrangements. The number of applicants for this service was so small that it was abandoned after several months. The Committee on Economics keeps in constant contact with federal, state and local relief agencies regarding the care of the indigent. Cleveland has never had any federal assistance for the care of the indigent, except transients and persons injured on county relief projects. The Committee on Economics is continually studying such local and national problems as arise and acts in an advisory capacity to all agencies concerned in this work.

There are numerous and changing special programs that are conducted with the cooperation of the academy. Special attention has been given to tuberculosis and cancer and to the care of crippled children, both in health education and as addresses to the public and also to physicians. The academy acts as official adviser to the Association for the Crippled and Disabled. It sets the professional standards for all of their activities, and no effort is expended by them without consultation with the advisory committee. The problem of tuberculosis comes under the province of the Committee on Public Health, largely through its contact with the city Division of Health and the schools. The local chairman of the Cleveland Cancer Committee is a member of the Academy Committee on Health Education, so that the work of this committee is closely concerned with the activities of the academy.

The Academy of Medicine is a nonparticipating member of the Welfare Association. This gives it a place on the Health Council, a group of organizations engaged principally in the field of health education, which includes such organizations as the Visiting Nurse Association, the Red Cross, the Adult Education Association, Parent-Teacher's Association groups, the Association for the Blind, the Association for the Crippled and Disabled, the Association for the Hard of Hearing, etc. The policy is maintained to place the academy in cooperative contact with any group or activity concerned, directly or indirectly, with health matters. This contact is met at the beginning and is found more satisfactory than seeking to influence an agency already set in its way of doing business and which might be resentful of suggestions for changes.

GRADUATE EDUCATION OF PHYSICIANS

The academy conducts an annual post-graduate course of about twenty-two Friday afternoon lectures. This year the subject is "Pediatrics and Contagious Diseases." In addition, it has eight sections meeting monthly or quarterly in the following fields: Clinical and Pathological Section, Experimental Medicine Section, Ophthalmological and Oto-Laryngological Section, Industrial Medicine and Orthopedic Section, Obstetrical and Gynecological Section, Pediatric Section, Military Medicine Section and, Practice of Medicine Section. The programs of these sections are not confined to presentations in the auditorium of the academy, but in many cases are given in hospitals with the staff of the hospital acting as host. The experimental section holds all of its meetings jointly with the Cleveland Section of the Society for Experimental Biology and Medicine and has at its disposal the facilities of the Institute of Pathology of Western Reserve University.

## WASHINGTON, D. C., PLAN

A statement describing the organization and operation of the "Washington Plan" was prepared by the Bureau of Medical Economics and was submitted to official representatives of the Medical Society of the District of Columbia. The suggestions of these representatives have been incorporated in the following description of the Medical Economic Security Administration, which is operating with the approval and cooperation of the Medical and Dental Societies of the District of Columbia.

The leading editorial in the *Medical Annals of the District of Columbia* for November 1934 called attention to the amount of free medical service given in the outpatient departments and in the wards of the community hospitals. In this editorial, the inadequacy of social service departments, the abuse of free services by those able to pay something for private medical attention, the burden on not only the practicing physicians of the community, but also on the tax-payers and many public spirited citizens who have donated to the support of the Community Chest, and the misuse of funds paid for services for patients not eligible to free medical attention were cited as conditions which merited careful study and the adoption of some method by which to prevent these abuses.

The Committee on the Coordination of Resources for Medical Care of the Medical Society of the District of Columbia, with the help of Mr. Ross Garrett, coordinator of the Health and Hospital Council and health secretary of the Council of Social Agencies, at this time announced a plan for the establishment of a Central Admitting Bureau for Hospitals, financed by the Community Chest, the purpose of which was to eliminate unwarranted use of medical services by persons able to pay for this care and thus to make more money available for those who deserved help. This bureau was placed in operation early in January 1935.

The Medical Society of the District of Columbia, on Jan. 2, 1935, adopted resolutions and a set of principles to govern in any plan for providing medical care for the indigent. It was pointed out that, with respect to

his ability to secure medical care for himself or his dependents by the ordinary expedient of purchase, the citizen falls into one of three groups:

. . . (*a*) the group whose members are financially able to meet the exigencies of any given medical situation from current funds, immediately or within a reasonable time; (*b*) the group whose members are financially able to defray the reasonable and, considered from the viewpoint of their financial status, appropriate costs of medical care, provided means are available to spread the payments over a sufficient length of time; (*c*) the group whose members are without resources to meet such demands at all.

In the statement accompanying the resolutions it is stated that the object is to promote an accord between all agencies responsible for furnishing medical care to the indigent and to secure cooperation and understanding rather than friction and discord in order that no deserving person in need of such care shall go without it. The statement calls attention to the responsibility of officials to see that available tax and voluntary funds are used economically and appropriately for the benefit of the truly indigent.

The Central Admitting Bureau is said to have three functions, two of which are handled by a staff of social workers whose employment is approved by the Board of Directors on the budget allotted from the Community Chest. The two functions of this staff are (1) to issue admission cards entitling the holder to attend free hospital outpatient clinics and (2) to investigate hospital inpatients who can pay but part of their hospital bill, the balance of which will be paid from Community Chest funds. A separate staff, employed by the Public Welfare Department of the District, handles admission of wholly indigent patients to Gallinger and other District-owned hospitals.

The Medical-Dental Service Bureau, Inc.,—Washington Physicians and Dentists, Proprietors,—was the subject of an editorial in the *Medical Annals of the District of Columbia* for March 1935. The advantages of the bureau were stated in this editorial as:

(1) The individual who needs an operation to correct existing physical defects handicapping health, or prolonged medical care, may apply through his physician to the Bureau; payments will be arranged satisfactorily to both the physician and patient. The operation will be performed. Medical attention will be given.

(2) Friendly interviews will reveal the amount of income and the budget for necessities of the first order, i. e., shelter, food, clothes. Charges for work to be done or already accomplished may be adjusted through contact between physician and Bureau.

(3) The citizen needing medical or surgical care for himself or family may maintain his self-respect by having the work done by his family physician or surgeon. How different from entering wards of city hospitals and being operated upon by a surgeon who, although highly competent, is often not known to the patient and is the recipient of no monetary remuneration from either the patient or the state.

The Medical-Dental Service Bureau is *not* a collection agency, yet the physician, Medical Society member, may send a patient who seems hopelessly in arrears, to the Bureau with a card of introduction for a review of his resources. A plan may be worked out for the making of regular payments. Employers of labor may make deduction from pay checks with the consent of the employee. All charges, i. e., x-ray, laboratory, and personal services of physician selected, may be placed in a lump sum which is amortized monthly.

The Medical-Dental Service Bureau opened March 1, 1935. Although it appears that the Medical-Dental Service Bureau was not established primarily as a collection agency, a prominent function seems to be to arrange for instalment payment of hospital, physician's and dentist's bills.

The determination of the amount of the fee charged by the physician or dentist remains under the plan a direct agreement between the patient and the individual or individuals rendering professional services or providing facilities for those services. Whether the patient takes advantage of the service of the bureau depends upon whether the physician or dentist agrees to allow him to do so. In other words, it is the physician or dentist who sends the patient to the bureau with a card which gives the physician's or dentist's consent and which shows the amount of the bill and the services rendered to that date. When the patient or his representative appears at the bureau, he is required to give all the data concerning his financial status, viz., his income, regular expenses, and unusual expenses. From these data the bureau helps him to determine how much he can pay each pay-day on his bill or bills for medical and dental services. He is then expected to pay this amount regularly as long as the conditions exist under which he made the agreement. If other medical or dental bills accrue while he is still making payments on the original account, an adjustment is made so that all physicians or dentists who are involved receive their pro-rata amount of the installments. Of if the patient's economic status changes so that he can pay on his account faster, larger installments are determined upon. If the patient's economic status changes in the reverse direction so that he can pay only a smaller installment or nothing at all, the amount of the individual installments is decreased or the whole amount

canceled. How the physician and dentist avoid total loss when the latter conditions come about will be discussed later.

When the patient pays his installment, the bureau deducts 10 per cent for expenses and to establish a sinking fund. No interest is charged the patient. The physician or dentist is paid each month his pro-rata share of the amount collected for his bill, less 10 per cent.

The bureau is incorporated in the State of Delaware (now incorporated in the District of Columbia also) as a non-profit organization without capital stock. It is governed by a Board of Directors consisting of one representative for each 100 active members, and one extra representative for 50 or more active members beyond the last 100 members of each of the following societies: The Medical Society of the District of Columbia, the District of Columbia Dental Society, the Medico-Chirurgical Society (the Negro medical society), and the Robert T. Freeman Dental Society (the Negro dental society). The latter organization, having less than 50 active members, is represented by one director. These directors are appointed each year to begin service on the first day of March by the organizations represented in any manner of selection each society desires and serve for a period of one year, after which they must be reappointed. One director is appointed by the Hospital Superintendents' Association. The directors have general direction of the policies and running of the bureau according to the By-laws of the bureau. The services of the bureau are available to all active members of the four societies in good standing. The number of physicians and dentists who may use the bureau is, therefore, about 1,400.

The bureau has a manager whose salary is $300 per month, and one stenographer-clerk whose salary is $125 per month. If and when the board of directors deem it advisable, upon recommendation of the manager, an additional clerk-bookeeper shall be added, whose salary shall be $100 per month. Rental charge allowed shall be determined by circumstances, but should not exceed $100 per month at the start. . . . . (These details were modified somewhat during the first year of operation.)

The expenses of the bureau are met from the treasuries of the four societies, pro-rated according to the number of active members, until such time as a surplus exists, after which the monies expended by the societies shall be refunded without interest. It is estimated that $2,000 will be sufficient to finance the bureau until it becomes self-sustaining and that this amount can be returned within the first year.

If the bureau is used sufficiently by the members of the societies, a substantial sinking fund should accrue. Since this is a non-profit corporation this sinking fund could be used for one or both of two purposes. It might be used to reduce the percentage deducted for expenses; or it might be used to settle the accounts of those patients who through adversity become unable to continue payments. The latter plan will probably be adopted. . .

1. The plan relieves the physician or dentist of the time-consuming business of getting the necessary data to formulate a plan of payment for the patient. It puts the economic aspect of medical and dental practice on a business-like basis, relieving

the professional man of the unpleasant relationship with patients.

2. The patient, dealing with a business organization and knowing that he has signed a contract for payment, will be much more apt to pay regularly on his account.

3. The patient learns how to budget the expense caused by illness or the prevention of illness, and when another illness arises will be familiar with the plan.

4. The doctor is much more apt to keep his clientele intact since the patient not being in default will not find it necessary to go to other physicians or dentists for future illnesses.

5. Patients are permitted to maintain their self-respect, since there is little likelihood of defaulting carelessly. Also, they are much more willing to pay a small amount regularly to a business bureau than they are to a professional man since there is a tendency in the latter instance to consider a small payment demeaning.

6. No interest is charged the patient and, therefore, he has reason to understand that he is being rendered a service and not being exploited.

7. It is more likely that employers in general will cooperate in helping their employees fulfill their contracts for the payment of medical and dental bills.

8. If the professions get squarely behind this plan, they will go a long way to demonstrate the lack of necessity for health insurance such as is being agitated at the present time.

It appears that most patients handled by the Medical-Dental Service Bureau are referred to it by the Central Admitting Bureau for hospitals and by physicians or dentists. Few seem to come directly to the bureau, but many are now requesting their physicians and dentists to allow them to use the bureau's services.

Persons applying to the bureau to have their bills budgeted must provide the budget consultant with complete information as to income, dependents, normal expense and obligations. The consultation is a combination of a social and financial investigation. Consultants are said to be trained to create good will toward the medical and dental professions.

In addition to the consultants, the bureau employs an auditor, a cashier and a combination consultant collector and statement clerk.

Statements setting forth the advantages of the Medical-Dental Service Bureau have been distributed as payroll inserts. A typical insert reads as follows:

IMPORTANT NOTICE TO OUR EMPLOYEES

Are you neglecting your health because of an old medical, dental or hospital bill, or because you feel that the cost of treatment you need will be more than you can afford to pay?

Members of the Medical-Dental Societies, through the Medical-Dental Service Bureau, will help you solve this problem.

You may now request your physician, dentist or hospital to let you use their Medical-Dental Service Bureau. This Bureau it a part of the Medical and Dental professions and maintains a qualified staff with whom you may work out cost adjustments for all your medical care.

Through the Bureau, you may arrange small regular payments for your Medical, Dental, and Hospital bills.

THERE IS NO CHARGE FOR THIS SERVICE

This is the Medical and Dental professions' new plan to help you out in these times of money pressure.

Ask your doctor or hospital to let you use their Bureau to arrange for the payment of their bills—new or old.

Call Mr. Rawlings at the Medical-Dental Service Bureau, Metropolitan 3900 (8th and Eye Streets, N.W.) or consult your Director of Personnel for any information pertaining to this service.

The experience of the bureau seems to indicate that only 1.4 per cent of patient's accounts have fallen in arrears. It is claimed that this low percentage may be accounted for by the sales talk on the value of medicine given by the budget consultant at the time terms are arranged. It is stated that the bureau uses the Social Service Exchange, the employer and the landlord as a check on financial statements made by patients.

Both the Central Admitting Bureau for Hospitals and the Medical-Dental Service Bureau, the essential elements in the so-called "Washington Plan," were organized with the help of Mr. Ross Garrett, who graduated from the University of the State of Washington in 1923 with the degree of Bachelor of Science in Public Health. Mr. Garrett's subsequent connection with physicians in laboratory work in Boise, Idaho, and elsewhere has given him some understanding of medical practice. Mr. Garrett has also had some experience in politics. This experience seems to have given him a more direct approach to certain organization details.

The Medical Economic Security Administration in Washington, D. C., is an effort to effect an equitable distribution of medical, dental and hospital services through coordination of the available facilities. It appears that the central organization in this coordination is the Central Admitting Bureau. To this bureau patients are referred by physicians, dentists, hospital outpatient departments, firms, employers and unions, public agencies, private agencies, schools, health departments and relief agencies.

From the Central Admitting Bureau the patients are routed for necessary care through the Medical-Dental Service Bureau or the Board of Public Welfare Permit Bureau, to physicians, dentists or hospitals for appropriate care, including nursing and needed pharmaceuticals.

In this coordinated plan, the Board of Public Welfare Permit Bureau, which is housed in the same building with the Central Admitting Bureau and the Medical-Dental Service Bureau, but only from the standpoint of coordination and housing a part of the Medical Economic Security Administration, issues permits for clinic and hospital care of indigents in District-owned and operated institutions, To the Medical-Dental Service Bureau are referred the patients in the lower income brackets for private part-pay or full-pay care by physicians, dentists and private hospitals.

In many instances the fees of physicians and dentists have been reduced with their permission in order that the patients may be able to defray their expenses within from eight to twelve months.

It appears that the Community Chest plays the most important part in the plan by providing funds with which to pay for hospitalization and clinic facilities for the semi-indigent.

Information is not complete regarding the detailed cost or method of financing the Medical Economic Security Administration. It appears that the Community Chest has provided funds for the organization and operation of the Central Admitting Bureau, for the salary of the executive director, Mr. Garrett, and for the inpatient hospital facilities and outpatient clinic facilities to patients designated by the Central Admitting Bureau. The latter is now incorporated as an agency of the Community Chest.

The Medical-Dental Service Bureau was established by borrowing $2,100 from the Medical and Dental Societies of the District of Columbia. The operating cost of this bureau seems to be covered by a 10 per cent deduction from the collections made by the bureau from the low income bracket patients who have been assisted in budgeting the cost of the medical care received. The expense is therefore borne by the physicians, dentists and hospitals whose patients use the bureau. The Medical and Dental Societies of the District of Columbia

do not contribute to the operating costs of the Medical Economic Security Administration. These societies did, however, advance funds in the form of a loan, to organize the Medical-Dental Service Bureau. A sufficient reserve has been acquired to enable the Medical-Dental Service Bureau to retire these initial loans, and the Board of Directors have recently directed that the loans be paid.

Although it is believed that the development of the Medical Economic Security Administration should be credited largely to the energy of Mr. Garrett, the degree of success that has been attained has been due to the high degree of cooperation which has been secured among the numerous health and medical agencies of the community, such as the medical and dental societies, the hospitals, the health officer, the Board of Public Welfare, the Community Chest and the Council of Social Agencies. It is stated that the active opposition or even the failure to cooperate of any one of these agencies would have greatly weakened or might have caused the complete failure of the plan. It required about two years of the most intensive work and organization both within and outside the Medical Society of the District of Columbia to create a situation in which thorough cooperation of all the aforementioned agencies could be assured.

It is claimed that another important element in the Medical Economic Security Administration was the combination of several different agencies into a consolidated organization, with all agencies housed in the same building and under the control of one individual, the "Coordinator."

It is believed by those who are in control of the "Washington Plan" that the close association of these agencies in one building and the coordination of their activities by one person has resulted in the elimination of waste and duplication of efforts, and consequently has contributed to greater efficiency. Briefly, the Medical-Dental Service Bureau assists the people of moderate incomes by arranging for them a post-payment plan by which they may pay their medical bills; the Central Admitting Bureau arranges for the hospital and clinic care of the partially indigent, and the Permit Bureau of the Board of Public Welfare cares for the totally indigent.

A majority of the Directors of the Central Admitting Bureau and the Medical-Dental Service Bureau are members of the Medical and Dental Societies of the District of Columbia, and are designated by these societies to serve on the Board of Directors.

It is difficult to find anything unique in this plan to distinguish it from several other medical service plans now operating in other communities. The elements of the plan have been copied from several plans that seemed to have been found practical elsewhere. It seems clear, however, that there is a certain machinery of operation and combination of forms that might be considered characteristic of the "Washington Plan." There also seems to be a careful, studied selection of personnel for the several detailed steps of investigation, advice, record keeping and administration.

The medical service plan in the District of Columbia has attracted considerable attention. It is reported that medical societies in St. Louis, Kansas City, Joplin, Mo., Baltimore, Richmond, Va., Newark, Paterson and Elizabeth, N. J., Boston and elsewhere have either adopted the plan or portions of it, or are considering its feasibility.

No information is available to indicate what changes may be necessary in a plan that has been organized for one community, to place it in operation in another community. The Community Chest in the District of Columbia has been induced to make available an appreciable amount of money to pay for hospital facilities for those with low incomes who need hospitalization and has assumed much of the administrative expenses, especially of the Central Admitting Bureau. Without this financial assistance the Medical Economic Security Administration would have much less to offer the low income group.

Moreover, even though the financial assistance of the Community Chest might be guaranteed in other places, it is extremely improbable that any single plan can be made to operate in every section of the United States with equal success. The medical profession has always maintained that any plan to supplement existing medical facilities must conform to local conditions and requirements. The wide diversity of social, economic, industrial and many other factors make it impracticable to utilize for the benefits of every one in all sections of

the United States any plan except the regular private practice of medicine.

Group Hospitalization, Incorporated, Washington, D. C., with nine member hospitals, was organized prior to, and has no connection with, the Medical Economic Security Administration.

From the time of its organization to the close of 1935 the type and volume of services performed by the "Washington Plan" are represented in part by the following statistics:

| | | |
|---|---|---|
| 1. Number of patients handled by each bureau from the beginning to Dec. 31, 1935. | | |
| Central Admitting Bureau..... | Inpatients | 7,944 |
| | Outpatients | 34,461 |
| Medical-Dental Service Bureau..... | | 10,126 |
| 2. Disposition of patients | | |
| Referred to hospitals..... | | 6,032 |
| For free care..... | | 368 |
| For part or full pay care..... | Inpatient: | |
| | Full pay | 1,288 |
| | Part pay | 4,376 |
| Referred to free clinics..... | | 33,700 |
| Referred to physicians | | |
| For free care..... | | 9 |
| For part or full pay care..... | | 732 |
| Referred to dentists | | |
| For free care..... | | 19 |
| For part or full pay care..... | | 33 |
| 3. Gross revenue from these same patients for same period.....$ | | 187,885.04 |
| 4. Outstanding accounts (deferred payments not due) Dec. 31, 1935, to be collected from patients using bureau services .....$ | | 54,169.41 |
| 5. Other sources of revenue to | | |
| Central Admitting Bureau.....$ | | 25,000.00 |
| Medical-Dental Bureau .....$ | | ..... |
| Name sources....Community Chest | | ..... |
| ..... | | |
| 6. Distribution of gross income: | | |
| Remitted to hospitals.....$ | | 86,376.55 |
| Remitted to physicians.....$ | | 41,982.19 |
| Remitted to dentists.....$ | | 5,356.89 |
| Retained by bureaus: | | |
| Central Admitting Bureau.....$ | | ..... |
| Medical-Dental Bureau.....$ | | 8,033.28 |
| 7. Total cost of administration from beginning to December 1935 | | |
| Central Admitting Bureau.....$ | | 25,000.00 |
| Medical-Dental Bureau .....$ | | 10,477.88 |
| 8. Accumulated reserves to December 1935 .....$ | | 2,893.68 |

## WAYNE COUNTY MEDICAL SOCIETY

All plans for medical care sponsored by the Wayne County Medical Society are based on and have preserved the private physician-patient relationship.[3] For this reason, the program in Detroit has maintained unity in the medical society and has made it the center of all medical activities within the county. (Wayne County encompasses Detroit and some twenty suburban communities with a combined population of approximately 2,000,000 people.) The society was incorporated "not for profit" in 1902 and has been organized to meet problems with flexibility as they arise. It has an active membership of 1,600 physicians.

Financial administration is based on a division of the population into the following four income classes, with corresponding departments of the society operating to handle the specific problems presented by each. In all cases the patient is given free choice of physician, and financial arrangements are kept secondary and apart from questions of medical service.

1. The well-to-do. This class has the ability to secure medical care when necessary, and therefore presents no organization problems.

2. The unemployed on public charity. To meet with the needs of this class the Medical-Dental Bureau was formed to work in cooperation with the governmental relief organizations, particularly the local welfare commission.

3. The unemployed not on public charity. Persons in this class are served by the Medical-Dental Aid.

4. The employed on small wages or salaries. For this class the Medical Service Bureau of Wayne County Medical Society was established.

### MEDICAL SERVICE BUREAU

The expenses of minor illnesses can usually be met out of even low incomes. A major disability requiring lengthy treatment and operation or hospital care may be truly catastrophic. If costs appear too great, necessary medical care may be unduly postponed. The actual giving of medical care is the same in all classes. All

3. Burns, W. J.: Wayne County Medical Society Detroit Demonstration, J. Indiana M. A. 28: 138-140 (March) 1933; Detroit M. News 26: 1-2 (Dec. 31) 1934.

members of the county medical society automatically become the active staff caring for all patients, without regard to financial arrangements. Nurses, dentists, hospitals, laboratories, pharmacists and all others necessary to give medical care cooperate wherever necessary.

Any person desiring medical service is referred to the Medical Service Bureau, located in the headquarters of the Wayne County Medical Society, and asked to fill out a financial statement much like that required for a loan on installment credit. On the basis of this statement and all other available information the plan of payment is prepared in cooperation with the patient. Financial arrangements are based on the size of installments the patient is able to pay, but the total indebtedness is so adjusted that the period of payment will usually not exceed one year.

The patient is then referred to the physician of his choice, who fixes his fee with regard to the facts as to the patient's ability to pay. The physician also arranges for hospital, laboratory or other services through the agency of the bureau. The financial details are handled exclusively by the bureau to which the patient makes his payments. When received, collections from the patients are distributed in the following manner: The first $25, which is a trifle less than half of the average hospital bill, goes to the hospital. Subsequent collections are distributed, with half going to the hospital and half being prorated among the professional people who cooperated in giving services. The bureau makes a service charge of 10 per cent on all money collected. The patient pays no interest or additional assessments.

While no separate constitution exists for the organization of the bureau and all financial control is vested in the trustees of the Wayne County Medical Society, immediate operating policies are determined by a Board of Arbitration composed of three representatives from each of the organizations of the physicians, dentists, nurses, pharmacists and hospital executives.

To date (Aug. 1, 1936), after twenty-nine months of operation, the bureau has collected and distributed to its cooperating agencies $182,687.65, received from 3,279 patients who preserved their self-respect and escaped public charity in spite of catastrophic illness

(63.6 per cent required hospitalization). Considering the near indigency of these people, the bureau's contribution to the taxpayers of Detroit is a most important consideration. As a matter of fact, one of six patients at the Medical Service Bureau actually had applied for charity before coming to the bureau.

### MEDICAL-DENTAL BUREAU

In recent years there have been a considerable number of unemployed who have managed to live without becoming recipients of public relief. These are usually compelled to use all their remaining resources for food, clothing and shelter and can pay little or nothing for any other necessity.

The Medical-Dental Aid Bureau seeks to assist this anomalous group by determining the exact financial condition of the patient and refers him to the physician of his choice among about 600 members of the county medical society who have volunteered cooperation. In most cases, the bureau's efforts result in maintaining or restoring the family physician-patient relationship. Control is vested in a joint committee composed of three members of the Wayne County Medical Society and three dentists representing the Detroit District Dental Society. This bureau does not fix fees or make collections. While no extensive system of records or red tape is used which would permit the giving of exact figures, it is estimated that about 5,000 persons per year receive service through this bureau. Considerable newspaper publicity at its inception made the public generally aware of its existence and scope.

### MEDICAL-DENTAL BUREAU (E R A)

This bureau was organized to cooperate with the F E R A and other government relief agencies. The executive secretary of the Wayne County Medical Society is the health service coordinator. Medical services and their administration are controlled and managed by a joint committee composed of three representatives from each of the following organizations: Wayne County Medical Society, Detroit District Dental Society, Detroit Branch of the Michigan State Nurses Association and the Retail Druggists Association.

All payments for medical service as well as administration have been made from relief funds which hitherto have been predominantly from federal sources. The medical society houses this bureau at no charge. Fees were fixed by agreement between the state medical society and the state emergency relief administration. Only those on relief rolls are eligible for this free medical service. The patient does not apply to the bureau, but goes directly to his own physician, who gives the service and then telephones the bureau, which checks the welfare status of the patient and issues an authorization to the physician. The patient has a choice among all licensed physicians who are willing to accept the terms of service.

### COOPERATION WITH HEALTH DEPARTMENT

The Chamber of Commerce of the United States has three times awarded first place in its National Health Conservation Contest to Detroit. It may be assumed, therefore, that the society's program of medical participation in preventive medicine and public health activities is a decided success.

The plan of operation is completely in accord with the general principles that have been maintained in all phases of medical care in Detroit. For the function of preventive health work, the Wayne County Medical Society forms a group to cooperate with the Department of Health. All details of administration and operation that concern both parties are determined by joint agreement.

The central purpose is to enlist every physician in the practice of preventive medicine as a part of his regular practice. A joint statement by the two men who have been most prominent in developing the plan follows:[4]

> The ultimate objective of the plan is to have the family doctor take care of his patients in health, as well as in time of illness. Another objective is to re-educate the public to look to the physician in private practice for such preventive services as diphtheria protection, smallpox vaccination and periodic health examinations, rather than to depend upon public agencies and free clinics—in short, to impress upon the public

4. Vaughn, H. F., and Geib, L. O.: The Doctor's Office as a Health Center, Clin. Med. & Surg., May 1934, p. 231. See also, Studies on Completeness of Diphtheria Immunization in Detroit, Detroit Department of Health, 1935.

mind the fact that preventive medicine is a purchasable thing, and something that is to be paid for in the same manner as any other desirable commodity.

About 1,100 physicians cooperate in the plan, and have, in effect, made every one of their offices a branch of the Detroit Department of Health and a center for preventive medicine. An intensive educational program is conducted to impress on the public the need of preventive measures. Those in need of immunization or other preventive work are urged to pay their family physicians for such service, but if they are unable to pay, the physicians who have agreed to cooperate have set aside certain office hours during which such preventive services are given. The Department of Health pays a reduced fee (about half what is charged to those able to pay) to the physicians and also furnishes the essential materials.

This plan enables the Department of Health to use all available organs of publicity and education in support of preventive medicine and to assure every person, without regard to income, that preventive care is available. The plan was first introduced for immunization against diphtheria and succeeded in reducing the morbidity and mortality from this disease below that of any other city of comparable size and to but a fraction of the rate in any large city with compulsory insurance or any form of state medicine.

Other forms of preventive medicine have been added, including a campaign against tuberculosis. Children and adults are urged to visit their regular physicians for examination and a tuberculin test, materials for which are furnished by the Department of Health and distributed through the Wayne County Medical Society. A roentgenologic examination is given on recommendation of the physician with arrangements for payment or gratuitous service according to the resources of the patient.

The Wayne County Medical Society, in cooperation with the Board of Health and with any special societies interested in the problem, maintains a Tumor Registry for the purpose of discovering, registering and following up all cases of cancer in the county.

This plan was initiated by a branch of the county medical society over six years ago and has been gradu-

ally extended and expanded as experience showed its value. This method of gradual growth, based on experience, is characteristic of all phases of the Detroit medical program.

PUBLICITY

The Detroit Department of Health, in cooperation with the Wayne County Medical Society, conducts a continuous and extensive publicity that utilizes practically all available agencies to enlist interest in the plan of preventive medicine already described. The Wayne County Medical Society also uses various organs of publicity to carry health information to the public. There is a weekly broadcast over a local station by members of the county medical society on timely health subjects. A Speakers' Bureau arranges for addresses by physicians before various civic organizations. The society publishes the *Weekly Bulletin* for its members. An Information Bureau, maintained at the society headquarters, is available to every one for any sort of information on medical matters. There is such close cooperation with the press that the society has become the main source of medical news.

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