

**ORGANIZED
PAYMENTS
FOR
MEDICAL
SERVICES**



**Bureau of Medical Economics, American Medical Association
Chicago
1939**

Organized Payments for Medical Services

A Report Prepared
by
Bureau of Medical Economics
American Medical Association

1939

AMERICAN MEDICAL ASSOCIATION
535 NORTH DEARBORN STREET
CHICAGO, ILL.

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CONTENTS

	PAGE
INTRODUCTION	5
CHAPTER I, CONSISTENT PROGRESS.....	7
Care of Indigent Sick.....	9
Contract Practice.....	11
Action on Sickness Insurance.....	12
Social Security Legislation.....	14
Hospital Insurance.....	18
National Health Program.....	21
A Uniform Policy.....	24
CHAPTER II, CARE OF THE INDIGENT.....	28
Public Duty to Care for Indigent.....	30
Development Since 1930.....	30
Federal Emergency Relief Administration.....	33
Medical Society Experiments.....	35
Development in County Medical Society Plans.....	36
Lump Sum Contract.....	39
Medical Society Surveys.....	42
Plan with Fee Schedule.....	43
Necessity of Medical Society Cooperation.....	50
CHAPTER III, EFFECTS OF SOCIAL SECURITY LEGISLATION	54
Effects on Maternal and Child Welfare.....	55
Medical Society Cooperation.....	56
Michigan Filter System.....	58
Maternal Welfare in Pennsylvania.....	60
Development of Public Health Services.....	62
Cooperation in Michigan.....	63
Legal Provisions in Wisconsin.....	66
Relief Plan in Washington.....	67
CHAPTER IV, FARM SECURITY ADMINISTRA- TION	70
Types of Plans.....	71
Pooled Fund Plans.....	72
Loan Plans.....	77
Contract Association Plans.....	81
State Agreements.....	83
Extent of Plans.....	86
Arrangements for Clients.....	87
Experience Gained.....	88

	PAGE
CHAPTER V, MEDICAL CARE ARRANGEMENTS ORGANIZED BY MEDICAL SOCIETIES.....	90
Postpayment Plans.....	90
Prepayment Medical Care Plans.....	98
Unit Service Plans.....	99
Cash Indemnity Plans.....	108
Modified Cash and Unit Plans.....	115
Credit and Collection Bureaus.....	120
Other Medical Service Plans.....	120
Medical Service Plans in Industry.....	121
Medical and Hospital Benefit Organizations.....	130
Union and Fraternal Arrangements.....	139
Attitude of Medical Profession.....	141
Cash Versus Service Insurance.....	144
Deception of Insured.....	147
Extension of Cash Systems.....	148
Legislation	150
CHAPTER VI, GROUP HOSPITALIZATION.....	153
Form of Organization.....	153
Initial Funds and Sales Programs.....	156
Essentials of a Group Hospitalization Plan.....	158
Relations with State and County Medical Societies...	163
Hospital Insurance Companies.....	167
CHAPTER VII, PLANNING AN ORGANIZATION OF MEDICAL SERVICES.....	173
Place of Financial Arrangements.....	173
Importance of Prevention.....	174
Educate the Public.....	175
Investigate Before You Plan.....	175
Persons for Whom the Plan Is Intended.....	177
Confusing Classifications.....	178
Where a Problem Exists.....	178
The County Medical Society.....	181
Conclusions	182
INDEX	183

INTRODUCTION

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

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

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

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

CHAPTER I

CONSISTENT PROGRESS

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

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

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

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

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

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

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

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

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

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

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

CARE OF THE INDIGENT SICK

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

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

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

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

CONTRACT PRACTICE

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

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

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

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

ACTION ON SICKNESS INSURANCE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SOCIAL SECURITY LEGISLATION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

HOSPITAL INSURANCE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NATIONAL HEALTH PROGRAM

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A UNIFORM POLICY

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

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

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

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

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

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

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

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

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

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

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

CHAPTER II

CARE OF THE INDIGENT

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

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

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

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

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

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

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

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

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

4. Money Value of Free Medical Service, J. M. Soc. New Jersey **33**: 495 (Sept.) 1936.

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

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

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

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

PUBLIC DUTY TO CARE FOR THE INDIGENT

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

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

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

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

DEVELOPMENTS SINCE 1930

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

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

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

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

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

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

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

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

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

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

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

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

FEDERAL EMERGENCY RELIEF ADMINISTRATION

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

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

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

a pattern, the outlines of which had long been evident, for all future schemes of medical care. This section reads:

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

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

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

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

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

The Federal Emergency Relief Administration as an attempt to establish a national pattern of medical care

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

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

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

MEDICAL SOCIETY EXPERIMENTS

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

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

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

DEVELOPMENTS IN COUNTY MEDICAL SOCIETY PLANS

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

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

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

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

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

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

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

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

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

14. Footnote 13, p. ix.

4. Maintain the traditional physician-patient relationship in which the recipient needing medical care may consult a physician of his own choosing;
5. Provide compensation for all physicians rendering medical services to public assistance recipients.

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

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

1. The contract enables the county board of social welfare to budget and control expenditures for medical care.
2. Under the controlled fee schedule, an individual accounting of services rendered can be made, to permit reimbursement from state funds.
3. More adequate services were considered to be available under a contract with an organized group than is possible under other methods.
4. Clients are permitted a free choice among those physicians agreeing to the contract.
5. Compensation is provided for all physicians in the group who render services to public assistance recipients, thus eliminating a large share of the burden of free services found necessary under most present systems.
6. In addition, it was believed that the provision of a committee of physicians selected by the medical society to function as a liaison committee between the physicians and the county board of social welfare, would result in solving many of the difficulties and misunderstandings associated with the provision of county medical care.

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

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

The advantages of this plan are:

1. The individual recipient may call any physician entering into the agreement. The personal relationship between the physician and the patient is thus maintained.
2. All the doctors have an opportunity to share in the counties' expenditures for medical assistance.

15. Footnote 13, pp. ix-x.

16. Footnote 13, p. xi.

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

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

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

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

LUMP SUM CONTRACTS

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

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

WITNESSETH:

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

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

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

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

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

COUNTY OF WASHINGTON, STATE OF IOWA

By Chairman of County Board of Supervisors

ATTEST:

..... County Auditor

By Committee

COOPERATION WITH HEALTH DEPARTMENT CONTRACT

THIS AGREEMENT, made the day of January, 1934, between the Board of County Commissioners of Butler County, State of Kansas, of the first part, and Butler County Members of the Butler-Greenwood County Medical Society, of the second part:

WITNESSETH:

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

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

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

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

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

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

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

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

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

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

.....

 Party of the First Part.

.....

 Party of the Second Part.

ADDENDA :

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

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

MEDICAL SOCIETY SURVEYS

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

PLAN WITH FEE SCHEDULE

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

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

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

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

Enclosure (B)

Effective September 15, 1938

\$1 for office calls.

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

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

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

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

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

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

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

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

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

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

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

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

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

FORMS FOR COUNTY CONTRACTS

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

- I. Appointment and Authorization of Agent
- II. Bid
- III. Contract

IMPORTANT INSTRUCTIONS

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

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

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

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

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

* * * * *

APPOINTMENT AND AUTHORIZATION OF AGENT

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

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

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

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

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

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

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

* * * * *

BID

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

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

Name of Agent

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

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

.....

 By.....
 Agent

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

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

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

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

CONTRACT

This Agreement made and entered into this day of A. D. 193..., by and between, by, their duly authorized agent, (Name of Agent) parties of the first part, and the Board of Supervisors of..... County, Iowa, on behalf of said County, parties of the second part, Witnesseth:

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

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

2.

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

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

Name of Agent

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

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

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

.....
.....
By.....
Agent

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

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

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

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

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

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

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

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

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

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

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

NECESSITY OF MEDICAL SOCIETY COOPERATION

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

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

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

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

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

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

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

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

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

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

Another much more detailed study made in Michigan²¹ showed that in the systems of relief in eight of the counties surveyed, which exclude many of the

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

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

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

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

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

CHAPTER III

EFFECTS OF SOCIAL SECURITY LEGISLATION

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

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

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

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

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

Certain titles in the Social Security Act are closely related to medical relief. These are: Title IV, grants-in-aid to the states to assist them in giving aid to dependent children; in making these grants the federal government contributes, within certain limits, one third of the total amount paid for aid to dependent children; Title V, grants-in-aid to states to increase the funds available for services relating to maternal and child welfare, the care of crippled children, and vocational rehabilitation; most of these grants are made on an equal matching basis; Title VI, grants-in-aid made to states for developing their public health services and assisting the United States Public Health Service to carry on scientific research.²³

SECTIONS ON MATERNAL AND CHILD WELFARE

The sections of Title V and those sections of Title VI pertaining to the development of public health services are so largely concerned with health and medical care that in a majority of the states their administration and supervision have been confided to the state

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

health departments. The administration of services to crippled children has also been allocated to state health departments in some cases. Aid to indigent children under Title V is usually administered by the state department of public welfare, state board of charities, or some similar department.²⁴

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

MEDICAL SOCIETY COOPERATION

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

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

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

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

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

In Ohio the State Division of Public Assistance, which administers the medical and health program of

the section on dependent children, after consultation with the State Department of Health and officials of the Ohio State Medical Association, has recommended the creation of a professional advisory committee of five in each county, to assist the county administrator and county board of public assistance.²⁵

In New Jersey the state medical society rejected the proposal that federal officials should come into the state and supervise the expenditure of funds in the maternal and child health field. As a result, the supervision of the medical work was finally delegated to the Medical Society of New Jersey. The "Field Physicians" to be appointed in New Jersey under this law are to be "local physicians in general practice with general experience in maternal welfare and child health." Such a physician is to be active in his county medical society and make regular reports to it concerning his work. He is to be chosen from three members nominated by the county medical society.²⁶

MICHIGAN FILTER SYSTEM

In Michigan the following points in regard to the administration of the maternal and child health sections of the Social Security Act were agreed to by the State Health Department and the Michigan State Medical Society:²⁷

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

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

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

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

26. The Field Physician, *J. M. Soc. New Jersey* 34:482 (Aug.) 1937.

27. *J. Michigan M. Soc.* 35:415 (June) 1936.

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

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

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

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

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

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

Although questions were raised as to the possible effect of governmental funds and political influence on

this program, the medical profession participated in the program with the same objective of maintaining high standards of medical service and the principles of practice most essential to public welfare as is the motive in private medical practice.

In a few instances medical directors or other officials who were physicians were placed on a salary, but the great majority of the administrative work required in organizing and conducting the medical features of the Social Security Act was contributed freely and willingly by state and county medical societies.

MATERNAL WELFARE IN PENNSYLVANIA

The Commission on Maternal Welfare of the Medical Society of the State of Pennsylvania submitted the following program of cooperation with the Bureau of Maternal and Child Health of the Pennsylvania State Department of Health. This program is suggestive of the work undertaken by state and county medical societies in furthering cooperation in this field.²⁸

I. *The State Medical Society.*

A. Maternal Welfare Committees.

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

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

B. The State Medical Society should encourage the formation of obstetric sections in the larger counties, and joint hospital obstetric staff conferences in smaller communities to which all practitioners should be cordially invited.

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

- C. Encourage the development of the newly created Scientific Section on Obstetrics and Gynecology in the State Society.
- D. See that more articles dealing with obstetrics are published in the *Pennsylvania Medical Journal*.
- E. Help secure more extensive and better training in obstetrics for interns.
- F. Secure better technic among physicians through extension of graduate training in obstetrics throughout Pennsylvania.

II. *The State Department of Health.*

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

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

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

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

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

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

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

- C. *Education of the Public.* The important task is to teach the people what good obstetric care is and how they can get it. This can best be begun by the public health nurse. Realizing that the nurse must first be helped in this work, plans were discussed for institutes and various plans for refresher courses, as given in some other states, the education of the public to be continued by the establishment of prenatal clinics in various communities, especially in outlying districts where there is little conception of what prenatal care really means.
- D. *Survey Analysis of Maternal Deaths.* If notices of maternal deaths could be sent promptly from Harrisburg to chairmen of maternal welfare committees of the county medical societies, it would help greatly, especially in the counties where an effort is being made to analyze such deaths.

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

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

DEVELOPMENT OF PUBLIC HEALTH SERVICES

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

One of the developments under this Section of the Social Security Act has been the extension of whole-time county health services. The additional funds made available and the interest aroused have led to a rapid increase in such county health departments. These

increased in number from 615 in 1935 to 946 in 1936.²⁹ No accurate report is at present available to show the increase in the number of such health departments since 1936. These local health services are largely dependent upon subsidies from sources outside the counties in which they are located. "Of the 946 counties, townships, or districts with health service under whole-time local health officers at the close of 1936, 926 or 97.7 per cent were receiving financial assistance for the support of their health service from one or more of the following agencies: The State Board of Health, the United States Public Health Service, the Rockefeller Foundation, the American Red Cross, the American Women's Hospital Fund, the Rosenwald Fund, the Commonwealth Fund, and the Milbank Memorial Fund."

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

COOPERATION IN MICHIGAN

The following instructions issued by the Public Relations Committee of the Michigan State Medical Society to all county medical societies on the organization of

²⁹. *Extent of Rural Health Service in the United States, December 31, 1932, to December 31, 1936, Public Health Reports 52: 1662 (Nov. 19) 1937.*

county health units set forth the attitude and policies which have been suggested by organized medicine in relation to the extension of public health activity in that state.³⁰

* * * * *

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

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

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

1. Through cooperation with other interested groups.
2. Through newspaper stories.
3. Through a Speakers' Bureau (to contact Lions, Kiwanis, Parent-Teacher Associations, etc.).
4. Contacts with public officials.

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

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

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

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

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

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

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

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

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

The Michigan State Medical Society has also made a contribution to the operation of that section of the federal Social Security Act which deals with crippled children. This is the establishment of what was described in the previous chapter as the "filter system," which functions as follows:³¹

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

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

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

1. An Economic Filter: a social servicing agency which shall determine:

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

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

The "afflicted children's" act is a state act, but the "crippled children's" act is a part of the federal system of Social Security. This filter system has now become a legal part of the operation of Social Security in Michigan by an executive order issued by the governor on June 4, 1936, providing that no state money shall be paid for the care and treatment of afflicted or crippled children until there shall have been a physical examination by the Medical Committee of the Filter Board.³²

LEGAL PROVISIONS IN WISCONSIN

In Wisconsin the method of organization of medical care for the indigent through contracts by county medical societies described in the previous chapter has been given legal recognition and has been extended in connection with pensions for the aged, the blind, and dependent children to cover the care of the "medically indigent."³³ This is done through the following Section of Chapter 148 of the Wisconsin Statutes:

Sec. 148.01 (3). The state society, or a county society in manner approved by the state society, may undertake and coor-

^{32.} Footnote 31.

^{33.} Keith, George M.: *Social Security Aids; Medical Examinations and Care in Their Administration*, Wisconsin M. J. 37: 418 (May) 1938.

dinate all sickness care of indigents and low income groups, through contracts with public officials, and with physicians and others, and by the use of contributions, cooperative funds and other means, provided only that free choice of physician within such contracts shall be retained and that responsibility of physician to patient and all other contract and tort relationships with patient shall remain as though the dealings were direct between physician and patient.

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

RELIEF PLAN IN WASHINGTON

In 1935 a plan, which was discontinued for lack of funds in 1938, merged Social Security and medical-dental care for the indigent in a single department.³⁴ This department, known as the State Department of Social Security of Washington, approved a plan for medical-dental care which is based on one "previously in effect under the Federal Emergency Relief Administration and follows closely the plans submitted by the Washington State Medical Association and by the Washington State Dental Association." The plan is in line with the following Resolution passed by the Washington State Association of County Commissioners in their Annual Meeting held in Yakima from June 24 to 26, 1937:

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

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

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

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

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

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

Any licensed physician or dentist who agrees to abide by the rules and regulations is entitled to practice under the agreement and can be chosen freely by any of the patients covered. A fee schedule was established with the provision that this schedule "shall be subject to prorating in keeping with the budgeted funds available for the Medical-Dental Program for the county." This fee schedule covers the following items:

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

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

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

Eye examinations (refractions and subsequent checkup) 5.00

Special physical examination or special examination by a psychiatrist in certain Child Welfare cases (not subject to prorating)..... 3.00

Requisition must read "Special—Net—not subject to prorating."

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

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

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

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

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

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

CHAPTER IV

FARM SECURITY ADMINISTRATION

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

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

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

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

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

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

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

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

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

TYPES OF PLANS

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

POOLED FUND PLANS

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

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

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

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

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

RESOLUTION PROPOSED FOR CONSIDERATION
OF MEDICAL SOCIETY

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

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

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

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

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

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

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

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

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

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

B. Preventive Services:

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

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

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

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

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

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

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

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

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

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

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

LOAN PLANS

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

RESOLUTION ADOPTED BY THE
COUNTY, MEDICAL SOCIETY

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

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

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

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

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

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

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

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

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

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

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

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

A description of the operation of this type of agreement is as follows:³⁵

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

³⁵ Journal of Iowa State Medical Society 28: 108 (March) 1938.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CONTRACT ASSOCIATION PLANS

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

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

..... COMMUNITY COOPERATIVE
MEDICAL ASSOCIATION

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

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

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

Membership privileges include:

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

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

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

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

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

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

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

STATE AGREEMENTS

Agreements have been worked out for a medical care program by the Farm Security Administration with state medical societies in Alabama, Arkansas, California, Colorado, Georgia, Indiana, Iowa, Louisiana, Mississippi, Missouri, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin. An

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

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

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

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

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

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

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

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

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

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

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

In the event that clients make excessive demands on doctors for unnecessary services, such fact shall be reported to the local

administrator who will consider this fact in judging the client's eligibility for further benefits of any character from the Farm Security Administration.

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

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

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

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

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

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

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

As indicated in this letter, some of the state medical societies require that the plans for each county be approved by a committee of the state medical society before being placed in operation. Other state medical societies, such as Delaware, Maine, Maryland and New Hampshire, have under consideration agreements proposed by the Farm Security Administration.

EXTENT OF PLANS

Farm Security Administration plans for medical care of clients in operation or proposed as of January 1, 1939, are shown in table 1.

TABLE 1.—*Farm Security Administration Plans Jan. 1, 1939*

State	Number of Counties	
	Operating	Proposed
North Dakota.....	1*	—
South Dakota.....	1*	—
California	1*	—
Alabama	4	20
Arkansas	58	12
Georgia	7	23
Iowa	2	—
Indiana	2	14
Mississippi	14	36
Missouri	13	7
Ohio	8	8
Oklahoma	19	7
North Carolina.....	5	—
Tennessee	3	—
Virginia	2	—
Texas	25	—
Total	165	127

* State-wide plans.

There is some indication that district plans may be developed in certain states to include several counties which have a relatively small number of Farm Security families. State-wide corporations have been established in North Dakota and South Dakota to receive grants from the Farm Security Administration to meet the unusual situation caused by repeated drouths. A state-wide corporation has also been recently organized by

the Farm Security Administration in California to provide a medical care program for the migrants from the "dust bowl" areas.

As of January 1939, medical societies in 30 states have cooperated with the Farm Security Administration in the organization of medical care plans for low-income farm families. Out of the total estimated one-half million Farm Security families in the country, it is reported that approximately 100,000 families now receive medical services from some 165 operating Farm Security Administration plans. At least 127 Farm Security Administration plans are proposed and it is expected that a total of 200,000 Farm Security families will be enrolled.

ARRANGEMENTS FOR CLIENTS

The amount of money loaned to farm clients by the Farm Security Administration for the purpose of paying for medical services varies considerably but usually averages somewhere between \$12 and \$30 per year for a family. Under certain circumstances when it is impossible for the client to make an additional loan, or if the client's ability to repay a loan is not good, it is sometimes possible to obtain a subsistence grant to meet necessary medical bills.

The arrangements for the medical care of the Farm Security Administration clients usually provide a general practitioner's services. If obstetric care or medicines are required, a special charge may be made. The provision for hospitalization, x-ray services, emergency dental care, and drugs is sometimes borne by the State Welfare Board or in some of the arrangements, as has been indicated, a portion of the funds placed with the trustee are pooled for the provision of such special services.

Noticeable preference has been shown by the administrators of the Farm Security Administration for the first type of arrangement whereby a trustee or a corporation receives a monthly or annual prepaid sum from

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

EXPERIENCE GAINED

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

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

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

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

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

CHAPTER V

MEDICAL CARE ARRANGEMENTS ORGANIZED BY MEDICAL SOCIETIES

The preceding three chapters have outlined the activities of medical societies concerning medical care plans for the indigent, medical care programs under the Social Security Act and medical care plans for destitute or low-income farm families under the Farm Security Administration. In addition, county medical societies have experimented with many other arrangements for the distribution of medical services. These can be classified into four main types: (1) postpayment plans, (2) prepayment plans, (3) credit and collection bureaus, and (4) group hospitalization plans.

This chapter will be devoted to the first three types of arrangements, which are primarily concerned with medical care. Chapter VI will deal with group hospitalization plans, which are mainly concerned with organizing payments for hospital service.

POSTPAYMENT PLANS

At present, throughout the United States at least twenty-two county medical societies, in cooperation with dentists and hospitals, have organized postpayment plans, commonly known as "medical-dental service bureaus."³⁶ These medical-dental service bureaus enable persons in the low-income group to receive medical, dental and hospital care at rates reduced according to the person's ability to pay, with the payments arranged on an instalment basis requiring no interest or carrying charges.

Medical-dental service bureaus were developed in the midst of the depression to assist persons in the low-

36. Organization of Medical Services, Bureau of Medical Economics, American Medical Association, Chicago, 1937. Medical Service Plans, Bureau of Medical Economics, American Medical Association, Chicago, 1935.

income group to obtain medical services and to aid the physician in determining that the patient's financial status was such as to warrant free services or reduced charges. It was believed that such an agency could arrange for an equitable reduction of charges by the physician, the dentist and the hospital by combining the several bills into one bill that the patient could pay with regular monthly instalment payments fitted to his budget.

The medical-dental service bureaus were, therefore, conceived as a sort of financial counselor to assist the patient in budgeting his medical bills and to assist the physician in determining his charges more accurately according to the patient's ability to pay.

Prior to 1934 the idea of a postpayment plan was considered by several medical societies but the Medical Service Bureau (sometimes called the Pino plan) of the Wayne County Medical Society, Detroit, which began operation in February 1934 is generally considered the first postpayment plan. A description of the original plan is as follows:

MEDICAL SERVICE BUREAU OF THE WAYNE COUNTY MEDICAL SOCIETY

DETROIT, MICHIGAN

Purpose.—The Medical Service Bureau was organized to supply complete medical service to employed people of modest income, when they need it, and on terms they can afford to pay. It commenced operation on Feb. 16, 1934, and is located in the Wayne County Medical Society Building, 4421 Woodward Avenue, Detroit.

Control.—The Bureau is under the financial control of the Board of Trustees of the Wayne County Medical Society. Its operating policies are decided by an advisory board composed of three representatives from each of the following organizations: Wayne County Medical Society, Detroit District Dental Society, Detroit Branch of Michigan Nurses Association, Detroit Retail Druggists Association, and the Hospital Executives. These five professional groups are working together to provide high-grade service for the employed worker of small means.

How the Bureau Operates.—When a patient applies to the Bureau for assistance in obtaining medical service, he is given an investigation and referred to the doctor of his choice. The doctor diagnoses the illness and, when necessary, obtains the services of hospital, specialists, etc., through the Bureau. All who supply service send bills to the Medical Service Bureau which are charged to the patient. Out of his weekly wages the patient pays to the Bureau a small amount agreed upon at the time he applied for service. These sums are based solely upon the patient's ability to pay; his total indebtedness is so adjusted that the period of payments will not exceed one year. When received, collections from patients are distributed to the cooperating professional units in the following manner: the first \$25.00 (approximately 50 per cent of average hospital bill) goes to the hospital. Subsequent collections are distributed: half to the hospital and half prorated among the professional people who cooperated in the service. The Bureau makes a service charge of 10 per cent on all monies collected. No assessment is paid by the patient.

Illustration.—John Brown applies to the Bureau for assistance in obtaining surgical service and estimates that he can pay \$25.00 down and \$10.00 per month. Service is rendered by Dr. Jones \$40.00, Dr. Watts \$10.00 and Harper Hospital \$60.00. John Brown's account would be entered as follows:

<u>Charges</u>	<u>Dr.</u>	<u>Cr.</u>	<u>Balance</u>	<u>Distribution of Collections</u>			
				<u>Dr.</u>	<u>Dr.</u>	<u>Harper</u>	<u>Service</u>
				<u>Jones</u>	<u>Watts</u>		<u>Fee</u>
Dr. Jones....	\$40.00						
Dr. Watts....	10.00						
Harper	60.00						
Total Charges.			\$110.00	\$36.00	\$9.00	\$54.00	\$11.00
Payments:							
Down Pay'mt		\$25.00	85.00			22.50	2.50
2nd Month...	10.00	10.00	75.00	3.60	.90	4.50	1.00
3rd Month...	10.00	10.00	65.00	3.60	.90	4.50	1.00
4th Month...	10.00	10.00	55.00	3.60	.90	4.50	1.00
5th Month...	10.00	10.00	45.00	3.60	.90	4.50	1.00
6th Month...	10.00	10.00	35.00	3.60	.90	4.50	1.00
7th Month...	10.00	10.00	25.00	3.60	.90	4.50	1.00
8th Month...	10.00	10.00	15.00	3.60	.90	4.50	1.00
9th Month...	10.00	10.00	5.00	7.20	1.80	Pd.out	1.00
10th Month...		5.00	....	3.60	.90	Pd.out	.50

The Doctor Sets His Fee.—The doctor or other professional man sets his own fee; all charges are checked by the Board of Arbitration. If reductions are necessary the Bureau obtains the consent of the doctor, etc., who worked on the case and asks him to permit his bill to be reduced to the figure which can be paid by the patient.

In two years' time this bureau served 3,065 patients. About one half of these patients were referred from physicians, one third from industry and the remainder

from charitable organizations. Total bills submitted amounted to \$293,378, with collections of \$144,409. Inasmuch as the patients served were in the very low income group—an average of one out of six having applied to a free clinic—it was considered worth while to have assisted 62 per cent to pay their medical accounts completely or to have kept their payments up to date. Bad debts amounted to only 5.4 per cent of the total charges during this two-year period. The plan actually enabled persons in the low-income group to receive rate reductions and credit instead of charity.

Early in the operation of the plan the hospital administrators expressed dissatisfaction because hospitals lacked sufficient capital to carry accounts over a long period when direct costs for food, laundry, nursing, etc., had to be met regularly. Despite the special arrangement whereby hospitals immediately received the first \$25 or approximately 50 per cent of the average hospital bill, four hospitals withdrew from the plan in November 1935.

Medical societies in the more populous counties throughout the United States organized similar bureaus. A brief description of one well known bureau is as follows:

MEDICAL-DENTAL SERVICE BUREAU, INC.

WASHINGTON, D. C.

The Medical-Dental Service Bureau was incorporated in the State of Delaware and the District of Columbia, and began operating March 1, 1935, as a non-profit organization without capital stock. It is governed by a Board of Directors, elected by the members of the following societies: Medical Society of the District of Columbia, District of Columbia Dental Society, Medico-Chirurgical Society (the Negro medical society) and The Robert T. Freeman Dental Society (the Negro dental society). These societies elect one member to the Board of Directors for each 100 active members and one for 50 or more active members beyond the last one hundred. One director is appointed by the Hospital Superintendents' Associations.

The services of the Bureau, which are available to all active members of the four societies, provide an investigation of the patient's economic status and an arrangement with him for

instalment payments of hospital, physician's and dentist's bills. The director employs a manager and clerks to carry on the operation of the Bureau.

The expenses of the Bureau were met by the treasuries of the four societies, prorated according to the number of active members, until the Bureau earned enough to pay its own expenses. The Bureau's income is derived from a 10 per cent deduction of each payment it collects for its members.

The Bureau does no advertising nor does it attempt to contact patients. The physician, dentist or hospital decides whether the patient shall be entitled to the services of the Bureau. The physician, dentist or hospital determines the amount of the fees to be charged, and if they wish, they send the patient or the head of the family to make arrangements with the Bureau for payment of the bill.

A person who is sent to the Bureau by a physician, dentist or a private hospital is required to give the Bureau all necessary data on his financial status, viz., income, regular and unusual expenses. From this information the Bureau aids him in working out a plan of instalment payments that will be within his ability to pay. If a person's financial situation changes, new arrangements can be made with the Bureau.

From the instalment payments the physicians, dentists and hospitals who have rendered the services are paid their pro rata share after 10 per cent has been deducted by the Bureau for expenses. No interest is charged the patients on unpaid balances. It is intended that any surplus that may accumulate will be used to settle accounts of patients who through adversity are unable to continue payments.

The Medical-Dental Service Bureau also accepts persons referred to it by the Central Admitting Bureau for Hospitals which is a filter system to determine the economic status of persons deserving free hospital services. The totally indigent are sent to the Permit Bureau of the Board of Public Welfare to be placed in state maintained institutions. The semi-indigent in need of hospitalization are handled by the Central Admitting Bureau which may send them to the Medical-Dental Service Bureau to make arrangements for instalment payments. In those cases where the Medical-Dental Bureau arranges to collect only a part of the hospital bill, the Community Chest contributes funds through the Central Admitting Bureau to supplement the patient's payments.

The advantage of the Medical-Dental Service Bureau plan is that it encourages patients to budget medical care expenses along with their other expenses, and therefore they are better prepared to pay for needed medical care. The plan also relieves the physician and dentist of the time-consuming business of trying to obtain the necessary information and data of a patient's economic status in order to arrange their fees according to the patient's ability to pay. The plan does not interfere

with a patient's choice of a physician and maintains the personal relationship between a patient and his physician. The cost of the administration of the Medical-Dental Service Bureau is borne by the physicians, dentists and hospitals.

In a two-year period, the Medical-Dental Service Bureau served 2,076 patients, receiving instalment payments of \$118,000 out of a total of \$198,000 billed. The average obligation incurred by patients served through the Medical-Dental Service Bureau was \$95 and was ordinarily paid in monthly instalments of \$10. About one third of the patients were also found to have some other obligation such as a small loan or an instalment account.

The Medical-Dental Service Bureau in Washington had an experience somewhat similar to that of the Medical Service Bureau in Detroit in regard to hospital accounts. The hospital administrators decided that the 10 per cent retention fee was too costly and created a Department of Records and Accounts to collect the hospital accounts at cost. However, after a year of operation under this arrangement, it was found that the costs were 9.44 per cent, but it is believed that the net savings warrant the collection of the hospital accounts separately from the Medical-Dental Service Bureau.

Another arrangement of the postpayment plan is as follows:

MEDICAL SERVICE BUREAU
SEDGWICK COUNTY, WICHITA, KANSAS

The Medical Service Bureau of Sedgwick County was established March 15, 1937. The Bureau's headquarters are in Wichita, and it is directed by a committee of six. Three of the members are appointed by the County Medical Society and three by the Wichita Community Chest. An experienced case worker is employed to operate the Bureau and to investigate and to prepare reports on a patient's economic status. The Wichita Community Chest contributed \$1,000 to the Bureau to pay for the services of the case worker. The County Medical Society provided office space and equipment for the operation of the Bureau.

The purpose of the Bureau is to aid the people in the low-income group in obtaining medical care at a cost within their ability to pay. The Bureau acts as a filter system to investi-

gate the person's financial status, and if the person is found to be in the low-income class, he is referred to the physician of his choice. The Bureau sends the physician a report on the patient's economic condition and the amount he will be able to pay for medical care in weekly or monthly part-payment instalments over a 12-month period. The physician can then arrange his fees to fit the patient's ability to pay.

In May 1938, the Bureau reported that it had handled 700 cases during the 13 months it has been in operation. Eighty per cent of the cases handled showed an income of less than \$60 a month. In making up a budget for these families, the Bureau found that on an average, a surplus of \$4 a month was available for medical care. The Bureau referred 79 per cent of these patients to their family physician. The majority of the patients were children, referred to the Bureau by school nurses or physicians. The total number of patients were classified according to medical treatment needed and were as follows :

1. Glasses	235
2. Tonsillectomies	104
3. Medicine	161
4. X-ray (Chest)	47
5. Examinations	42
6. Venereal	37
7. Obstetrical	32
8. Surgery	28
9. Dental	23
10. Orthopedics	15

The Bureau assumes no responsibility for the collection of physicians' fees. It simply works out a budget which includes medical care costs, after the necessary amounts for food, clothing and shelter have been provided for, with the payments according to the patients' incomes and expenses. The Bureau performs an additional service that the individual physician does not have time to do himself in that it filters out patients financially able to pay regular fees from obtaining medical care at reduced rates, and the totally indigent who are provided with medical care by the county or state from obtaining free medical care.

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

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

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

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

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

ties in California and by 1935 central admitting bureaus were established in Midwestern and eastern cities.

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

PREPAYMENT MEDICAL CARE PLANS

The development of methods for organizing payments for medical services has been a subject of much controversy, especially since the depression years beginning in 1930. Literally thousands of articles and hundreds of plans for distributing medical services on some group payment basis have been publicized. Innumerable newspaper stories have been printed to the effect that the medical profession opposes "socialized medicine" or plans for group payment of medical bills. When the term "socialized medicine" is used in the sense of some arrangement for government control of medical services for individual persons in the general population, it is true that the medical profession objects to such state-managed systems. However, when the term is more properly used to include the variety of arrangements whereby individuals receive medical ser-

vices without directly paying physicians or without being required to pay at all, it is evident that such group payment or what might be called "socialized medicine" plans are not opposed by the medical profession. As a matter of fact, the medical profession has in operation more experiments with "socialized" methods of distributing medical services than all the proponents of socialized medicine have ever proposed.

The prepayment or group payment medical service plans that have received consideration from medical societies vary extensively in details but can be classified into two main types:

First, medical service plans on a *unit service basis* whereby an organization is created to collect funds from members and to provide medical services through participating physicians who agree to accept a prorated division of whatever funds are available after administrative and other expenses have been paid.

Second, medical service plans on a *cash indemnity basis* whereby an organization is created to collect funds from members and to pay a designated amount of cash to assist members in meeting their medical bills.

Under the unit service plan a schedule of the number of units to be allowed for each service is established, and the value of the unit is determined by dividing the amount of money available for medical bills by the number of units of service rendered. Under the cash indemnity plan benefits are paid according to a listing of benefits which limits the amount that can be paid to the member or on assignment to his physician. The cash indemnity method does not fix the physician's fees but does assist the member to meet his medical bills.

UNIT SERVICE PLANS

Most of the proposals to provide medical care on a prepayment basis have contemplated the organization of some unit service plan. The simplicity of this type of arrangement which entitles members to all necessary medical services with the participating physicians agreeing to divide the funds collected on an equitable basis is most appealing. Experience with this unit system

method seems to indicate that there are difficulties which must be overcome before satisfactory results can be expected.

Much of this experience has been gained under plans for the care of the indigent and low-income farm families. These plans have been described in Chapter II and Chapter IV. When participating physicians are not dependent on such plans, they can continue to provide good medical services even though they must accept whatever payments are made. The quality of the medical care under such arrangements is maintained on the momentum of the practice of medicine for private patients.

There has been little experience with the operation of a unit service plan for a large section of the population where the participating physicians are primarily dependent on the plan for the major portion of their practice. Some of the first arrangements to include persons from the general population in a unit system plan were organized in Washington and Oregon. The workmen's compensation laws in these states, contrary to the practice in most states, permit a deduction from the employees' wages to provide medical services for compensable injuries and diseases and consequently brought into existence so-called "hospital associations," which are private corporations organized to contract with employers for the provision of medical services for employees entitled to compensation. To provide the medical services, these corporations in turn contracted with physicians, hospitals, nurses, druggists and ambulance firms. Such corporations almost surreptitiously added medical and hospital care for non-compensable accidents and diseases.

A full account of the experience of these contract "hospital associations" can be found in several sources.³⁷ It is important to notice that in Washington and Oregon

37. (a) Dodd, Walter F.: *Administration of Workmen's Compensation*, The Commonwealth Fund, New York, pp. 423-436, 1936. (b) *Medical Relations Under Workmen's Compensation*, Bureau of Medical Economics, American Medical Association, Chicago, 1938.

medical service bureaus using a unit system arrangement for payment were developed by medical societies in an effort to overcome evils that had grown up under the contract arrangements controlled by private "hospital associations." A description of one such medical service bureau is as follows:

KING COUNTY MEDICAL SERVICE BUREAU
SEATTLE, WASHINGTON

The King County Medical Service Bureau of Seattle, Washington, is one of 14 bureaus that have been developed by county medical societies in Washington as a means of meeting the situation created by the workmen's compensation law which permitted private corporations to contract with employers for the provision of medical services. The King County Medical Service Bureau is a voluntary association of physicians who agree to furnish services to the King County Medical Service Corporation, a non-profit corporation that contracts with employers to provide medical and surgical care, hospitalization, nursing and ambulance services for its employees. The Corporation in turn forms an agreement with the physicians of the King County Medical Service Bureau to provide the medical and surgical services; and with hospitals, druggists, and ambulance firms to provide hospitalization, medicines, and ambulance service.

As to the method of operation, the Medical Service Corporation sells two contracts: a Medical Aid Contract which provides medical care for employees injured in the course of their employment, and a Standard Group Contract which provides care for sickness and nonoccupational injuries. In King County, only employees earning less than \$1,800 annually are allowed to participate and about 32,000 such employees are under contract with the King County Medical Service Corporation.

The Department of Labor and Industries classifies all industries in the State and stipulates the premiums which range from 1 cent to 15 cents for each day worked by an employee, to be paid into the Medical Aid Fund. One half of the premiums are paid by the employer and one half by the employees. The Medical Service Corporation receives 89 per cent of the premiums for the employees covered by the medical aid contracts, the remainder going to the State for administration of the Act and for the care of employees in need of treatment after the expiration of the contracts. The Department of Labor and Industries also draws up a maximum fee schedule for all services to be rendered employees under medical aid contracts.

The Standard Group Contract is paid for by the employee who authorizes his employer to deduct the premium from his wages. The premiums for the Standard Group Contract vary,

but range from \$1.25 to \$1.75 monthly for each employee. For the services under the Standard Group Contract, a fee schedule is agreed upon between the participating physicians and the Medical Service Corporation. A "French" unit system is used to divide the monies received in order to avoid any difference in the amounts paid to the physicians rendering service to patients under workmen's compensation (the Medical Aid Contract) and to physicians rendering general medical or nonoccupational service (the Standard Group Contract). Under this method of payment each service is allotted a specified number of units. The total number of units of service during a month is divided into the amount of money available to pay medical bills, and each participating physician is paid the resulting unit value for the units of service he has rendered.

The unit method of payment used by these bureaus in Washington and Oregon, similar to the French method of payment under compulsory sickness insurance, appears to be the origin of the unit service arrangements in the United States now being developed by medical societies for general medical care plans. For example, the by-laws of the California Physicians' Service, a state-wide plan proposed by the California Medical Association, provide:

The unit system is stated to be a means whereby each kind of service is given an arbitrary number of units and each professional member, upon rendering a particular service, is given credit for the number of units assigned to that service and at the end of stated intervals the total number of units earned is divided into the fund available and the monetary value of the unit for that period is thus ascertained.

One of the contemplated arrangements for medical care plans in Michigan is a unit system outlined as follows:

The "unit system," whereby an employed subscriber would be entitled to a maximum block of units (not dollars) of medical service, as for example:

50 calls of a physician.....	300 units
1 major operation	300 units
1 minor operation	100 units
1 fracture	150 units
Miscellaneous diagnostic service.....	150 units
<hr/>	
Total	1,000 units

All types of medical and surgical care performed by a doctor of medicine would be included, with the patient assuming the cost of minor charges for the first ten or fifteen units of service.

. . . The payment arrangement contemplates a unit fee schedule with the financial value of the unit to be determined at the end of each month. For example, if \$50,000 were collected over and above operating cost and the total number of units of service for the month were 50,000, the unit value would be one dollar. Each physician would then be paid according to the established value of the unit for the number of units of service rendered.

The following description of the experience gained by the Fulton County Medical Society in the operation of a medical service bureau outlines one method of arrangement and some of the problems encountered:

MEDICAL SERVICE BUREAU

FULTON COUNTY, GEORGIA

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 not usually furnished by the physician and are not included in this service.

Freedom of choice of physician is permitted 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. The physician 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. The

directors of the Bureau employ a manager, secretary and three part-time collectors to carry on the functions of the Bureau. The Bureau does no advertising. Persons in the low-income group are brought in by their friends or referred by their family physician.

The following income limits 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. Since 1935 a prospective member has been required to obtain a statement from a physician indicating freedom from chronic conditions.

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 enrolment fee is paid only once.

Graduated membership dues for a family group are as follows :

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

For an average family group of five, the initiation cost would be \$3.50 and the monthly dues would be \$4.25. The part-time collectors are paid 10 per cent of the membership dues.

Maternity cases are accepted if one year's dues are paid in advance with an additional delivery fee of \$10. Persons in need of a tonsillectomy are accepted on payment of one year's dues and a surgical fee of \$15. Applicants in need of other surgical services are considered individually by the Board of Directors.

A fee schedule of approximately 50 per cent of the prevailing charges in the community was established as a guide for payment for services to be rendered members. The schedule was based on charges that would ordinarily be made to persons in an income group similar to that required for membership. Each physician bills the Medical Service Bureau monthly for his services according to this fee schedule. Originally all bills were paid in full in the order of receipt at the Medical Service Bureau. When payments fell behind many physicians became dissatisfied and did not send in their bills even though

they continued to render services for members. Consequently the method of payment was changed to a monthly pro rata division of the funds available. For the fiscal period just prior to the change in payment arrangement, the total bills sent to the Bureau amounted to 7 per cent more than the total funds collected. After the deduction of administration and other expenses physicians received payments amounting to 64 per cent of their total bills and inasmuch as the fee schedule for billing equaled 50 per cent of regular charges, the payments were approximately 32 per cent of prevailing charges in the community. On the other hand, it should not be overlooked that much of the medical service rendered members would not have been provided or would have been charity service. Likewise, there is some indication of a tendency on the part of physicians to render more service than they ordinarily would have provided.

The Medical Service Bureau began functioning in April 1934 with a membership of 13. As of March 1938, the total active membership was 1,101. A total of 1,963 were enrolled, but 862 lapsed their memberships. The slow growth of the plan is attributed to many causes. First, is the lack of cooperation on the part of many physicians caused by the inability of the Bureau to pay bills submitted on a satisfactory basis. Second, is the ready access of persons eligible for membership to free services in the municipal hospital. Third, is the inability to obtain groups on a payroll deduction basis because of the foregoing factors and because of contract and corporate practice medical care plans in industries.

Following is a brief outline of another variation of the unit system plan under consideration by the Academy of Medicine of Cincinnati:

THE UNIT SYSTEM

CINCINNATI, OHIO

The Academy of Medicine on Oct. 11, 1938, voted approval of the principle of a plan for medical care, to be known as the "unit system." An enlarged committee has been instructed to work out the details of the plan and submit a report at a later date. Just how long it will take to complete these details, get them approved and start the plan to working, we cannot say. It may take several months or longer, because there are a number of problems to be solved before the plan can be definitely started.

The proposed plan embodies this general idea: An organization is to be set up by the Academy to furnish complete medical service to subscribers in the low income group for a fixed sum to be paid by the subscriber monthly. Of the money thus collected not over ten per cent is to be used for administrative

purposes. The balance, or 90 per cent, is to be distributed to the physicians furnishing the medical services, in proportion to the amount of service they have rendered. The distribution is to be made in accordance with what we choose to call "The Unit System."

Each service that the cooperating physicians may furnish will be valued in "units," and at the end of a month, or some other designated period, 90 per cent of the total sum collected in that period, will be divided by the number of units of service rendered, to fix the value of the "unit" for that particular period. The physicians will then be paid this unit of value for each unit of service they have rendered during the time period agreed upon.

When the subscriber consults the doctor of his choice, who may be any physician in the community, he will hand him a card which the doctor will sign and mail to our organization. The card will be so worded that the doctor by his signature will accept the case for such compensation as the organization will pay according to "The Unit System."

The adaptation of some form of the unit system of payment to a medical care plan for the general public calls for careful investigation of the difficulties involved.

Under such plans the members are often led to believe that they are entitled to complete medical services including all of the new and expensive developments in medical practice. As a consequence the participating physicians find that patients later request services which could not be contemplated when the plan was organized. The result is a tendency either to depreciate the value of the unit paid to the participating physician or to restrict the services that participating physicians may render to members. A depreciation of the value of the unit is ordinarily the first step taken but when the value has been reduced to a point where participating physicians complain that they do not receive sufficient remuneration to enable them to practice good medicine, the administrators of the plan are then compelled to effect economies by restricting services. These restrictions often seriously interfere with the individual physician's judgment as to the requirements of his patient. Frequently also, financial conditions imposed by the limited funds of the plan necessitate the inauguration

of practices which are not now considered desirable, such as, for instance, the use of resident physicians in hospitals to make house calls.

Some indication of the practical realization of this difficulty is shown by reports of the operation of a medical care plan on a unit payment basis for municipal employees organized by the City of San Francisco. Fees under the plan were established at 25 per cent to 75 per cent of the usual fees. In four months payments to physicians were but 50 per cent of the agreed fee schedule. As a result, several physicians are threatening to withdraw from the plan and the medical director has announced that preventive medical services will be curtailed so that the limited funds of the system can be used to provide for the necessary medical services that the sick members of the system require.

Another difficulty of the unit system is that it cannot allow for differences in ability among the physicians of like training. For example, a specified number of units must be set for each surgical operation. All participating surgeons are therefore constrained to accept the agreed number of units at whatever value may be given to each unit. Surgeons of outstanding ability will be allowed no more units for their services than surgeons who have a shorter and more limited experience. In many fields of medical practice the operation of a plan on a unit system basis will require the establishment of some standard of treatment in order that all physicians may receive the same number of units for their services. (The problem of deciding in advance what the desirable procedures in medical practice should be renders it extremely unlikely that any agency can set up all necessary standards for medical practice.) There are many physicians who consistently render services equal to, in excess of, or different from what might be the standard adopted for some administrative or fiscal agency. Furthermore, continual change and improvement in the standards of medical practice lead to prog-

ress in medicine. If physicians tolerate dictation as to all treatment procedures, they will become emasculated and irresolute.

A third difficulty is the determination of an income status for the group to be included in the unit system plan. If any income limit is specified, above which there is to be no depreciation of the unit value, experience has shown that there will be a strong movement to increase the income limit so that all persons in the community may be eligible for membership. The effect will be that persons unable to pay for medical services on a full fee for service basis will be contributing for the medical services received by members who are able to pay full fees. This in itself would not be so undesirable if the consequences were not that participating physicians are then unable to assure good medical service for all members.

It should be noted that the organizers of unit system plans strive to be absolutely honest with the members and do not attempt to deceive them as to the quality or quantity of the medical services given. Such a deception ultimately arises out of the operation of any system of insurance that attempts to offer "complete medical care" for a definite fixed premium. The progress of medical science inevitably introduces additional and unforeseen methods of diagnosis or treatment which cannot be furnished for the premium originally established.

CASH INDEMNITY PLANS

Cash indemnity plans have been proposed as an arrangement to avoid the difficulties of unit service plans. These cash indemnity plans take a number of forms and there appears to be no one "best" arrangement. The House of Delegates of the American Medical Association gave particular encouragement to the development of cash indemnity plans by adopting the following:³⁸

³⁸. Proceedings of the House of Delegates, J. A. M. A. 111:59 (July 2) 1938.

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

Likewise, at the Special Session of the House of Delegates in September 1938, it was suggested that:³⁹

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

* * * * *

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

No suggestions were made as to the particular type of organizational or administrative arrangement for such cash indemnity plans. However, the Reference Committee did suggest that county or district medical societies be encouraged with the approval of the state medical society of which they may be a component part to develop appropriate means to meet their local requirements.

In accordance with these and previous suggestions of the House of Delegates of the American Medical

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

Association, state and county medical societies throughout the United States undertook to study the possibility of inaugurating various proposals for cash indemnity medical service plans.

The Medical Society of the State of New York and several of the county medical societies have under consideration what are known as "medical expense indemnity plans"—a form of insurance that permits the individual to purchase a definite amount of benefits in cash for the payment of his physician's charges for professional services by paying specified monthly or annual premiums. It is contemplated that a payment of \$1 per month would entitle the member to an annual credit of \$150 for physicians' bills and that a payment of \$2 per month would entitle him to an annual credit of \$300.

To permit the organization of non-profit medical expense indemnity plans in the state of New York, it was found that the insurance law must be amended. The Committee on Economics of the Medical Society of the State of New York has formulated a model bill for this purpose. It is expected that this bill will be passed by the state legislature.

Medical expense indemnity plans have been tentatively approved by at least five county medical societies in the state of New York. An outline of the provisions of these proposals is as follows:

NEW YORK MEDICAL EXPENSE INDEMNITY PLANS

Name.—Associated Medical Service of.....

Purpose.—To provide medical insurance plans wherein the individual by paying a stated premium makes available to himself a definite sum of money for the payment of physicians' charges for professional services. Responsibility for the quality of the medical services can be met only if the control of the professional activities is in the hands of the medical profession itself, and this means that the medical profession must determine the qualifications of the individual physician and that no organization should dictate whether a patient may or may not have a specific therapeutic procedure.

Membership Requirements.—All persons, individuals or families, in the low-income group may be insured. The low-

income group is to be those above the level of indigency and below what would be a comfortable income for the community in question. An income level of \$1,500 or less for single persons and \$3,000 or less for families is specified for one plan. No physical examination will be required of the subscriber, but conditions existing at the time of application will not be covered under the contract.

Benefits.—Members are to be entitled to payments above a minimum incurred expense of \$10, which \$10 shall be the direct obligation of the member, up to a policy limit of \$150 to \$300 for an individual for expenses incurred by reason of professional services of lawfully qualified doctor of medicine.

Costs.—Costs are dependent on the limit to be specified in the policy. A premium of \$1 per month or \$12 per year is contemplated for policy with a limit of \$150 for an individual and \$24 annually for a benefit limit of \$300. For families, a membership charge of \$32 is estimated to provide benefits for an entire family up to an amount not to exceed \$500 during the policy year.

Payments to Physicians.—Payments will be made to the physician for services to subscribers according to an amount specified as the limit the plan can pay. If a physician's charge for a particular service is greater than the benefit specified as payable under the plan, arrangement for payment of the excess is to be made by the patient and the physician individually. Some of the proposals also provide for a monthly prorata division of the funds available for payments for medical services according to a fee schedule which will establish the value of the services rendered.

Administration.—The direction and control of the organization will be vested in a Board of Directors of not less than fifteen members. Direct representation of subscribers, lay public and individuals is usually provided with a majority of the directors representative of the medical profession.

A somewhat similar proposal is as follows:

THE DALLAS MEDICAL ASSURANCE ASSOCIATION

DALLAS, TEXAS

The following tentative plan was proposed to the Dallas County Medical Society in a report by the Medical Economics Committee. The plan was unanimously accepted and ordered filed, not with the view of putting it into immediate operation, but for future consideration.

The Dallas Medical Assurance Association, a non-profit association, is to be organized by members of the Dallas County Medical Society for the purpose of making available to the low-income group a form of prepaid medical care through a form of cash indemnity insurance.

The association will have a board of directors composed of members of the Dallas County Medical Society, representatives of the Dallas private hospitals and such individuals from the laity as will be deemed necessary to the organization.

Proposed Benefits for Subscribers

1. Subscriber shall have the freedom to choose his own physician; the Association will pay for medical services rendered in the office, the home or the hospital. Hospitalization benefits are not included.
2. The Association will, upon receipt of the attending physician's statement, pay to the attending physician or physicians his or their fee or fees for services rendered, provided such fee or fees do not conflict with any of the reservations of the policy, and provided, further, that the subscriber has authorized payment to be made directly to the physician by signing an assignment clause or power of attorney form attached to the subscriber's application blank which is made a part of the contract.

Standard Provisions

1. The Association reserves the right to cancel any contract for abuse of privilege or misrepresentation by the policyholder.
2. The policy is available only to subscribers whose net income does not exceed \$1,800.00. In case of married couples, this means the combined income.
3. The Association, when authorized to do so by a properly signed assignment clause or power of attorney, will pay cash benefits to any qualified ethical doctor of medicine.
4. The first two office visits or the first home visit for any one illness are not included in the contract benefits and must be paid by the subscriber directly to the attending physician, except in hospital or accident cases.
5. The Association only guarantees payment of the expense incurred for medical services according to the terms of the contract and is in no manner responsible for the acts or character of service performed by the attending physician. The Association does not guarantee to furnish the service of a physician to any policyholder.
6. Laboratory work and diagnostic procedures will be paid for according to a fee schedule arranged by the board of directors.

Special Provisions

The following conditions are not covered under the policy for more than three weeks.

1. Mental diseases of any type.
2. Epilepsy.
3. Tuberculosis.
4. Syphilis (above the age of 12 years).

5. Gonorrhea (above the age of 12 years).
6. Any condition which is now covered, or for which medical care will subsequently be provided, by the Workmen's Compensation Law.

Rates

1. The policy will become effective after payment of the third monthly premium and will remain effective so long as premiums are paid in advance and none of the contract provisions are violated.
2. The policy will become effective for obstetric cases after the tenth monthly premium becomes due and is paid.
3. All subscriptions shall be paid monthly and become due and payable on the first day of each month with a period of grace allowed to and including the tenth day of the month. Failure to pay any premium before expiration of the grace period automatically cancels the contract and reinstatement can be made only upon reapplication and approval by the board of directors of the Association.

Schedule of Rates

- | | |
|---------------------------------------------------------------|--------|
| 1. Subscriber (individual) | \$1.50 |
| 2. Husband and wife..... | 2.50 |
| 3. Individual and dependents..... | 2.00 |
| 4. Family (husband and wife and two or more dependents) | 3.00 |

Dependents

1. Dependent child or relative of subscriber who is totally dependent for support upon the subscriber and who is not in receipt of an income exceeding \$7.00 per week.

Physicians' Fees

1. Fees are interpreted as being the average or usual for this community.
2. The difference between the amount of fees received for the care of beneficiaries under this plan and the regular fees which the physician receives for similar services to full-pay patients represents the physician's contribution to this particular income class of patients.
3. The benefits provided under this proposal are for a low-income group of the population. It is believed that the Association would be able to collect from this group a sufficient amount in premiums to enable it to pay a reasonable proportion of the full cost of medical services as measured by the customary fees to the well-to-do. There would be little excuse for an insurance plan if full maximum fees for medical care were to be paid, since the group in question would probably not be able to pay the premium required.

Cancellation

1. The Association reserves the right to alter any part or cancel the entire contract upon written notice to the subscriber after sixty days from the effective date of the policy.

The Medical Society of New Jersey appointed a special committee in October 1938 to study cash indemnity insurance for medical societies. This committee completed its work and reported its findings as follows: ⁴⁰

1. We believe that some form of voluntary cash indemnity insurance for medical costs is practical, either through old line insurance companies, or a non-profit company to be organized along the lines of the hospitalization insurance plan with the endorsement of the State Society, or by the State Society itself.

2. We have recommended the preparation and distribution of a comprehensive brochure to the individual members of the State Medical Society, giving them at some length the results of our studies.

3. We have recommended that, if individual members, by an actual poll, show an interest and willingness to cooperate, the plan be tried out in one, or possibly two counties of this state.

A committee organized to determine the advisability of developing a medical expense indemnity plan for the state of New Jersey found that special enabling legislation would be necessary and that it would be desirable to establish a separate organization for the conduct of the plan, but under close sponsorship of the medical society. Some of the fundamental principles suggested for such a plan were as follows:

1. The plan to be on a non-profit basis with community interest.

2. All licensed physicians of the state to be eligible to participate.

3. Free choice of physician to be preserved.

4. Administrative control to be directly or indirectly vested in the Medical Society of New Jersey with administrative expenses restricted to not more than 15 per cent.

5. Local county plans to form units of the state plan.

40. Jour. Med. Soc. N. J. 36: 103 (Feb.) 1939.

6. The contract to specify a definite limit of payments not to exceed \$300 in any one year.
7. No fee schedules to be developed at the outset.
8. An income limit to be established for membership.

MODIFIED CASH AND UNIT PLANS

Several proposals for medical care plans embody arrangements that are similar to straightforward cash indemnification in that benefits are payable according to a specified schedule of payments. However, the participating physicians in these arrangements must agree to accept the payments specified whenever they provide services for members. To assure members that the funds collected will be adequate for the provision of benefits, participating physicians are asked to permit the administrative organization to retain a portion of the first payments for the establishment of a reserve. In some plans the participating physicians agree to accept a pro rata division on the unit system basis if the funds become inadequate to provide the benefits specified in the schedule of payments.

The following digest of the plan of Mutual Health Service proposed by the Medical Society of the District of Columbia is one type of modified cash indemnity arrangement:

MUTUAL HEALTH SERVICE

1710 M. Street, N.W.

WASHINGTON, D. C.

In October 1938 the Medical Society of the District of Columbia proposed the inauguration of a prepayment medical service program. In December 1938 the Committee on Medical Economics prepared an outline of a proposed plan "Mutual Health Service," which was sent to the members of the society with a ballot for approval or disapproval and suggestions. Out of the 1,718 members, 529 returned ballots with 482 votes for adoption of the proposed program.

The Mutual Health Service proposal is that an association of physicians be formed, and that all participating physicians sign an agreement to render service for members at stipulated fees during a given period of time. The following is an outline of the tentative provisions of the proposal:

Administration.—A board of eleven trustees representative of the medical society, subscribing members, and public health agencies, will administer the Mutual Health Service.

A Medical Advisory Committee of three physicians, to be appointed by the Board of Trustees, will review and decide complaints against patients or physicians, and will review and approve payment of bills. Qualifications of physicians participating will be determined by their privileges in any hospital approved by the American Medical Association or the American College of Surgery. Appeal from the decisions of this Committee may be made to the Board of Trustees, whose decision will be final.

Membership Requirements.—Subscribers of the Mutual Health Service will be limited to employed persons, in groups of not less than ten, who are under the age of sixty, are sound in body and mind, and have no pending need for service. Annual income limits also required are \$2,000 for single persons and \$2,500 or less for husband and wife, with an additional allowance of \$200 for each dependent. At least 70 per cent of the eligible persons in any group must participate.

Dependents of the subscriber include the wife or husband, any child or legal ward under the age of twenty-one years and not earning in excess of \$15 a week, and any other relative who is wholly dependent upon the subscriber for support.

Benefits.—Subscribers are to be entitled to surgical and medical care including office, home, and hospital calls, obstetrical care, consultant service, laboratory service, and services of anesthetists.

The total amount of services which any one subscriber may receive is limited to \$250 for a single person, \$350 for a husband and wife, and \$450 for the entire family.

Limitations.—Medical and surgical services will be available at once in the event of accident. A one month waiting period will be necessary before services for medical conditions will be available and a twelve month waiting period for obstetrical care and elective surgery. The first \$5.00 for services required by the subscriber or his dependents is to be paid by the subscriber. Treatment of mental illness, epilepsy, feeble-mindedness, tuberculosis, venereal diseases, alcoholism, and drug addiction will not be provided. The care of conditions for which members are entitled to workmen's compensation is also excluded.

Costs.—A registration fee of \$1.00, monthly dues of \$1.50 for a single person, \$2.50 for a husband and wife, and \$3.50 for a family of any size are the tentative rates.

Payments to Physicians.—The agreement to be signed by physicians and the fee schedule of payments has not yet been completed. It is contemplated that physicians, by signing the agreement, will agree to provide services for the members according to the fee schedule to be established. Participating

physicians will also be asked to agree to a withholding of 20 to 40 per cent of the payments due during the first year, in order that a cash reserve may be established. It is proposed that the amount retained will be refunded when it is possible to do so.

It was also recommended that the Medical Society of the District of Columbia make a loan of \$2,800 for the establishment of Mutual Health Service, to be repaid when the Service is financially able to do so. The plan will not be placed into operation until a membership of at least 5,000 is reached.

A somewhat similar medical care plan is the Associated Medical Services Incorporated of Toronto, Canada, a non-profit membership corporation which was organized on June 1, 1937, with the cooperation and some financial support from the Ontario Medical Association. A subscriber and his dependents are provided with extensive benefits for medical and hospital services at a monthly rate of \$6.50 for an average family of four. Health examinations, medicines outside of the hospital and treatment for conditions existing at time of application are not included. Participating physicians agree to render services according to the rules of the corporation and to accept a schedule of fees as agreed upon by the Ontario Medical Association. Branch medical boards approve all bills for payment in branch areas. All duly registered physicians may become participating physicians and as of December 1938 the plan had 826 participating physicians to provide services for a reported membership of 4,020.

The Honolulu County Medical Society has also cooperated in the organization of the non-profit mutual Hawaii Medical Service Association organized under territorial insurance laws. This association began operation in June 1938 with nearly 1,000 members. The initial fund required, approximately \$10,000, was contributed by industrial firms in Honolulu. The contract provides payments for designated medical services on receipt of a written report from the member and his physician. A member's medical bills are paid directly to the physician in accordance with a fee schedule drawn

up by the Honolulu County Medical Society. Hospital bills are also paid directly to the hospital for the usual hospital services. A limit of \$300 is placed on medical and hospital benefits for the first year and definite limits are placed on each type of benefit—for example, \$20 for office and home calls and \$35 for x-ray and laboratory services. A summary of this plan is as follows:

HAWAII MEDICAL SERVICE ASSN.

1411 Alapai

HONOLULU, HAWAII

Membership Requirements.—Membership is limited to those earning \$300 per month or less.

Benefits.—Medical benefits include operations, office, home and hospital calls. Members may also receive physical examinations if they so desire. Members using more than \$20 in office and home calls within the first six months shall be required to pay half the amount of such calls during the balance of their membership year. Hospital benefits include: room, board and nursing care not to exceed \$4.50 a day for twenty-one days; operating room, anesthetic, and ambulance service; x-ray and laboratory not to exceed \$35 per year; medicines, drugs, supplies and dressings not to exceed \$15 per year; one blood transfusion including the donor; one cystoscopy during membership year.

Private nursing care when required will be furnished in the home or hospital for twenty-one days. (8-hr. nursing day.)

Total medical and hospital benefits are limited to \$300 in the first year and if the service received does not exceed \$10, the benefits will increase to \$350 the second year.

The Association will pay half of the medical and hospital expense for illnesses that have existed prior to membership. In no such case shall the Association be liable for more than \$100 in any one membership year.

Limitations.—Waiting periods of one day for accidental injury, ten days for general illnesses and ninety days for surgical conditions and dental extractions are required.

Prenatal or obstetrical care or any disability resulting from childbirth, eye refractions, glasses, restorative dental care, alcoholism, drug addiction or material appliances are not provided for.

Costs.—A registration fee of \$1.00 is required when a member first joins. The dues are \$3 per month payable monthly, quarterly, semi-annually or annually. If the member is away on leave or vacation dues are reduced to \$2 per month but benefits are restricted to hospital care up to \$150 anywhere in the world.

Some of the proposals for medical care plans embody a combination of the cash indemnity arrangement with a unit system. For example, in the plan under consideration by the Cleveland Academy of Medicine, it is proposed to provide a specified cash indemnity payable on a per diem basis for members who are hospitalized in private rooms and at the same time to provide services for members who are not hospitalized in private accommodations, according to a unit system payment arrangement.

The idea of the cash indemnity plan is to offer a feasible arrangement which recognizes that in any system of prepayment for medical services the benefits offered to a group of members must necessarily be definitely limited by the fund of money that can be collected. Therefore, instead of offering unlimited or extensive medical services which later must be restricted according to the funds available, the cash indemnity plan in the beginning places a definite limit on the benefits which it is estimated can be paid out of the funds collected. No limitation is placed on the service that a member may require or on the nature of the treatment that the physician may desire to render. The member and the physician know in advance that a certain cash payment will be made available by the plan to assist the member in obtaining medical services. If the payment is not sufficient to provide all the medical services the member needs, he and his physician can agree on a mutually satisfactory arrangement for the amount in excess of the cash benefit to be provided by the plan. It is believed that this arrangement for additional services can be arranged better by the individual patient and physician than by some administrative organization which must spend time and money to find out what the patient and physician already know.

Under the cash indemnity plan, if the benefits originally offered cannot be provided with the funds col-

lected, the amount of the benefits can be reduced without interfering with the usual procedure of obtaining necessary medical services.

CREDIT AND COLLECTION BUREAUS

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

Professionally controlled credit and collection bureaus have also served as a nucleus for organizing the "business" side of medical practice, especially to eliminate undesirable features between the physician who has extended credit and his patient. Greater attention to the "business" side of medical practice is not unprofessional nor beneath the dignity of the medical profession, particularly when it can be shown that lack of attention to the proper conduct of the "business" side of medical practice interferes with the delivery of good medical service by threatening to destroy the essential personal and friendly relations between physicians and their patients.⁴¹

OTHER MEDICAL SERVICE PLANS

In addition to the medical service plans organized by or under the auspices of medical societies, it should be noted that there are many medical care plans organized by other agencies. These plans can be conveniently divided into three groups: (1) those organized by employers or employees in industries, (2) those avail-

41. For a full discussion of professionally controlled credit and collection bureaus see *Collecting Medical Fees*, Bureau of Medical Economics, American Medical Association, Chicago, 1938.

able for general residents of the community as well as groups of employees, and (3) those designed for fraternal or union groups.

Medical Service Plans in Industry.—Particular attention should be called to the more than 300 mutual benefit associations in operation throughout the country.⁴² These associations are organized by groups of employees who make regular weekly or monthly payments into a fund which is used to assist members to pay for medical and hospital services. A digest of one such mutual benefit association is as follows:

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

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

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

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

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

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

Since July 1, 1937, for an additional 25 cents per month, members may receive hospital benefits of \$4 per day for 37 days of hospitalization in a year, and \$22 for extra services during the first week, but only for services ordinarily provided by the hospital. No hospitalization benefits are allowed for obstetric cases, venereal diseases, or for illness due to intoxication or self-inflicted injuries. Hospital bills, within the limits established, which are incurred by members at recognized hospitals will be paid directly to the hospital.

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

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

SPAULDING EMPLOYEES' MUTUAL BENEFIT ASSOCIATION

BINGHAMTON, N. Y.

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

A Board of Trustees appointed by the company (Spaulding Bakeries, Inc.) is in charge of the administration of each plant division. The constitution and by-laws may be amended by the Board of Trustees subject to the approval of the company and a two-thirds vote by the membership.

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

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

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

Upon application to the Trustees, a member may receive benefits for medical care as follows: \$3.00 for house calls and \$2.00 for office visits up to a maximum of \$50 in any one year; designated cash benefits for surgical procedures such as a \$100 limit for major operations, and a \$50 limit for tonsillectomies, with the fee schedule of the county medical society accepted for other surgical services and for x-ray and laboratory services. A hospitalization benefit of \$3.00 per day, not to exceed 30 days (i. e., \$90) is also provided. Members have free choice of any physician or hospital in the locality. A cash income of \$7.50 to \$20 a week after a waiting period of two weeks is also paid each member, depending on his salary. These cash benefits are limited to ten weeks. (No member can receive benefits in excess of \$350 in any one year.) This program provides the employees with considerable financial assistance in the event of any sickness or accident excepting for maternity cases. The five year average of medical costs has been \$25.47 per employee per year. Dependents are included for \$1.00 per family with the expenditure limited to \$50 a family for any one year. The three year average annual cost for dependent medical service has been \$7.71 per dependent.

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

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

The Spaulding Employees' Mutual Benefit Association has gained considerable prominence as a sort of model arrangement and has been the basis for the organization of similar plans in a number of industries.

Several million employees are also members of group accident and sickness insurance plans. These plans, which are underwritten by insurance companies, pay the employee a certain percentage of his wage if he becomes disabled through sickness or accident. Within the past few years insurance companies writing group insurance have offered a special type of group hospitalization and surgical insurance coverage, which pays the employee a specified cash benefit for designated services in the hospital, including payments for surgeons' fees as well as daily cash benefits for hospital room and cash allow-

ances for special medical services such as anesthesia, radiologic and pathologic services. These arrangements will be discussed more completely in the chapter dealing with group hospitalization plans.

In addition to the foregoing mutual benefit associations and group accident and sickness insurance arrangements for employees, there are several other organized arrangements which make medical services more readily accessible to groups of employees. The most extensive arrangements for plant medical services are the "industrial health services" usually financed entirely by the employer to provide first aid and emergency care for employees and to supervise plant hygiene and safety conditions. These arrangements are essentially preventive health measures to protect the employee against the hazards of his occupation and do not generally undertake the provision of extensive medical care for the employee but instead refer employees requiring general or special medical care to physicians in the community. However, a large number of companies do provide extensive medical care for employees and sometimes for their dependents. These "industrial medical service plans" take a variety of forms and may be classified as follows:

1. Arrangements that are usually financed entirely by the employer whereby the employees and sometimes their dependents receive extensive medical services from physicians employed by the company-owned hospitals or from physicians in hospitals under contract with the employer. Digests of such arrangements are given below:

ENDICOTT-JOHNSON CORPORATION WORKERS MEDICAL SERVICE

JOHNSON CITY, N. Y.

A complete medical service is furnished by the Endicott-Johnson Corporation, manufacturers of shoes and tanners of leather, to its employees and their families. Employees do not contribute to the cost of medical care. The corporation has

plants in three cities, Binghamton, Johnson City and Endicott, and it maintains a medical center in each city. The plan was established in 1918 and has been operating in its present form since 1928.

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

In 1934, the corporation employed a staff of over 100 persons, which included 40 physicians, 5 dentists, 5 dental hygienists, 4 physical therapists, 26 trained nurses, 5 bacteriologists, 5 pharmacists and a number of technicians, office clerks and assistants to care for approximately 19,000 employees and their dependents. In that year the employed physicians made 133,580 house and hospital calls and received 183,168 ambulatory patients at the clinics. The patients receive complete medical care including dentistry, nursing and hospitalization, and all types of illnesses and diseases are included. Specialists and consultants among the private practitioners in the locality are called in whenever a medical service doctor believes it necessary.

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

MUTUAL AID SOCIETY OF THE CONSOLIDATED EDISON COMPANY

NEW YORK, N. Y.

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

The employees are organized into a voluntary Mutual Aid Society and the financial affairs of the Society are controlled by the company. The company deducts $\frac{5}{8}$ of 1 per cent from the employees' weekly salaries and the company contributes additional funds so that an annual fund of \$1,100,000 is established to pay for the medical care required by the members during each year.

Membership to the Mutual Aid Society is limited to employees earning less than \$46.00 per week. Weekly wages range from \$17.00 to \$45.00, the average is \$32.40. Further limitations are that an employee without any dependents cannot earn more than \$900 a year to be eligible; for a married employee the maximum is \$1,260 a year with an allowance of \$200 more for each dependent.

The Society contracts with a limited number of physicians to furnish home and office care at less than the minimum fees established by the Workman's Compensation Law. It also has agreements with certain hospitals to provide unlimited hospital services in wards at \$4.00 per day. The physicians and surgeons who perform medical services for members in the hospital are paid on a fee basis, but according to a minimum fee schedule far below the regular established rates.

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

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

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

2. Employee associations financed largely by the employees and in part by the employer to provide members and their dependents with extensive medical services in an association-owned "clinic" or hospital. This type of plan includes the few mutual benefit associations which undertake to provide medical services "in kind" through salaried physicians and association-owned hospitals. A digest of one such association is as follows:

STANOCOLA EMPLOYEE'S MEDICAL AND HOSPITAL ASSOCIATION, INC.

BATON ROUGE, LOUISIANA

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

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

necessary to carry on its purposes shall be devoted to charity." The corporation was organized with a capital of \$100,000 consisting of 5,000 shares of stock at \$20 a share. This stock was sold on the basis of \$2.50 a month for eight months—each member being required to purchase a share of stock. The funds obtained by the sale of stock were used to purchase a building for the clinic to be operated by the Association.

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

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

Membership Requirements.—White employees who have been employed for more than one year are eligible for membership. Dependents and relatives of these employees as well as a small group of former employees, annuitants, and widows of deceased employees are also included as members. As of May 1938, the number of employee members was 2,700, or approximately 90 per cent of the eligible employees. The total membership, including employees, dependents, and others, was approximately 11,000.

Benefits.—The Association employs a staff of eleven salaried physicians and the members are entitled to the services of this staff at the clinic, in their homes, and in the hospitals. Diagnostic services at the clinic, including x-ray, laboratory tests, and physical therapy, are also available to members.

Hospitalization and private duty nursing in the home or in a hospital are allowed up to \$250. The Association obtains a 15 per cent discount from the two hospitals in Baton Rouge and pays a flat \$2.00 rate for laboratory charges in these hospitals. Members are entitled to ward room accommodations.

Limitations.—Employees who are entitled to benefits under the Workmen's Compensation Law are not included in the services of the clinic. Likewise, "unusual or intricate" surgery and mental and tuberculosis cases are not accepted. An extra charge is required for home calls beyond seven miles from the clinic at the rate of 50 cents per mile one way. Drugs and medicines used to an unusual degree are not included, although drugs are available at the pharmacy in the clinic which allows a discount of 15 per cent for proprietary medicines and 25 per

cent for compounded prescriptions. Eyeglasses, crutches, and appliances must be purchased by the patient. Splints are furnished for a deposit charge which is refunded if the splint is returned undamaged. Consultation fees for other physicians are not allowed. Special laboratory and x-ray fees in the hospital must be paid by the patient. Obstetrical conditions are not hospitalized unless involving surgical intervention or other abnormal experiences.

Costs.—Members pay monthly dues of \$3.00 and may be assessed three times each year for not more than \$3.00 each assessment. Dependents who are immediate family members are included at no extra cost, but a fee of \$1.00 per month is required for additional relatives. The average charge per employee, including dues, assessments, and fees, was approximately \$40. The average charge per member was about \$10. To this charge must be added expenditures by members for services not included. No record is kept of these additional charges.

Since 1936 the Standard Oil Company has had a Thrift Plan for its employees, and participants in this Thrift Plan may authorize the payment of their regular \$3.00 dues to the Association from the cash balances standing to their credit in the Thrift Plan. Under the Thrift Plan the Company adds substantially to the individual employee's contribution.

Payments to Physicians.—The staff of physicians are paid a monthly salary and are allowed one day off each week with two weeks vacation. Salaries are reported to range from \$6,000 to \$9,000 annually. The staff physicians maintain their own automobiles, but gasoline is furnished by the Standard Oil Company at a wholesale price. The physician's pay is continued when he is sick providing the other staff doctors assume the additional work. No arrangement has been made for prolonged absences because of illness or for pensions.

The Stanocola Employees Medical and Hospital Association, Inc., in several respects, is somewhat subsidized by the Standard Oil Company because of its value in employee relations. However, the company has not seen fit to introduce this type of plan in other communities where Standard Oil employee groups are located. The building which was sold by the Standard Oil Company to the employees' Association resulted in an estimated \$18,000 donation to the Association. Several attempts to raise dues are reported to have been met with disapproval by the employees who feel that the Association will be supported by the Standard Oil Company.

Aside from a complaint that the closed staff of the clinic prevents the large group of Standard Oil employees from choosing their own physician in Baton Rouge, complaints were voiced by physicians that while the services given in the clinic were as good as could be expected, there are several serious

shortcomings. One is that continuity of treatment is not maintained as the patient must accept the physician available at the clinic when he calls. Another is that young physicians are brought up from New Orleans for a small monthly salary. These physicians look on the plan as a sort of extension of intern training and expect to go into private practice as soon as possible. The rapid turnover in the staff of physicians is said to be an indication of this practice. Likewise complaints were voiced that the Association, because of its favored position and emphasis on low costs, disrupts medical practice in the community for patients who are not members. It was also pointed out that the Association's income in excess of \$111,000 was insufficient to meet expenses by more than \$1,000 in 1936 and more than \$3,000 in 1937. After 14 years of operation the Association has accumulated assets of about \$70,000 which are exceeded by liabilities leaving a net deficit of approximately \$5,000.

Some groups of employees arrange to obtain medical services by means of a contract with an independently organized "clinic" or medical care plan administered by an outside agency. Such arrangements, which may include general residents of the community as well as employee groups, will be described in the following section.

A special type of organized medical service arrangement in universities and colleges is known as "student health services." These arrangements are somewhat comparable to industrial health services with more emphasis on health education. Student health services are primarily organized to supervise and protect the health of students on campus through entrance examinations, consultations, infirmary care and control of communicable diseases. However, many of the student health services have undertaken to provide extensive medical service for students, faculty members and employees. A number of surveys of these student health services have concluded that too much effort is spent in providing curative medical services for minor conditions to the detriment of the more important function of health education for students.⁴³

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

Medical and Hospital Benefit Organizations.—A large variety of medical service plans for general residents of the community as well as for special groups have been organized by promoters, individual hospitals, "clinics," and so-called community health associations. Under these plans funds are accumulated from members through the sale of membership certificates or contracts, and the medical or hospital services are offered through hospitals and "clinics" owned by the organizers or through physicians and hospitals under contract with the organizers.

In many respects the plans promoted by individual organizers have been the most undesirable of all proposals for the distribution of medical services. In one state alone 143 organizations promoted as medical insurance plans defrauded thousands of persons who thought they were purchasing low cost medical services. The promoters who organized these medical insurance plans were enterprising individuals who found that through a loophole in the insurance requirements of the state law, they could undertake to sell contracts promising to provide the members with medical and hospital services in return for the payment of premiums from \$1 to \$5 monthly. The individual promoter acted as a sort of medical broker, undertaking to contract with "clinics," or private groups of physicians and hospitals for the services promised in the contract. Complaints by members of failure to obtain the medical services promised or failure to receive satisfactory service led to an investigation by a grand jury. As a result of these investigations many of the organizations ceased operations, and the officers of several of the schemes received fines or jail sentences.⁴⁴

Another type of individually promoted organization is what might be called "wholesale buying groups" organized to induce physicians to provide services at a

⁴⁴. *New Forms of Medical Practice, Bureau of Medical Economics, American Medical Association, Chicago, 1934.*

large discount for members who pay dues. A digest of the organizational arrangement of such plans is as follows:

THE PEOPLES MEDICAL LEAGUE, INC.

FAMILY HEALTH SERVICE LEAGUE, INC.

THE NEW YORK MEDICAL SERVICE
COMPANY, INC.

NEW YORK, N. Y.

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

The annual membership dues are \$2.00 for a single person, and range from \$3.00 to \$7.50 for married couples with dependents. Membership is not restricted by age limits or conditions of health although it is stated that these organizations are primarily for single persons whose income is \$25.00 a week or less, and for families whose weekly income does not exceed \$50.00.

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

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

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

A special type of plan for medical services is organized around what are called "clinics," which consist of groups of physicians. The organizer arranges with the employer or with a group of employees to enter into a contract whereby the employees pay a specified monthly or annual premium and in turn receive medical services from the group of physicians under contract with the organizer. These plans are sometimes called "medical centers" or "health associations" as well as "clinics," and frequently undertake to provide contract medical services for the general population. An outline of one such arrangement is as follows:

THE ROSS-LOOS CLINIC⁴⁵

LOS ANGELES, CALIF.

The Ross-Loos Medical Group, also known as the Ross-Loos Medical Service and more commonly as the Ross-Loos Clinic, began in 1929 when Dr. Donald E. Ross, a surgeon in private practice, and Dr. H. Clifford Loos, also a surgeon in private practice, both in Los Angeles, agreed to contract with the Los Angeles County Employees Association (Bureau of Water Power) to provide members of the Association with medical and hospital services on a monthly prepayment basis. Drs. Ross and Loos constituted themselves as a copartnership with the official title of Ross-Loos Medical Group.

With the signing of the first contract, Drs. Ross and Loos were assured of a clientele of 2,650 employees and their dependents who were obliged to have all necessary medical services performed only by Drs. Ross and Loos. A headquarter building was rented and remodeled to provide examination rooms, laboratory and x-ray rooms, etc., for the Medical Group. Since the Medical Group did not own a hospital, Drs. Ross and Loos contracted with a hospital which agreed to provide members with hospital service including drugs, dressings, laboratory services, etc. Before the end of the year, other groups of governmental employees had contracted with the Ross-Loos group so that it became necessary to increase the staff by hiring physicians on a full-time salary basis.

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

In August, 1932, the Medical Group moved into a four story brick office building located at 1355 Wilshire Boulevard, Los Angeles. Today, the Medical Group also maintains sub-offices at Glendale, Van Nuys, Westwood, Pasadena, and Alhambra in California, with each office equipped with facilities for minor surgery, laboratory, physio-therapy and drug dispensaries, as well as physicians' offices and reception rooms. Likewise, the Medical Group has associated doctors located at Montebello, Wilmington, Santa Monica, Banning, Independence, Lone Pine and Bishop in California. These associated doctors are paid by the Medical Group for providing services to subscribers in their districts. Medical Services are made on the basis of the payment of \$1.50 per month for each subscriber. It soon became apparent that this amount was not sufficient and since then contracts have carried the provisions of \$2.00 per month for each subscriber. For this monthly sum the Medical Group agreed to provide the subscriber with medical services including the attention of either a general practitioner or a specialist in the headquarter offices, in the hospital or in the subscriber's home if he should be unable to come to the Clinic. Subscribers were also to receive laboratory, x-ray services, physical therapy, ambulance, drugs and dressings, and hospitalization in a ward bed. The service for subscribers was supposed to be all inclusive, but certain services are excluded for which the subscriber must pay. For example, dental services are not provided. Special drugs such as insulin, are not provided; and appliances such as crutches, eyeglasses, wheel chairs, etc., must be paid for by the subscriber. A mileage chart is made for calls beyond a certain limit.

The dependents of subscribers were provided with services similar to those indicated above with the exception that a charge was made for hospitalization, drugs, dressings, x-ray films, ambulance service, and the services of a specialist called in consultation. In 1935, as a result of a tendency on the part of the dependents to tax the resources of the Clinic because of free services, the contracts were voided at the close of the year, and new contracts were submitted which provided a fee schedule for services to be provided to dependents. These fees for dependents include charges such as \$1.00 for home calls, \$5.00 for tissue examinations, and \$25.00 for major operations.

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

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

Since the monthly premium per subscriber was \$2.00, a deficit of \$0.17 per subscriber per month was incurred. Consequently, as a straight insurance proposition, the \$2.00 premium per member per month was inadequate. The deficit was apparently made up by income from sources such as fees for services to dependents; extra charges to subscribers; income from soda fountains, magazine, and candy sales; sub-rentals, etc. The income from such sources amounted to \$0.51 per subscriber per month which offset the deficit of \$0.17 leaving a profit to the Medical Group of \$0.34 per subscriber per month.

Dr. Loos himself has stated "It is evident therefore were it not for the fact that a charge was made for dependents and further that dependents availed themselves of the service offered, for which they pay, the plan could not financially continue with subscribers only." During this two-year period, 1933-1934, the receipts from soda fountain, magazine, and candy sales amounted to \$18,471.68. Apparently it is necessary for the Ross-Loos Medical Group to rely on fees from dependents who are not included on the monthly prepayment insurance basis. Likewise, receipts from the sale of items such as chocolate sundaes, magazines, and candy bars are an essential part of the financial structure of this medical care plan. The Medical Group also contracts with hospitals at a reported rate of \$2.75 per day for services which are valued by the Medical Group at \$7.30 per day. There is no indication that the Medical Group contributes to the care of indigent patients in a degree proportionate to other physicians in the county.

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

Because of alleged practices engaged in by Drs. Ross and Loos through the Ross-Loos Medical Group in violation of medical ethics on matters such as advertising, denying members free choice of physician, and prohibiting reasonable competition among physicians, the Los Angeles County Medical Association voted to expel Dr. Ross and Dr. Loos. Appeal was taken to the California Medical Association which upheld the action of the Los Angeles County Medical Association. Further appeal was taken to the Judicial Council of the American Medical Association which reversed the decision of the California Medical Association and the Los Angeles County Medical Association on the grounds that the by-laws of both medical associations providing for the disciplining of members had not been followed.

The decision of the Judicial Council of the American Medical Association was on the basis of the procedure used in bringing in Dr. Ross and Dr. Loos to trial, and did not give consideration to the merits of the charges against them.

The more recently developed community health associations are too frequently privately operated organizations which undertake to contract with a small group of physicians or with cut-rate clinics in order to provide the medical services promised members. The "clinic" plans organized by private groups of physicians have been less undesirable than those organized by individual promoters. Such private groups, sometimes called group practice plans or private group clinics, include those arrangements whereby three or more physicians cooperate in their practice by sharing office space and owning certain equipment in common. Not more than 9 per cent of these private groups of physicians have entered into contract practice arrangements with groups of employees or with the general public.⁴⁶

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

THOMPSON BENEFIT ASSOCIATIONS FOR HOSPITAL AND NURSING SERVICE

BRATTLEBORO, VT. (Pop. 9,816)

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

⁴⁶ Group Practice, Bureau of Medical Economics, American Medical Association, Chicago, 1933.

\$1,000 to the fund of the Nurses Benefit Association and \$1,500 to the fund of the Hospital Association when the associations were formed.

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

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

In return for the annual premium the members are assured of cash benefits above \$30.00 but not to exceed \$300 in case of an operation at the Brattleboro Memorial Hospital including the costs of surgical fees, nurses fees and room charges. Nonsurgical cases with the exception of obstetrics and chronic cases are provided with one-half payments within the limits of \$30 to \$300, but physicians' fees are not included. The directors of the Brattleboro Hospital may at their discretion advise that the surgical services be secured at other hospitals and payments within the limits set up will be paid. The directors also have the final decision as to the necessity of the service, the amount of benefit a member is entitled to and as to the emergency nature of the case.

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

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

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

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

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

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

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

ROCKFORD HOSPITAL SERVICE ASSOCIATION

ROCKFORD, ILL. (Pop. 85,864)

This association sponsored by residents of Rockford was incorporated in 1912 under the nonprofit laws of Illinois, and is entirely independent of any hospital in the city. The plan was introduced by an Englishman who had been active in similar work in Leeds, England, and hoped to transplant the "cooperative" hospital service and home nursing system operative in England.

Membership in the association is open to any resident of the city under 50 years of age. Members pay an entrance fee of \$1.00 and annual dues of 50c with regular assessments of 5c each week. Thus, not including the entrance fee, the total annual dues are \$3.10. Special assessments not to exceed 3c a week may be levied to make up any deficits.

Members are entitled to cash benefits at the rate of \$18.00 a week for six weeks of hospital service or home nursing care. Charges in excess of this amount must be paid by the sub-

scriber. An allowance of \$10 is made for use of operating room. Members may be entitled to double benefits by paying double entrance fees and dues. A waiting period of 13 weeks is imposed on all new members, and hospitalization of obstetrical conditions is not allowed unless husband and wife have both been members for one year. Claims are not allowed for any medical services, laboratory examinations, x-ray services, anesthetics, drugs or dressings, therapeutic treatments, or for specified conditions such as rheumatism, chronic diseases, "rest cures," nervous and mental conditions, sanitarium service, drunkenness, etc.

The membership of about 500 has remained practically constant throughout the entire life of the plan. In 1918, an influenza epidemic threw the Association into debt for several thousand dollars which has been carried by the hospitals and is being repaid year by year by the Association. It is now reported that the organization is getting "out of the red."

In a few rural communities groups of residents have organized health associations to guarantee a physician an annual income as an inducement to locate in the community, which could not otherwise support a physician. A number of these associations have been reported to be in operation but a recent survey of rural medical services⁴⁷ found that most of the plans were either no longer in operation or were not conducting successful programs. While there is little objection to the theory of such plans, they do not seem to succeed in actual practice. After a short time of operation the members tend to grow tired of contributing to the physician's salary and feel that once he is located in the community he should be able to support himself on a fee-for-service basis. A description of a rural health association which received considerable attention is as follows:

ECONOMY MUTUAL HEALTH ASSOCIATION

ECONOMY, IND.

In April 1936, a university student and a minister in Economy, Ind., proposed to collect \$15 annually from each of 200 families to guarantee an income of \$3,000 a year for a physician to come

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

into the community of Economy. The medical benefits to be provided under the plan were not very definite but all the members of a family were to receive medical attention, both preventive and curative, as well as surgery, from the physician who would accept the proposal. The physician could make extra charges for special medicines, x-rays, obstetrical conditions, and other special services. According to a report in May 1937, 80 families agreed to pay \$1.25 per month, payable quarterly in advance to the physician.

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

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

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

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

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

with physicians and hospitals in the community to provide medical services and hospitalization for members. A digest of fraternal lodge arrangements is as follows:

LODGE PRACTICE

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

In general, there are two types of fraternal orders in regard to their activities in providing members and their families with medical services: (1) Orders which organize insurance associations under Fraternal Insurance Laws to insure members against death, disability or sickness; (2) Orders which do not organize insurance associations. Both types of fraternal orders may make arrangements to provide medical services directly to members and their families. The lodge or fraternal order either collects special dues from its members to cover the costs of the services or benefits, or it includes the cost in the regular dues.

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

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

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

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

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

ATTITUDE OF THE MEDICAL PROFESSION

Toward all these special arrangements for organizing the distribution of medical services, the medical profession has been pictured as autocratic and dictatorial. When it is recognized that many of the arrangements are nothing more than the old type contract practice plans which violate many of the principles which the medical profession has found essential for the delivery of good medical care to sick persons, it becomes evident that the medical profession has good reasons for criticising and opposing the extension of certain of these medical care plans. It is as much the duty of the medical profession to warn the public of unsound medical care plans as it is to assure the public of good medical services by improving the standards of medical schools, hospitals, drugs and physical appliances or by exposing quacks, medical fakers, and harmful patent

medicines. The welfare of the sick is the primary element in any analysis of arrangements to assist in the distribution of medical care. There can be no defense or support by organized medicine of those individuals and organizations whose activities are not for the best interests of the patient.

In regard to all arrangements for the distribution of medical services, the medical profession through long years of experience has found that when certain features or conditions are present the result is a lowering of the quality of the medical services. These features or conditions have been definitely outlined in the "Principles of Medical Ethics." For example, one such feature or condition is the prohibition of advertising or solicitation of patients. The almost inevitable result of advertising medical services or soliciting patients has been a vicious price competition which has led to a lowering of the quality of the services offered. Consequently the principles of medical ethics require that a physician must establish a reputation for the delivery of good medical services in order to obtain patients.⁴⁸

In place of what is essentially "cut-throat price competition" that has so frequently demoralized business, the medical profession has substituted the requirement that there be reasonable competition among qualified physicians. Therefore, the organization of a medical care plan which gives a few physicians a monopoly on the provision of medical services for members by denying those members the right to choose their own physician from among all qualified physicians in the community has been opposed by the stipulation in the "Principles of Medical Ethics" that there must be no interference with reasonable competition in a community.

Some contract practice plans which violate the principles essential for good medical practice have recently

48. For a full discussion of the relation of medical ethics to the welfare of the patient, see *Economics and The Ethics of Medicine*, Bureau of Medical Economics, American Medical Association Chicago, 1937.

been labeled as "cooperatives" or "group health associations." This is misleading.⁴⁹ The Rochdale principles of cooperation, which are recognized throughout the world as fundamental standards of the cooperative movement, cannot be applied to the distribution of medical services. The strongest advocates of medical cooperatives have admitted that "patronage dividends" which is one of the fundamentals of cooperation cannot be made a part of a medical service plan. To do so would mean that the members who use most of the medical and hospital services under the plan, thereby causing most of the expense, would nevertheless be entitled to the largest dividend. Such an arrangement would encourage the use of benefits by members to such an extent that it is deemed impossible to operate a medical care plan on a strictly cooperative basis. Medical service cannot be purchased in wholesale quantities, stored in a warehouse and later sent to a retailer for distribution to the sick. Medical service is produced and consumed at the time and place that the patient and physician meet.

When plans called "cooperatives" or "group health association" are nothing more than contract practice arrangements which violate the principles of medical ethics, then it is of course necessary for the medical profession to oppose such arrangements just as it opposes other unethical contract practice plans or activities that threaten the welfare of sick persons.

The history of unethical contract practice arrangements in industry, in lodge practice plans, in medical and hospital benefit plans organized by individual promoters, in workmen's compensation, and even in the medical care plans for the poor offers most convincing evidence that violations of the principles of medical ethics prohibiting advertising, solicitation, restriction

49. *Cooperatives and Medical Service*, Bureau of Medical Economics, American Medical Association, Chicago, 1937.

of competition, monopoly, and commercialism in medical practice do lead to a lowering of the quality of medical care.⁵⁰

CASH VERSUS SERVICE INSURANCE

As is indicated by the foregoing outline of medical service plans, an individual resident of a community at present has a considerable number of agencies designed to assist him in obtaining medical services. Many of these organized arrangements for the payment for medical services are restricted to special classes of persons. The development of a separate administrative agency for provision of medical services to a resident when he is considered as a member of some restricted social industrial or cultural group does not seem to be an economical way to organize the distribution of medical services. When the resident is a student and later an employee and at the same time perhaps a member of some social or cultural group, is it necessary that he have a separate organizational arrangement to provide him with medical services in each of his several capacities as a resident of the community?

Medical services can be organized either geographically or by occupational or cultural groups. The use of both methods of organization at the same time creates overlapping and duplication. The geographic location of physicians in communities for the private practice of medicine has been the method by which persons have for centuries obtained their medical services. If, in order to bring the patient and the physician together, it is now considered necessary to systematize payments for medical services, it is believed essential that such systems be limited to *payment* for medical services,

50. Footnotes 9, 37(a), 37(b), 42(b). Contract Practice, Bureau of Medical Economics, American Medical Association, Chicago, 1932. Medical Relations Under Workmen's Compensation—Developments Since 1930, Bureau of Medical Economics, American Medical Association, Chicago, 1938. Hoge, A. H.: A Medical Retrospect, West Virginia M. J. 28: 289 (July) 1932. Rogers, Lindsay: Investigation of Administration of the Department of Labor, 1928, New York Legislative Document 49, 152d Session, p. 135. Report Jeremiah F. Conner, Moreland Act Commission, May 27, 1919, Legislative Document 74, pp. 15, 32, 33. J. A. M. A. 104: 479 (Feb. 9) 1935.

allowing the individual to obtain the services of a physician in the same manner whether he be a student, an employee, or a member of a particular social or cultural group.

The medical profession, contrary to frequently repeated statements by propagandists for sickness insurance and contract medical service systems has never objected to organized methods of paying medical bills, nor has the American Medical Association ever opposed the principle of insurance for the payment of medical bills.⁵¹ What is opposed is misadministration or manipulation in the application of the insurance principle which results in control over the relations between the physician and his patient and diverts a considerable portion of the funds obtained from members to maintain a bureaucratic organization for activities not directly concerned with the problem of helping sick persons to regain health. The medical profession has suggested that the insurance principle can best be applied if restricted solely to the *payment* of medical bills by returning to the insured a specified cash benefit for the services covered in the insurance.

The question so often addressed to physicians by propagandists for sickness insurance and contract medical systems, "What difference does it make to the physician how his bill is paid?" is largely rhetorical. Objection is made not to the way the bill is paid but to the way third parties intervene between the patient who pays the bill and the physician who performs the service. Such third parties in their effort to achieve financial security endeavor to gain control over the services provided members. To a certain extent the question of sickness, insurance and contract practice involves a struggle between lay administrators or politicians and the medical profession for control of the character and method of delivery of medical services.

51. For the resolution on Insurance as a method of payment for medical services, see p. 17.

Both sickness insurance and group contract plans are outstanding exceptions to the general principle of insurance. Fire, life, marine, accident and nearly all other forms of insurance collect definite premiums in cash, for which a definite cash benefit will be paid on the occurrence of a specified loss or injury. This is the only method that permits accurate bookkeeping. Most systems of sickness insurance and contract practice violate this principle. They keep the premium side of the balance sheet in cash, but the service side is kept in elements of an uncertain, undetermined service. Since the receivers of the medical service benefits are unable to judge the quality of that service, it is somewhat as if premiums were collected in legal tender and benefits paid in currency printed by the medical service organization.

That such a system of sickness insurance inevitably results in a deterioration of the value of the service is something for which the administrators are not wholly or sometimes even partially to blame. The very nature of medical service makes such a result inevitable. There are few fields in which the advance of science is so rapid as in that of medicine. Even though the premiums, at the time they are fixed, might be adequate to pay for a complete and satisfactory service, it is inevitable that within a few years they will be wholly inadequate. It is then much easier to reduce the quality of the service by ignoring the advances of science than to increase the premiums; indeed, in many cases there is really no choice, since experience has shown that it is almost impossible to increase premiums, once they are fixed, and quite impossible to increase them in proportion to the advances of medical science.

A plan of sickness insurance on a service basis drawn up twenty years ago could not have foretold, or provided for, the use of deep radium therapy for cancer, insulin for diabetes, serum for pneumonia, liver therapy for pernicious anemia, pneumothorax for tuberculosis,

or for any other advances that have taken place during that period. Because of this fact, every system of compulsory sickness insurance and most voluntary systems which provide service benefits are compelled to balance their books by ignoring the advances of medical science. It is easy to do this because the patient is not able to judge when new methods of diagnosis and treatment are required. Experience with sickness insurance on a service basis and with contract practice plans has shown that essential services are often left out of the system of benefits because of cost. Health examinations, special services, consultations, serums, etc., are not usually provided despite the fact that prospective members are promised "complete" services.

Deception of Insured.—Where benefits are paid in services, administrators are almost compelled to deceive the patient. It may be said, without fear of contradiction, that no system of prepayment contract practice or of voluntary or compulsory sickness insurance which provides service benefits has ever existed for even a half dozen years without resorting to deception of the patient as a means of balancing the books. There is no system of compulsory sickness insurance in existence that gives a "complete medical service" in the sense of including all the services that are available according to the standards of medical science existing in the country in which such insurance operates. Persons who advocate such systems in the United States are always complaining that the low-income classes do not receive the best service that modern medical science could make available. This is true, but the difference between this ideal "complete medical service" and the service received by the low-income classes is far greater in any insurance country than it is in the United States.

At least this one basic evil, the existence of which is so carefully concealed by the advocates of sickness insurance, would be removed by a system of cash indemnity insurance. Just as soon as both premiums and

benefits are paid in cash and the amount of the benefits is clearly described, it is no longer either necessary or easy to deceive the patient as to the character of the medical service that he can obtain. Payments for a "complete" medical service could be provided, but it is probable that the premiums required would be beyond the reach of the low-income classes and even beyond the resources that any government would be willing to appropriate. Since it is necessary to restrict benefits to obtainable finances, such restriction should be with the full knowledge of the patient. If the system is based on the principle, already familiar in automobile insurance, that requires the patient to meet an initial minimum portion of his expenses for medical care, it would be possible to meet most of the real, costly emergencies.

If the administrators of systems of cash insurance wish to restrict the service as it is already restricted in every system of contract and sickness insurance medical practice, this could be done openly and frankly by setting a limit of a few hundred dollars as the total amount that would be paid in benefits to any individual in a single year. If expensive biologicals must be excluded, it would be done openly and honestly and not surreptitiously. The subscribers of the plan would know just what restrictions on service existed and the physician would not be compelled to tell the patient that certain types of diagnosis and treatment were forbidden by the system or, what is more frequently the case in order to protect the physician himself, that they were not necessary in this particular illness.

Extension of Cash Systems.—A few years ago the opposition to a cash plan would have been greater than it is today. At that time social workers were almost unanimously opposed to the payment of any cash benefits in relief. Experience since 1930 has caused such a complete change of front that a majority of the very social workers' group that is still urging service benefits

in medical care has become convinced that cash benefits in other fields are far more desirable than benefits "in kind." The entire Social Security Law is based on cash benefits. If sickness insurance with service benefits is now introduced, it will be an anomaly in the whole field of social legislation.

Experiments are already being conducted under social security legislation in some states, and are being proposed in other states, to utilize the principle of cash indemnity insurance to provide medical care for recipients of old age pensions. Reference was made in Chapter II on the "Care of the Indigent" to legislation applying this principle to the indigent. There are signs, though not so clear as yet to justify acceptance of them as uncontradicted evidence, that even in the field of compulsory sickness insurance the principle of cash benefits is making headway. The most recent important changes in sickness insurance legislation are the French law and the amendments to the Swedish law, both of which are clearly in the direction of substituting cash for service benefits.

In their early history commercial insurance companies had some unfortunate experiences with service benefits. Undesirable practices soon developed between certain insurance companies and the insured concerning the disposition of benefits to which the insured was entitled. As a result a strong demand developed to require payment of all policy benefits directly to the insured. Most state insurance commissioners have also found it desirable to require a standard provision in all policies making benefits payable to the insured. As a consequence, today the policies of practically all insurance companies provide specified cash benefits to be paid directly to the policyholder.

A cash system will also show clearly the additional costs of new developments in medical science and will make it possible to know just where and to what extent premiums must be increased to cover these new costs.

The experience of commercial insurance companies, all of which use the cash system, indicates that it is not necessary to write an extensive fee schedule into the agreement with the patient. Definite sums may be fixed which will be paid as benefits for specific items such as office and home visits and general classifications such as major and minor surgery. The necessary flexibility can be given to such a short schedule of payments by following the already tested experience in workmen's compensation and medical service plans for the indigent by providing for a medical committee which will pass on the special conditions under which an additional cash benefit will be paid. Definite maximums can be fixed as to the amount which would be paid to any one person during a year. If the example of automobile insurance is followed and the insured is required to meet a minimum of expenses for minor diseases during a year, much lower premiums will be needed to provide a fund for the burdens due to serious illnesses.

Legislation.—In most states permissive legislation is apparently necessary to authorize the organization of prepayment plans for medical care—whether such plans are on a cash indemnity or a service basis. At present in a few states it is reported that medical service plans need not be organized under existing insurance laws or that special enabling legislation is not necessary. As will be shown in the next chapter, special enabling legislation has become increasingly necessary for the organization of nonprofit hospital service corporations.

An important problem in connection with enabling legislation for medical service plans is the tendency to legalize the corporate practice of medicine, thereby placing an association or corporation in control of the distribution of medical services and relegating the physician to the position of an employee. It has long been recognized as contrary to good public policy for corporations to attempt to practice a profession because it is virtually impossible to hold a corporation responsi-

ble for the maintenance of standards of practice. Corporations could scarcely be placed under the Medical Practice Acts as are individual practitioners and be held responsible for educational qualifications and ethical or moral conduct. The courts of the United States have generally held that the corporate practice of a profession is undesirable and that the public will be served better if individual practitioners are held fully responsible for the practice of a profession.

At present the type of legislation sought proposes to permit nonprofit corporations to conduct group payment or medical insurance plans without being held to the strict requirements of the insurance laws. In several states the medical societies are seeking legislation which will authorize nonprofit corporations to undertake medical insurance plans, but will avoid the dangers of corporate practice of medicine. This is not a simple problem, but again it appears that a cash indemnity provision whereby the corporation or association only undertakes to return a certain amount of money to the insured who requires medical services is the most direct method of avoiding the legal and ethical problems of the corporate practice of medicine.

The proposal that all transactions must be in cash, regardless of the system of prepayment for medical services, far from being a utopian proposal simply points out the way in which evolution seems to be moving. Those who oppose such an arrangement have argued that there would be an opportunity for the patient who receives a cash benefit to apply this to other purposes than the payment for medical service. This is also true of funds received by any individual from any source and therefore adds no new risk to the possibility of obtaining medical services or of payment to the physician. If it is thought necessary, provisions could be made by which payments for medical service could be assigned by the patient to the physician. This procedure of payment is now allowed by insurance com-

panies. The contention that the cash benefits which could be paid would be inadequate to provide for prolonged or numerous illnesses overlooks the willingness of physicians to provide medical services for a fair fee. There is also the fact that benefits must be limited to resources under any method of organization.

An estimate of the amount of cash benefits paid to members of medical service plans, including all types of plans—group and individual accident and health insurance, disability benefits under life insurance, mutual benefit, fraternal and trade union plans, and other cash indemnity medical service plans—would be approximately \$300,000,000 annually.⁵² This sizable sum is now made available through cash indemnity plans to help members pay their medical bills. An extension of such cash indemnity plans appears to be a more feasible method of assisting persons to obtain medical services through presently organized facilities than to reorganize medical practice by creating special medical arrangements through which members must obtain whatever services are offered.

There is much less likelihood of direct interference with medical practice under a cash system. To be sure, there would also be less opportunity for political spoils and administrative jobs—a fact that will undoubtedly turn powerful forces against any proposal for medical insurance plans on a cash indemnity basis.

52. 1936-1937 Premiums and Losses for Accident and Health Insurance, Health and Accident Underwriters Conference, Chicago, 1938. Best's Insurance Reports, Life and Casualty Editions, Alfred M. Best Company, Inc., New York, 1938. Register of Accident Insurance, The Spectator, Philadelphia, 1938. Cash Benefits Under Voluntary Disability Insurance, Social Security Board, Social Security Bulletin 2: 27 (Feb.) 1939. Fraternal Monitor, Consolidated Chart, 1936. Medical Supervision and Service in Industry, National Industrial Conference Board, Inc., New York, 1931. Trade-Union Benefits, 1936, Monthly Labor Review 45: 1360 (Dec.) 1937. Footnote 42.

CHAPTER VI

GROUP HOSPITALIZATION

Group hospitalization plans, which provide for the prepayment of hospital service, have aroused more interest and discussion during the past five years than any other development in medical economics. These plans are offered by a hospital, an association of hospitals or a hospital service corporation which contracts with groups of persons to furnish designated hospital services on a prepayment basis. The hospital service corporation or association, in turn, contracts with participating hospitals for the services promised members. Prepayment hospital service plans were organized as early as 1918, in Grinnell, Ia., and 1929, in Dallas, Tex., by single hospitals, but the group hospitalization movement dates from 1931 when the first nonprofit hospital service corporation was started. Today there are eighty group hospitalization plans in operation with more than two and a quarter million members enrolled.⁵³

FORM OF ORGANIZATION

Forms of organization for group hospitalization have differed because of varying local conditions and state statutes. In some communities single hospitals have undertaken a group hospitalization plan simply by issuing certificates promising certain hospital services in return for the prepayment of an agreed sum. In most communities, a nonprofit no-stock corporation governed by a board of directors representative of hospital administrators, physicians and lay persons is formed to contract with hospitals for the services to be provided. In other communities, a membership corporation or association is formed to secure funds by regular sub-

53. For a detailed discussion of the history, development and operating results of group hospitalization plans, see: *Prepayment Plans for Hospital Care. Group Hospitalization Contracts are Insurance Contracts, and Group Hospitalization, publications of Bureau of Medical Economics, American Medical Association, Chicago.* See also Rorem, C. R.: *Hospital Care Insurance, American Hospital Association, Chicago, September, 1937.*

scriptions from members for the provision of hospital services in accordance with the by-laws and charter of the association. Hospitals which agree to provide the services for members of such an association are made charter members, and the board of directors to govern the association is composed of one representative for each member hospital. It is important to note that the purchaser of the contract sold by a hospital service corporation receives an agreement, the terms of which cannot be changed as long as the contract is in force. The member of a membership association receives a certificate subject to the by-laws of the association.

Competent legal advice is essential for the proper organization of a group hospitalization plan. The type of organization depends primarily on the provisions and interpretation of insurance statutes, case law, or rulings of the attorney general in each state. According to the present division among the states, group hospitalization or hospital service plans are looked on as essentially insurance in 31 states, whereas in 17 states and the District of Columbia such plans are presumably held not to be insurance.

The first group of states, according to the latest available information, includes Alabama, California, Illinois, Georgia, Kentucky, Louisiana, Maryland, Massachusetts, Mississippi, New Jersey, New York, Pennsylvania and Rhode Island where special enabling laws have been passed to permit the organization of non-profit hospital service corporations with specified supervision by the insurance commissioner; Iowa, Michigan, Wisconsin and Indiana where similar enabling acts have been proposed; and Arkansas, Florida, Idaho, Kansas, Maine, Nebraska, New Hampshire, New Mexico, Oklahoma, Oregon, South Dakota, Utah, Vermont and Washington, where group hospitalization plans are considered as insurance, and must be organized under the existing insurance laws or special enabling legislation has to be passed.

The second group of states, in so far as present information goes, includes Arizona, Colorado, Connecticut, Delaware, District of Columbia, Minnesota, Missouri, Montana, Nevada, North Carolina, North Dakota, Ohio, South Carolina, Tennessee, Texas, Virginia, West Virginia and Wyoming, where group hospitalization plans are exempt from the insurance laws and nonprofit hospital service corporations can be organized under the mutual benefit, membership corporation or the general laws of the state. In some of these states, group hospitalization plans are considered not to be insurance only on the basis of definite qualifications or limitations. For example, in Ohio and Texas, hospital service associations are permitted to enrol members from the county in which the association is located, but if members outside the county were accepted, the plan would have to be organized under the insurance laws. In Tennessee, the benefits of the contract may not exceed \$150.

In those states where group hospitalization contracts are considered as service contracts there is a tendency to change to the attitude that hospital service contracts must be considered as insurance or that a special enabling act must be passed. This is particularly true in Missouri, Tennessee, Virginia, and West Virginia. Whether a hospital service plan in South Carolina or Wyoming would be considered as insurance is not definitely known.

The practical importance of the question whether a group hospitalization plan in any one state can be organized as a nonprofit hospital service corporation or must qualify under the insurance laws has to do, in part, with the amount of money necessary to organize such a plan. In states where group hospitalization plans must qualify as insurance companies, a deposit of a large sum of money is usually required and the activities of the corporation must be subjected to the rigid supervision of the insurance commissioner. A

deposit of \$50,000 or the posting of a \$100,000 bond is usually a real obstacle to the organization of a non-profit hospital service plan. Consequently, in those states where group hospitalization is considered as insurance, the procedure has been to secure the passage of a special enabling act which exempts nonprofit hospital service corporations from the deposit requirement of the insurance law. At the same time, the insurance commissioner is given certain supervision over these corporations.

The change in the legal relations of group hospitalization plans has made it more difficult for promoters to start commercial fly-by-night organizations. During the period 1931 to 1935, many group hospitalization plans were organized with little regard for the insurance laws and were largely operated for personal gain. It is encouraging to observe that in practically no state can hospital service corporations be organized in the slipshod manner that prevailed only a few years ago. It is largely to the credit of the American Medical Association and the American Hospital Association that the public is now more adequately protected from unsound ventures in hospital insurance.

INITIAL FUNDS AND SALES PROGRAMS

The funds for organizing a hospital service corporation and for the initial stage of operation are usually obtained from participating hospitals, individual philanthropists, community chests, or foundations. Sometimes such funds are outright gifts, but more commonly they are in the nature of loans that can be repaid when the finances of the plan permit. There is little agreement among the organizers of the plans as to the size of the fund required for promotional and hospitalization expenses until the premium income from members is sufficient to meet all expenses. However, such a fund must be large enough to provide for all costs of the plan during a period of several months. An attempt

to finance a group hospitalization plan during the initial period out of subscription income from members is "insurance on a shoestring"—a practice that is fraught with many dangers. Likewise, the initial funds borrowed should be repaid out of earned income only, and then only after operating expenses, payments to member hospitals, and reserves have been met.

When the necessary funds are obtained and the hospital service corporation has been organized, one of the next important problems is the conduct of an effective and ethical sales program without spending too large a percentage of the receipts from members. Membership payments should be used primarily to provide for hospitalization of members. Usually a salaried director is hired to administer the business affairs and to bring the plan to the attention of the community. Salaried representatives are ordinarily employed to describe the plan to groups of prospective members in place of usual insurance solicitors on a commission basis. Newspaper articles, posters, dodgers, bulletin boards, circular letters, radio broadcasts, motion pictures and almost every conceivable advertising medium are utilized to interest the public in the plan. Valuable free publicity is frequently obtained by securing the cooperation of women's clubs, charitable organizations and other civic agencies in the community. The support of these agencies has proved to be a large factor in the rapid enrolment of members in the plan.

In the actual selling of hospital service contracts, the primary requisite is groups of employees with single employers. The enrolment of members in groups serves a double purpose: first, the usual high cost of obtaining members and collecting premiums is reduced when groups of members are enrolled and the premiums are collected by means of payroll deduction; second, enrolment of groups permits a more normal diversification of risks by avoiding adverse selection which occurs when members are allowed to purchase contracts

individually. At the outset most plans do not enrol dependents or individuals, but as soon as the plan has established some reserves, benefits are sometimes extended to dependents but infrequently to individual subscribers or to miscellaneous groups without a single employer.

Care must be taken in devising sales programs for group hospitalization plans to avoid methods which are contrary to hospital and medical ethics. To assist in the protection of the interests of patients the principles of ethics oppose advertising and solicitation of patients for medical or hospital services inasmuch as such practices almost invariably result in a deterioration of the services. Advertising and solicitation usually over-emphasize price, and good medical or hospital services can never compete with poor services on a price basis.

The success of a group hospitalization plan is largely determined by the administrative personnel. Group hospitalization closely resembles casualty insurance and in no branch of insurance can mismanagement be more disastrous than in casualty insurance. Such insurance does not have the definite mathematical basis of life insurance, and it is essential that the management be insurance-trained in order that unwise practices or unsound underwriting of risks may be more readily minimized or avoided. The interests of the three groups concerned—hospitals, physicians, and patients—should be represented on the board of directors, but such representation must not be at the sacrifice of competent insurance administration.

ESSENTIALS OF A GROUP HOSPITALIZATION PLAN

Group hospitalization plans are predicated on the basis that one patient day of hospital service per member annually will be required for the average group of persons enrolled. Accordingly, it is expected that about 10 per cent of the members will be hospitalized for an average stay of 10 days. There is very little actuarial

basis for the determination of a proper rate to charge. The usual procedure is to estimate a flat sum, for example \$6, as adequate to pay for the costs of one patient day of hospital service, including all the benefits of bed and board, operating room, anesthesia, routine laboratory services, routine medicines and other benefits. To this cost for the anticipated one patient day of hospital service for each member is added an amount, such as \$3, which is estimated to be sufficient to provide for costs of administration and sales and for the establishment of reserves. Finally, an enrolment fee, such as \$1, is charged for the initial enrolment of a member to provide for promotional and recording expenses. The total cost to subscribers for the first year is therefore estimated at \$10.

This is the fundamental rate structure of a plan for group hospitalization, although not every plan is organized exactly according to the method just outlined. The extent and number of benefits to be provided in the contract and the basic rate which will be accepted by participating hospitals for providing such benefits constitute the basic elements of the rate structure. If a semiprivate room accommodations are offered, the prevailing or usual charge for such room accommodations is the starting point for estimating the flat amount that must be paid to member hospitals for providing the services which are to be promised subscribers to the plan. To this basic room charge is added an amount considered sufficient to pay the cost of extra services that will be provided members during each patient day in the hospital. The participating hospitals then must agree to provide the services for the guaranteed sum per patient day. Some hospital service corporations pay member hospitals a basic amount for bed and board, but instead of including an additional estimated amount necessary to provide for extra services, agree to pay participating hospitals according to a fee schedule.

Based on these general expectations, and with the indicated agreement between the hospital service corporation and the participating hospitals, the operation of a group hospitalization plan can be approximated as follows:

Members will be charged \$10 annually, so that each group of 1,000 members enrolled will mean an anticipated income of \$10,000. Ten per cent of the 1,000 members, or 100, will be hospitalized during one year for an average stay of 10 days. The group of 1,000 members will therefore require 1,000 patient days of hospital service—the expected one patient day per member per year. With \$6 per patient day as the agreed payment basis, the cost of such hospital service will be \$6,000. The remaining \$4,000 is then available for administrative costs and for reserves. Administrative costs during the first year will require an estimated 30 per cent, or \$3,000. The remaining \$1,000 will be utilized to create a reserve and surplus for future contingencies or catastrophies and to repay any loans obtained to start the plan.

Table 1, which is based on promotional prospectuses, outlines an estimated budget for the operation of a group hospitalization plan during one year.

It remains for the actual testing in practice to prove the correctness of the expectations and estimates on which any particular group hospitalization plan has been or may be based. A great many factors can have an important influence on the actual experience of a proposed plan. Probably the most important of these factors is the ability of the administrators of the plan to organize the plan carefully and to secure the cooperation of hospitals, physicians, and residents of the community. The liberality of the provisions in the contract

with subscribers and in the agreement with participating hospitals, as well as the interpretations that are given to these provisions, has much to do with the number of members that will be hospitalized, the length of hos-

TABLE 1.—*Estimated Budget for the Operation of a Group Hospitalization Plan During One Year**

Anticipated administrative and promotional expenses (will be about the same for any membership up to 3,000.)		
Salaries—		
Director	\$2,500	
Field representative	1,500	
Secretary	960	\$ 4,960
Promotion—		
Advertising and publicity.....		1,000
Office Expense—		
Furniture and equipment.....	400	
Rent	600	
Postage, telegraph and telephone.....	300	
Record cards and miscellaneous supplies.....	100	
Printed forms	300	
Insurance and bonding.....	120	
Traveling	100	1,920
Total administrative and promotional expenses.		<u>\$ 7,880</u>
Anticipated Hospital Charges (based on a membership of 3,000)		
Average number of patients expected—10%, or 300		
Average number of patient days of service expected—10 days per patient or 3,000		
Anticipated payments to the hospitals at \$6 a day....		<u>\$18,000</u>
Anticipated Income (based on a membership of 3,000)		
From enrolment fees at \$1 per member.....		\$ 3,000
From monthly dues at \$9 per member per year.....		27,000
		<u>\$30,000</u>
SUMMARY		
Anticipated Income	\$30,000	100%
Anticipated administrative and promotional expenses.	7,880	26%
Available for hospital charges.....	\$22,120	74%
Anticipated hospital charges.....	18,000	60%
Surplus	\$ 4,120	14%

* Illustrative only—based on actual promotional prospectuses.

pital stay, and the resultant costs for hospitalization and administration. The degree of care used in the selection of members and the method of enrolment—that is, whether dependents or individuals will be

included and whether members are enrolled as individuals, in miscellaneous groups, or only in groups with a single employer—will likewise influence hospitalization experience and costs.

Among the plans now in operation, the rates charged subscribers range from 60 cents to \$1 per month, or \$7.20 to \$12 annually. The usual charge is 75 cents monthly, or \$9 annually. An initial enrolment fee, usually \$1, is also generally required. There is a wide variety of arrangements for charges to include dependents. If dependents are entitled to discounts only, a nominal charge is made, ranging from \$1 to \$7, according to the number of dependents, size of discount, and the type of benefits and room accommodations offered. If dependents are entitled to full services, a special additional charge is made, ranging from \$7 to \$35, according to the number of dependents included, type of benefits and room accommodations offered. There has been a noticeable tendency to establish a family rate which avoids the more complex rate structure when dependents are enrolled as individuals. With dependents entitled to full service, a customary family rate is \$1.50 monthly, or \$18 annually, for the subscriber and spouse or first dependent, and \$2 monthly, or \$24 annually, for the subscriber and his family, regardless of the number of dependents. Several plans have family rates with the dependent entitled to half coverage or required to pay an additional charge such as \$1 per day for each patient day in the hospital.

The most recent information available concerning the hospitalization statistics for hospital service corporations indicates that approximately 11 per cent of the members are hospitalized and that the average length of stay is about 8 days. The actual hospitalization experience has, therefore, been less than the expected hospitalization of 10 per cent of the members for an average stay of 10 days each. The experience of hospital service corporations to date tends to support

the basic estimate that one day of hospitalization will be sufficient per member year. However, several important considerations should not be overlooked: First, the rapid enrolment of members by existing plans, some of which have increased the number of members by nearly 200 per cent annually, would necessarily tend to keep hospitalization at a minimum. Not until the membership in group hospitalization plans reaches a stationary point or begins to decline, will the resulting hospitalization experience be characteristic of the normal hospitalization which can be expected over a period of years. Second, the full extent of the tendency for members of a group hospitalization plan to demand hospitalization has not yet been determined. The present experience indicates that members of a group hospitalization plan are hospitalized almost twice as frequently as persons in the general population, despite careful selection of members and restrictions on services provided. During the first year of operation of a group hospitalization plan, a rather high incidence of hospitalization can be expected, which may decrease during the second year. Thereafter a steady increase in hospitalization of members may occur, up to the present level of hospitalization experience, which is less than one patient day per member per year. The important question yet to be answered is whether this present level of hospitalization will remain at less than one patient day per member per year during a long period of years when the number of members cannot be greatly increased.

RELATIONS WITH STATE AND COUNTY MEDICAL SOCIETIES

The nature of the provisions in hospital service contracts has been the center of much discussion. Most hospital service contracts uniformly provide for the essentials of hospital service—bed and board, use of the operating room, general nursing care, routine medi-

cines, surgical dressings, and routine laboratory services. The medical profession approves the principles of hospital service contracts which are confined to these essentials. However, the contracts of many hospital service corporations have been extended to include medical services, such as roentgen ray and radium treatments, and radiologic services, pathologic services such as tissue examination, anesthesia, first aid or treatment of ambulatory patients in the outpatient department, and gastro-intestinal, basal metabolic, and electrocardiographic tests.

The inclusion of special medical services in a hospital service contract has many far-reaching consequences on medical practice in hospitals and on the quality of medical services that patients will receive in hospitals. The medical profession has questioned the propriety of a hospital service corporation attempting to sell the professional services of anesthetists, pathologists, radiologists, and other medical specialists, because the selling of medical services by a corporation is a practice that has long been recognized as contrary to good public policy. The courts have rather uniformly held that it is unlawful for a corporation to attempt to practice a profession such as law, dentistry or medicine, even though licensed lawyers, dentists, and physicians are hired to perform the actual services.

This principle is adhered to for the reason that lawyers, dentists, and physicians hired by a corporation become employees of the corporation and, as employees, must follow specified rules and regulations. There is no assurance that these rules and regulations will be in the best interest of the patient, especially since the corporation is freed from liability for quality of services. The individual physician, dentist or lawyer can never avoid liability for quality of service. Under corporate practice the allegiance of the physician, lawyer or dentist also becomes divided, because he must protect the interests of the corporation while endeavoring to serve the

patient. It has therefore been held that only individual persons who can be subjected to examinations as evidence of their educational training and qualification for good services should be allowed to practice medicine, dentistry or law.⁵⁴

The attitude that has been taken by the American Medical Association toward the inclusion of medical services in group hospitalization contracts can be outlined as follows:

In June 1937 the House of Delegates of the American Medical Association recommended:

. . . that the contract benefits provided by group hospitalization insurance should be limited to the room, bed, board and nursing facilities ordinarily provided by hospitals and routine medicines. . . . In regard to certain benefits offered by many hospital insurance plans, combining professional and technical services, the committee is in complete sympathy with those who would make every possible provision to prevent inclusion of any and all types of services involving medical care.

Also in 1937, the House of Delegates adopted Ten Principles for the guidance of group hospitalization plans. [See pp. 13-15]. The fourth of these Ten Principles states that the provisions in a hospital service contract should be limited exclusively to hospital facilities which are defined to include "only hospital room accommodations, such as bed, board, operating room, medicines, surgical dressings, and general nursing care."

At the session of the House of Delegates in San Francisco (1938) the fourth of these Ten Principles was extended by the following statement:

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

At the Special Session of the House of Delegates in September 1938 approval was given to the principle of hospital service insurance, provided that these plans confine themselves to provision of hospital facilities and do not include any type of medical care.

54. For a full discussion of the ethical and legal problems involved in the selling of medical services in *service* contracts see Group Hospitalization, Bureau of Medical Economics, American Medical Association, Chapter IV.

It is therefore the recommendation of the House of Delegates that the difficulties concerning medical services in group hospitalization contracts can be avoided by entirely omitting all provisions for medical services on a service basis, or by providing cash benefits directly to the subscriber for designated medical services. The first of these arrangements has been put into effect in cities such as St. Louis, Washington, D. C., and Wilmington, Delaware, where the group hospitalization plans exclude practically all such medical service provisions. The second arrangement has been put into effect in Oakland, California, in Pittsburgh and Philadelphia, Pennsylvania, and in other localities, where the hospital service plans include certain medical services but on a basis which permits the payment of cash benefits directly to the patient or physician. In these localities the group hospitalization plans have the cooperation of the medical societies.

The recommendations of the American Medical Association that medical services be excluded from group hospitalization contracts or that such services be provided only on a cash indemnity basis is concurred in by the actions of state medical societies in a majority of the states. In many localities where group hospitalization plans are in operation or have been proposed, the county medical societies have likewise indicated the undesirability of including medical services on a service basis. National societies of specialists have also objected to the inclusion of special medical services in hospital service contracts. It can be accepted, therefore, that the conviction of the medical profession, in general, is that the inclusion of medical services in a hospital service contract on a service basis will have an undesirable effect on the practice of medical specialties in hospitals and on the quality of the service rendered patients.

There is, in reality, little need for a hospital service corporation to insist that special medical services be included on a service basis. If it is believed necessary

to include medical services in a hospital service contract, an acceptable arrangement can be organized by the simple expedient of providing cash indemnities for such medical services payable to the insured or an assignment to his physician or hospital. Such an arrangement overcomes the ethical and legal problems involved when medical services are sold on a service basis. The cash benefit arrangement permits each member to obtain medical services without altering or interfering with the relations between hospitals and physicians.

In the early history of insurance companies, an attempt was also made to contract for the services included in the policies sold. It soon became evident that a more satisfactory practice was to pay cash benefits to the insured person who was then free to replace his property or to purchase services in whatever manner he choose. Many state insurance laws now have a standard provision that all policy benefits must be payable to the insured. This minimizes the possibility of collusion between the company and some organization or individual concerning the benefits which the insured member is entitled to receive.

HOSPITAL INSURANCE COMPANIES

Since 1936 there has been a rapid development in the number of insurance companies which offer an individual "hospital expense" policy providing cash payments to the policyholder for specified services in a hospital. These companies are either new mutual assessment companies organized for the sole purpose of writing hospital insurance, or are already established stock or mutual companies which have undertaken the sale of special hospital expense policies in addition to their regular accident and health insurance policies. There are also a number of insurance companies which offer special hospital supplements in connection with

regular accident and health insurance contracts, and other insurance companies which offer group hospitalization insurance on a cash indemnity basis in connection with regular group accident and health insurance.

Prior to 1936 insurance companies had had some experience with hospital expense policies, but the loss ratios were high and the companies withdrew from the underwriting of this type of policy. By 1936 group hospitalization plans had attracted widespread attention and with the growing recognition that such plans had to be subjected to the insurance laws of the state or organized under special enabling acts a few of the early group hospitalization plans reorganized as mutual benefit assessment insurance companies. The mutual assessment insurance laws provided an already available method of organizing a hospital insurance company. Requirements usually were that such a company had to have a few hundred applicants, several thousand dollars as a minimum reserve, and to maintain a stipulated percentage of the premiums for a claim fund. It was not long before several privately organized companies were incorporated as hospital insurance companies under the mutual assessment insurance laws.

With the further development of both group hospitalization plans and these hospital insurance companies, the larger stock and mutual insurance companies again began to experiment with the selling of a hospital expense policy similar to the group hospitalization contract. The essential difference is that the hospital expense policy offers designated amounts of cash to the insured for specified services in the hospital and the insurance company does not usually have a contract or agreement with hospitals for the provision of services.

A typical hospital expense policy provides the following benefits:

- § 5.00 for each day of such hospital confinement, not exceeding a total of thirty days in any twelve consecutive months, and

- \$ 2.50 for each day of such hospital confinement, extending continuously beyond a period of thirty consecutive days, not exceeding one hundred eighty-two days.
- \$10.00 maximum allowance for the use of operating room in such hospital during any period of confinement.
- \$10.00 maximum allowance for anesthetic in operating room of such hospital during any period of confinement.
- \$10.00 maximum allowance for necessary x-ray or laboratory test in such hospital during any period of confinement.
- \$ 3.00 for routine laboratory examinations upon admission to such hospital.
- \$ 3.00 for each additional laboratory examination in such hospital, not exceeding five such examinations.
- \$10.00 maximum allowance for medications and dressings in such hospital.

The charge for such policy is about \$10 annually. Today these hospital expense policies are sold by several hundred insurance companies including regular stock and mutual companies such as The National Casualty Company, Detroit, Massachusetts Accident Company, Boston, Century Indemnity Company, Hartford, and assessment associations such as the Mutual Benefit Health and Accident Assn., Omaha, The Intercoast Hospitalization Insurance Association, Sacramento, and The American Hospital and Life Insurance Company, Houston. The number of policyholders of these hospital expense policies is unknown. Most of the larger insurance companies have undertaken to write the hospital expense policy partly as a frank experiment and partly to serve as a "leader" to interest prospective clients in some form of accident and health insurance.

For a number of years the established casualty or life insurance companies writing group life or accident and sickness insurance have offered a special form of group hospitalization insurance which provided for the payment of a specified amount per day for hospitalization and a reimbursement for charges in connection with use of the operating room and for special services such as anesthesia and laboratory examinations. Reimburse-

ment for surgical charges up to an amount specified in a schedule of surgical operations has recently been added. The present provisions and underwriting requirements of group hospitalization insurance as sold by insurance companies are as follows:

The minimum number of employees required is 50, or 75 per cent of the number eligible to participate if that number is greater than 50. No employee over 70 years old is eligible. Hospitalization insurance is not written alone, an employee must have, or obtain, Group Life or Accident or Sickness Insurance in order to be eligible for Group Hospitalization Insurance.

There are two plans based on the number of days that benefits will be paid for one disability; a 31 day plan and a 70 day plan. The plans are similar in other respects. The premiums vary according to the amount of hospitalization benefits desired within limits of a minimum of \$2.00 a day and a maximum of \$6.00 a day for hospital confinement. Confinement in a hospital is defined to mean a confinement for at least 18 hours. A maximum of 14 days' benefits is payable for obstetrical cases under either the 31 day plan or the 70 day plan. Members are not limited to 31 or 70 days of hospitalization during any one year if hospitalization after the 31 or 70 day period is for another disability.

In addition to the daily cash benefits, reimbursements are made for fees charged for anesthetics, x-ray, laboratory, delivery room and operating room during one disability up to five times the daily benefit.

The plans also provide that reimbursements are made for surgical fees for specified operations according to a surgical schedule with amounts ranging up to a maximum of \$150 during one disability or sickness.

The entire premium may be paid by the employer or the employee, or they may jointly share the premium. Rates are guaranteed for one year. The basic rate is 15 cents per person monthly for each \$1.00 of daily benefit under the thirty-one day plan, and 16.7 cents per person monthly for each \$1.00 of daily benefit under the seventy day plan. For example:

If the daily benefit is \$6.00, the monthly cost under the thirty-one day plan would be 90 cents (6 x 15).

This basic rate also includes reimbursement for x-rays, anesthetics, laboratory services, or the use of the operating room and delivery room, limited to five times the daily benefit. For example:

If the daily benefit is \$6.00 a total of \$30.00 would be available to reimburse a subscriber for any charge incurred for the services indicated above.

The basic rate is "loaded" depending on the percentage of females or colored employees in the group. For example:

The basic rate is increased by 10 per cent if the number of female and/or colored employees is 31 to 41 per cent of the employees in the group, the rate is increased by 20 per cent if the number of female or colored employees is from 41 to 51 per cent of the employees in the group, and so on for the other percentages which the female or colored employees may constitute of the entire group.

There is no "loading" or increase in the basic rate, if the percentage of female or colored employees does not exceed 31 per cent.

The basic rate for surgical benefits is 35 cents per person monthly for reimbursement for surgical fees specified in the schedule with the maximum reimbursement limited to \$150 for one disability. A maximum limit for any one surgical fee may be reduced to \$75.00 with a corresponding reduction in the basic rate to 18 cents per person monthly. The basic rate is also increased or "loaded" in somewhat the same manner as the basic rate for hospitalization benefits if the number of female or colored employees exceeds 11 per cent.

Hospitalization benefits are payable only, if the confinement is in a legally constituted hospital, and any medical services involved must be performed by legally qualified physicians or surgeons. Hospitalization benefits are not payable for injuries incurred during the course of employment, nor for "occupational diseases" which are compensable under Workmen's Compensation Laws.

This type of group hospitalization insurance can be obtained from companies which write group life or accident and sickness insurance such as Aetna Casualty & Surety Company; Connecticut General Life Insurance Company; and Travelers Insurance Company, all of Hartford, Connecticut; Equitable Life Assurance Society of the United States, New York City; John Hancock Mutual Life Insurance Company, Boston; Metropolitan Life Insurance Company of New York, New York; Provident Life and Accident Insurance Company, Chattanooga, Tennessee; and the Prudential Insurance Company of America, Newark, New Jersey. Several group insurance companies will write such group hospitalization insurance without the requirement that the employee be already insured under group life or group accident and sickness insurance. It

has been estimated that seven million employees receive benefits from group insurance. Not all of these employees have group hospitalization insurance but almost all are eligible to participate in a group hospitalization insurance plan as sold by insurance companies.

CHAPTER VII

PLANNING AN ORGANIZATION OF MEDICAL SERVICES

The medical profession has consistently maintained that its primary mission is the service it can render humanity. It has always sought to improve that service and to discover more suitable methods of assisting the people to solve their medical problems.

For centuries attention had to be focused primarily on methods of improving the quality of medical care. Attention was therefore centered on education, on purity of drugs, and on scientific progress. The medical profession has never expected to "solve" the problem of disease and death; it knows that death must come to all. Nevertheless, within recent decades the number of years of life expectancy has been increased and these added years made far more livable.

Through prolonged study and experimentation a definite pattern has been elaborated by which the value of types of research, methods of treatment and training, scientific discoveries, health education, and professional ethics can be accurately measured and evaluated. The various features of this pattern are so closely united that changing or destroying any one of them may seriously weaken some or all of the other elements. When such foreign factors as industrial, political, or economic considerations are permitted to enter into the pattern of medical care or to dominate the situation, morale is destroyed and professional effort weakened.

PLACE OF FINANCIAL ARRANGEMENTS

It is impossible entirely to disregard reward or financial gain. Many essential elements of good medical service are destroyed by an insufficient reward. The Principles of Medical Ethics do not err in making

financial elements a "subordinate consideration" in measures to insure the efficacy of drugs or medical appliances or in the distribution of medical services. Wherever financial factors become a primary consideration, the quality of the service declines.

It is especially necessary to keep these facts in mind in considering plans for the payment for medical care. The first consideration must always be the quality of the service and the first question which must be asked is whether any financial arrangement is likely to lower the quality of the service. The necessity of this attitude is often overlooked by critics of present medical practice. These critics seem to assume that if some arrangement is made by which the public will receive some sort of medical service—the quality of which it is necessarily unable to judge but which will meet certain financial considerations—public health and welfare will be advanced. Consequently, "experts" who propose new schemes of medical service give their first attention to administrative and financial questions and pay little attention to the quality of the medical service, which should be the primary objective.

IMPORTANCE OF PREVENTION

Organized medicine has always placed great emphasis on measures for the prevention of disease. It devotes much of its energies to educating physicians, patients, and the general public in the importance of immunization and regular physical examination.

It seeks to develop efficient health departments and to eliminate political influence from their operation. The medical profession seeks to raise educational standards and professional ability of the entire medical profession to a point where the public is assured that anyone permitted to practice medicine is capable of giving good service. It endeavors to educate the public so that it will be able to choose good physicians and thereby avoid the incompetent. It has long recognized that one

of the most important barriers between the public and medical service is ignorance of the need for and methods of obtaining medical care. Ignorance, indifference, prejudice, politics, and financial niggardliness have always been prominent obstacles to effective administration of public health programs and the effective distribution of medical care. When medical societies and public health departments lose contact, both suffer.

EDUCATE THE PUBLIC

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 proper that the medical journals and speakers at medical meetings should constantly urge greater interest and activity in preventive medicine by practicing physicians and the need of prompt and proper action by the public in obtaining medical service when needed. Medical societies should endeavor not only to extend desirable activities in the promotion of health but also to restrict undesirable ones. Such activities by medical societies have already placed the United States ahead of nearly every other nation in the general application of preventive medicine. The proof of this may be found in the statistics of the decline of such diseases as diphtheria and tuberculosis.

INVESTIGATE BEFORE YOU PLAN

When a change is proposed in any phase of medical practice, whether scientific or financial, the first question the medical profession asks is "How will such arrangements affect medical service?" 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 the improvement of medical service and of methods of supplying that service to the public. Organized medicine would betray its social function and sur-

render its reason for existence if it neglected this work in order to give primary attention to administrative machinery concerned with "reward or financial gain." It would be especially false to its duty if it were to permit financial considerations or administrative organizations to harm the quality of this service.

Study should precede action. It is as dangerous to rush into plans for the reorganization of medical service without previous investigation and experiment as to follow a similar hasty adoption of untried drugs or diagnostic and therapeutic procedures. The customs, traditions, principles, and policies which have been built into the present system of medical practice closely affect the quality of medical care, to the maintenance of which the preeminence of this country in the conquest of disease and the postponement of death is largely due. These elements are constantly changing and will continue to change in the future. Organized medicine has introduced and perfected more changes than any other section of society. It will continue to experiment with such changes, but if the interests of the public are to be protected any fundamental change must be preceded by much the same sort of study and experiment as is used in evaluating new methods in diagnosis and treatment of the individual.

Before making any fundamental change in the organization of medical service in any locality, there should be a careful study to determine just how present arrangements are operating and to what extent they may need alteration, and whether such alteration will be an improvement. It will sometimes be found that an adjustment of local fee schedules such as has already been made in many states for the care of the indigent, in workmen's compensation, and for other special classes will meet the financial needs without destroying established values in medical service.

It is essential that the direction of any such study should be in the hands of physicians, who alone can

ultimately deliver the service, and not be entrusted to economists, sociologists, and social workers without special training even in medical economics and with practically no knowledge of the safeguards that are essential to the maintenance of the only type of medical service that will protect the health of the people. When lay research workers are utilized, all the medical features of their work, at least, should be supervised by physicians. Some of the greatest obstacles to any real advance in the medical care of the American people have been due to misinformation assembled by investigators who assume the ability to diagnose disease and determine the treatment needed although actually incompetent to perform any such function.

A medical society undertaking any change in the organization of medical services should clearly determine the size of the problem which it intends to attack. Advocates of wholesale panaceas like compulsory sickness insurance may deprecate plans which cover a comparatively small portion of the community, but that portion may be the only one for which a change will be helpful while the alleged panacea may bring more evil than good in its train. It is easier to experiment with a small plan and later to expand it into a comprehensive one than to start with a large scheme involving new and cumbersome administrative machinery.

PERSONS FOR WHOM THE PLAN IS INTENDED

The scope of any proposed change should be determined as definitely as possible. A primary division must be based on income. Any financial plan for the distribution of medical care must be one which will best adjust the burden to the resources of the individual. It will inevitably be some variation of the familiar "sliding scale" or "class price"; those without any income — the so-called indigent — are essentially the responsibility of the entire community and their care must be paid for by those who do have incomes. If

adjustments are necessary in order to apportion the burden among low income classes, then there should be a definite limit set at the point where such income will enable the individual to be self-supporting. The share of the burden to be borne by any member of an income class should not be so great as to reduce the amount available for such health necessities as food, housing, and clothing.

CONFUSING CLASSIFICATIONS

When patients are grouped 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. The variable element is the ability to pay for that care. This is an economic, not a medical problem. It has usually been met by some variation of the "sliding scale" of payment according to income. The patient may pay nothing or whatever his income will permit and the remainder is contributed primarily by the physician in reduced fees.

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 the entire population. This is because the extent and expense of treatment vary 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.

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 con-

siderable 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 can not 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 problem. 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.

Nearly all of the discussion of medical service plans is focused on those with incomes below \$1,500 per family. It must be remembered that this is a considerable class. It includes about 35 per cent of the non-farming class and 72 per cent of the farmers. Not all of these, however, constitute a special problem. Many such persons are able to pay for their medical care in the same way that they meet 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 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 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. 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. Here education of the public is of primary importance.

The medical profession in the United States is favored by some features in the present situation. 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 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 demands for a change in medical practice arose; facilities for medical care are more extensive and diversified and are better distributed. One of the most important tasks of organized medicine is to make sure that future changes do not destroy the advantages already obtained and that such changes do not involve the evils that have come in other countries.

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 and 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 they cover.

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.

The county medical society is not only the logical unit on territorial and professional grounds but it is also, by tradition and discipline, founded on the basis that "reward or financial gain should be a secondary consideration." It cannot legitimately be organized for profit. It must be devoted as much to the constant improvement of the services that the medical profession can render to humanity as to the 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 controlled by 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 on them by this duty, have undertaken experiments such as have been previously described.

INDEX

- Accident and Sickness Insurance, 123-125
- Actuarial Basis of Group Hospitalization, 158-159
- Alameda County Central Admitting Bureau, 97-98
- American Medical Association
care of indigent, 30
cash indemnity plans, 108-110
group hospitalization, principles for, 18-20, 165-166
House of Delegates, 9, 13-14, 30, 108-109, 165-166
special session, 22-24
insurance principles and, 145
judicial council, 135
medical ethics, 11
medical service plans, 13-14, 17
national department of health, 9
national health program, 22-24
organization of medical care, 11
principles of medical ethics, 11
quality of medical care, 10
resolution in medical care plan, 13, 14
sickness insurance and, 12-17, 26-27
socialized medicine and, 98
social security, 14
state medicine, resolution on, 9
Arrangements with Farm Security Clients, 87
- California Physicians' Service Bureau, 102
- Camden, New Jersey, 28
- Carnegie Illinois Steel Corporation Employees' Relief Association, 121-122
- Cash benefits, amounts paid, 152
- Cash Benefit and Service Contracts, 21
- Cash indemnity plans, 99, 108-115
American Medical Association and, 108-110
insurance and, 146-152
modified type, 115-119
New Jersey, 114-115
New York, 110
Texas, 111
- Cash Systems, Extension of, 148-150
- Cash and Unit Plans Combined, 115-118
- Cash vs. Service Insurance, 144-152
- Central Admitting Bureaus, 97-98
- Cincinnati Service Plan, 105-106
- Classification for Medical Care, 178-180
- Cleveland Academy of Medicine Plan, 119
- Clinics, 126, 129
- Clinic Group Plans, 132-135
- Commercial Sickness Insurance, 149-150
- Community Health Associations, 135-139
- Companies Writing Group Hospitalization, 171-172
- Contract Association Plans, Farm Security, 81-83
- Contract Practice, 11
- Contract Practice, Attitude of Medical Profession Toward, 141-142
- Cooperative health associations, 12
group health associations, 143
- Cooperative medical association, 143
- County Health Units in Michigan, 64-65
- County Medical Society Plans, 36-50
- County Physicians, 30-32, 39
- County Poor Doctors, 9
- County Society as Unit of Medical Care, 181-182
- Credit and Collection Bureaus, 120
- Crippled Children Under Social Security, 65-66
- Dallas Texas Medical Assurance Association, 111-114
- Deception of Insured as to Service Benefits, 147-148
- Economy Mutual Health Association, 138-139
- Education to the Public, 175-176
- Endicott-Johnson Medical Service, 124-125
- Essentials of Group Hospital Plans, 158-163
- Ethics, medical principles of, 11, 142
contract practice and, 141-142
- Experience Under Farm Security Plans, 88-89
- Family Health Service League, 131
- Farm security administration, 70-89
plans, 86
- Federal Emergency Relief Administration, 26, 33-35
- Fees, Sliding Scale of, 26
- Financial Arrangements in Medical Plans, 173-174
- Fraternal Plans, 139
- Free Medical Services, 28-29
- Fulton County, Georgia, Bureau, 103-105
- Gratuitous Medical Services, 28-29
- Group Accident and Sickness Insurance, 123
- Group Health Associations, 143
- Group Hospitalization Plans, 153-172
American Medical Association and, 18-21, 165-166
budget for, 161
enabling legislation, 154
funds for, 156

- Group Hospitalization Plans—Continued
 group hospitalization insurance, 169-172
 hospitalization statistics, 162
 insurance and, 154-156
 medical societies and, 163-167
 membership, 153, 163
 rates charged, 162
 sales program, 157-158
- Hawaii Medical Service Association, 117-118
- Health Departments, Establishment of, 7
- Health, National Department of, 7
- Hospital insurance, 18-21, 153-172
- Hospital Insurance Companies, 167-172
- Hospitals:
 medical services in, 10
- Indigent, care of, 9-10, 28-53
 American Medical Association, and, 30
 community program, 31
 cost of care of, 51-53
 medically, 28
 physician and the, 30
 political control, 31
 public duty, 30
- Industrial Health Services, 124
- Industrial Medical Service Plans, 121-129
- Insurance Principles, 27, 145
- Iowa, County Contracts for Indigent Care of, 45-50
- Iowa, County Plans for Indigent in, 39-40
- Iowa Plan, 36
- Jefferson County, Iowa, Cost of Medical Care in, 52
- Kansas, County Plans for Indigent in, 40-42
- Kansas State Board of Social Welfare, 37-39
- King County Medical Service Bureau, 101-102
- Legal status of group hospitalization, 154-156
- Legislation Regarding Insurance Plans, 150-151
- Loan Plans of Farm Security Administration, 77-81
- Lodge Practice, 140-141
- Los Angeles County, California, 29
- Maternal and Child Welfare, 55-56
- Maternal Welfare, Pennsylvania, 60-62
- Medical Care Arrangements by Medical Societies, 90-119
- Medical Dental Service Bureaus, 90-97
- Medical and Hospital Benefit Organizations, 130
- Medical service bureaus, 100-105
 Fulton County, 103-105
 King County, 101-102
- Medical service plans, 120: See also Cash Indemnity Plans, Unit System Plans, Medical Service Bureaus, Central Admitting Bureaus, Group Hospitalization Plans, Fraternal and Lodge Plans, and Medical and Hospital Benefit Organizations
 American Medical Association and, 13-14, 17
 attitude of medical profession, 141-143
 in industry, 121
 Medical Services in Group Hospitalization, 166-167
 Medical Society Experiments, 35-36
 Medically Indigent, Definition of, 28
 Michigan, Cooperation with Social Security, 63-65
 Michigan, Cost of Medical Care, 52-53
 Michigan Filter System, 58-59
 Michigan Unit System, 102-103
 Minnesota, Cost of Indigent Care, 51
- National Health Conference, 21
 National Health Department, 25
 National Health Program, 21-24
 New Jersey, Social Security Operation in, 58
 New York Medical Expense Indemnity Plan, 110-111
 New York Medical Service Company, 131
- Oakland County, Michigan, Cost of Indigent Care, 51-52
- Ohio, Social Security Operation in, 57-58
- Organization of group insurance, 153-156
 medical services, 172
- Pennsylvania, Indigent Care Plans in, 43-44
- Pennsylvania Maternal Welfare, 60-62
- People's Medical League, 131
 Philadelphia, 29
- Planning of Medical Services, 173-182
- Policies of Hospital Insurance Companies, 167-171
- Pooled Fund Plans of Farm Security, 72-77
- Poor Physicians, 9
- Postpayment Plans, 90-98
- Prepayment Plans, 98-117
- Prevention in Medical Plans, 174-175
- Principles of medical ethics, 11
 American Medical Association and, 11
- Poverty, 35
- Public Health, Attitude of American Medical Association on, 8-9
- Public Health, Development Under Social Security, 62-63
- Public Health Under Social Security, 59-60

- Qualifications of Farm Security Clients, 70
- Rate Structure of Group Hospitalization, 159-160
- Rehabilitation, 56
- Reimbursement Policies for Hospitalization, 169-171
- Rockford, Illinois, Hospital Service Association, 137-138
- Ross Loos Clinic, 132-135
- Rural health associations, 138
subsidies, 139
- Salaried Physicians for Indigent, 30-31
- Sedgwick County, Kansas, Medical Service Bureau, 95-96
- Service Benefits, Difficulties of Insurance, 146-147
- Sickness Insurance, 12-13, 17
American Medical Association, 12-17, 26-27
- Socialized medicine, 98-99
American Medical Association and, 98
- Social Security Legislation, 54-67
- Social Security, Medical Society Cooperation with, 56-60
- Spaulding Employees Mutual Benefit Association, 122-123
- Stanocola Employees Medical Hospital Association, 126-129
- State Agreements with Farm Security, 83-86
- State medicine, 7
American Medical Association and, 9
- Student Health Services, 129
- Surveys by State Medical Societies, 42-43
- Ten Principles, Sickness Insurance, 13-14
- Thompson Benefit Associations, 135-137
- Toronto Associated Medical Service Incorporated, 117
- Union and Fraternal Associations, 139-141
- Unit Service Plans, 99-108
- Unit Systems, Difficulties of, 106-108
- United States Public Health Service, 21, 23, 59
- Vital Statistics, 11
- Washington, D. C., 29
- Washington, D. C. Bureau, 93-95
- Washington, D. C. Mutual Health Service, 115-117
- Washington, Relief Under Social Security in, 67
- Wayne County Plan, 91-93
- Westchester County, New York, 29
- Wholesale Buying Groups, 130-131
- Wisconsin, 29
- Wisconsin, Care of the Indigent in, 66-67