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CHAPTER X

FIXED PAYMENT MEDICAL SERVICE OFFERED BY GROUP CLINICS, COMMUNITY HEALTH ASSOCIATIONS, COMMUNITY HOSPITALS AND MEDICAL BENEFIT CORPORATIONS

CHAPTERS III to VIII dealt with plans of fixed payment medical service which are the outgrowth of special conditions in the mining and lumber industries. The isolation of the places in which those industries are usually carried on explains why the employer, has taken the initiative in organizing company medical service for employees and their families. Without some special arrangement by which a minimum remuneration was assured a physician, such communities would probably be without medical service.

The same thing may be said of the type of contributory hospital service for railroad employees described in Chapter IX. The trunk-line railroad systems which have hospital associations serve sparsely settled regions which lacked adequate hospital facilities until the different railroads provided them.

The four types of fixed payment medical service to be considered in this chapter are significant because they have developed in urban places where no claim has been made that the number of medical practitioners was insufficient or the existing hospital facilities inadequate to meet local demands. These urban plans may be said to embody the efforts of individuals to substitute certainty for uncertainty in the matter of medical and hospital expense. Quite definitely they represent attempts to modify the traditional basis of medical economics.

The organizations which undertake to provide medical or hospital care in consideration of a fixed periodic payment are of four types, as follows: (1) private group clinics; (2) community

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health associations; (3) non-profit community hospitals; (4) medical benefit corporations.

The total number of examples of these forms of fixed payment medical care presented here is so small as to occasion the question why they are considered important enough to justify devoting a chapter to them. Not over a dozen group clinics are known to be offering this form of medical insurance; only two community health associations have been found—both are in New England cities, and one grew out of the other; only three plans of hospital insurance offered by non-profit community hospitals are described; and the number of medical benefit corporations does not exceed half a dozen. Moreover, the total number of persons participating in these four types of plans constitutes a numerically insignificant fraction of the total population.

It is possible, of course, that the few examples cited do not represent all that is going on in the way of experimentation with fixed payment medical service in urban places. The difficulties of making any comprehensive survey are obvious. There is no central source where information as to existing plans of medical or hospital insurance can be had. The American Medical and American Hospital Associations, while they are the leading national bodies in the field of medical practice, and hospital administration, respectively, are not in possession of detailed knowledge as to experimental activities in these two fields. The fragmentary information contained in this chapter was gathered in the course of following "leads" furnished by state and county medical societies, state insurance departments, and others.

The plans about to be described are significant as experiments. What they may yield by way of experience will be of inestimable value in appraising the possibilities of medical and hospital insurance throughout the United States.

INSURANCE MAY BE EITHER INDIVIDUAL OR GROUP

The basis of the arrangement between the organization providing medical service and those entitled to it may be either indi-

vidual or group. In the former case, the individual makes his payments direct to the organization; in the latter, the individual makes his fixed periodic payments to some organized group (employees' or other association) which in turn contracts with the organization to provide service to any member of the group requiring treatment, upon proper identification as a contributing member.

The individual type of arrangement is basic with the community health association, the community hospitals, and the medical benefit corporations; the group arrangement is the most common one in the case of the private group clinics.

One of the three community hospital plans of fixed payment service, viz., that of Roanoke Rapids, N. C., is unique, and for this reason is difficult to classify. In this community the plan of fixed payment service to industrial employees was part of the original idea when the hospital was built out of funds provided by local industrial concerns. The bulk of the employed population of the town gain their livelihood in six local mills. A fixed periodic deduction is made from their wages by employers and turned over to the hospital to cover the estimated cost of service received by members of the employed group who use the hospital. This particular plan is closely related to the mining and lumber company plans described in Chapters III to VIII. It has been included in this chapter because the hospital is now owned and operated by a non-profit corporation.

These four types of organization may be further classified in two ways: (1) According to whether they operate on a profit or a non-profit basis; (2) according to whether they provide care through their own medical staff, or arrange with independent practitioners to provide treatment.

The private group clinics operate primarily with a view to profit; that is, the members of the clinic make their living as medical practitioners through this form of organization. Their aim in offering fixed payment service is probably to assure a certain measure of fixed income to their organization. It should be kept in mind that the group clinics also provide medical ser-

vice on the usual basis of payment by the patient for specific service rendered. Service is provided by the staff of the group clinic.

The medical benefit corporations also operate with a view to profit. They have been found only in the State of California. Except for the fact that the Insurance Department of that State refuses to recognize the contracts they sell as contracts of insurance, terming them "contracts of service," this type of fixed payment medical service might more logically have been included in Chapter XI, which treats of commercial accident and health insurance. The California medical benefit corporations do not have their own employed medical practitioners; neither have they hospitals. In consequence, they make arrangements with independent physicians, surgeons and hospitals to provide the service to which their individual contract holders may be entitled.

The two community health associations (Brattleboro, Vt., and New Bedford, Mass.) operate on a voluntary membership basis, with no idea of profit. Having no medical staff or hospital of their own, they arrange with local hospitals and practitioners to provide service to their members.

The three community hospitals providing care on a fixed payment basis (Dallas, Texas; Grinnell, Iowa; and Roanoke Rapids, N. C.) operate as non-profit institutions. Their motive in offering hospital insurance is to put their finances on a sound basis. The average community hospital consistently operates at a deficit. This deficit is usually made up from voluntary contributions. The insurance basis enables the hospital to count on a fixed amount of money from "insurance members," regardless of the total cost of service provided. Theoretically (and the experience to date is not sufficient to supply a solution to all the detailed administrative problems involved) the hospital can, if the total expense runs higher than was originally estimated, redistribute the cost in the form of an increase in the monthly "dues" to members.

More detailed information about these four types of fixed payment medical service plans will now be presented.

PRIVATE GROUP CLINICS

The essential features of this relatively new type of organization for medical service are given in the following extract from a report entitled *Private Group Clinics*, by C. Rufus Rorem.¹

"The practice of medicine has traditionally been carried on as the responsibility of the individual practitioner, although variations from the established method are undertaken by industries, governments, or hospital and out-patient departments which have provided medical services for wage-earners or other selected groups.

"*'Private Group Clinic' Defined.* The private group clinic, for the purpose of this analysis, may be defined by several characteristic features—professional, financial and administrative. (1) Its physicians and dentists are engaged in coöperative and contiguous medical practice. They use many facilities in common, particularly office space, laboratories, and medical equipment. (2) All or most of its physicians are associated with the clinic on a full-time basis. (3) Its services include two or more medical specialties, and an attempt is usually made to hold complete facilities available for the patients accepted by the clinic, although some groups avowedly exclude from their services such specialties as obstetrics, ophthalmology, or dentistry. (4) Its patients are the responsibility of the entire group, not merely of individual physicians, although when consultations and special diagnoses are not required, one practitioner may alone treat a given case. (5) Its income is 'pooled,' and its practitioners have little or no direct financial relationship with patients. (6) Its members determine individual incomes by contract among themselves, rather than directly from their services to patients. (7) Its administration is carried on by a business man, rather than a physician, as far as non-medical matters are concerned. (8) Its credit investigations and collection policies are the specialized functions of a business manager rather than the incidental concerns of the several practitioners.

¹ Abstract of Publication No. 8 of the Committee on the Costs of Medical Care; Washington, January 1931.

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"The characteristics listed above distinguish the group clinic from other developments in medical service, such as 'partnerships' between physicians practicing but one medical specialty, 'individual practice' in which assistant physicians extend rather than complement the services of an individual practitioner, or 'free' or 'part-pay' clinics in which physicians serve on a part-time basis. 'Diagnostic' clinics which serve independent practitioners in the study and interpretation of difficult cases should likewise be differentiated from private group clinics as defined in this report."

PRESENT NUMBER OF GROUP CLINICS

Dr. Rorem found that there were about 150 group clinics in the United States, most of them in the middle west. The average number of doctors per clinic is twelve. The importance of group practice is indicated by the existence of a national organization of clinic managers. The sixth annual conference of this organization was held in Toronto in 1931, just before the annual meeting of the American Hospital Association; 50 of the strongest private group clinics were represented. It is significant that the 1931 meeting included discussion of the subject of providing medical service for an agreed charge per year. This was referred to as "medical care insurance." A report of this discussion, by Dr. Rorem, was published in *The Modern Hospital* for January 1932. From that report it appears that a substantial number of the private group clinics have entered into arrangements for the medical care of certain groups of persons at annual rates, in addition to carrying on their medical practice on a fee basis for other patients. These agreements are, in substance, according to Dr. Rorem, policies of medical care insurance, although they are not identified with any private insurance companies. "These agreements assure the individual that his expenses for the kinds of medical care which are provided will not exceed the amount stipulated in the agreement. They also assure the clinic physicians that the revenue for the medical care of a group of patients will not fall below a stated amount.

Dr. Rorem goes on to say: "No two agreements are alike. Some are very inclusive as to types of cases accepted. Others avowedly exclude some classes of persons and medical cases. In most instances, however, the agreements refer to the medical care of employed groups; consequently the prospective patients covered in the agreements tend to be of about the same economic and social status. A series of agreements or plans made by various clinics may be cited. These are arranged roughly in order of scope of service. The earlier examples represent offers of partial service and to relatively small groups. The later ones in the list provide comprehensive medical care, including hospitalization, to large groups of persons."

Dr. Rorem points out that where such "insurance" contracts are made between the private group clinic and an employer, the service may include only injuries occurring in the course of employment, and entitling the injured employee to compensation and medical care at the expense of the employer, under the state workmen's compensation law. In this instance, the fixed charge is paid by the employer, who thus "self-insures" his liability to provide an injured employee with all necessary medical aid arising out of a compensable injury.

The following instances of group clinic practice on an annual charge basis cited by Dr. Rorem in his article will serve as excellent examples of this new development in the field of "medical care insurance."

Clinic "D" is a group of 20 doctors in a city of 300,000 inhabitants. It has an arrangement with a local street railway company, whereby employees may consult one of the clinic physicians free of charge, during a regular "office hour" which he conducts at the company's general office. For this service the clinic receives a specified monthly amount from the company. In addition, there is a special fund for the care of hospitalized cases (non-compensable disabilities), to which employees contribute through a monthly payroll deduction. This fund, administered by the employees' association, pays all physicians', surgeons' and hospital fees up to

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\$50, any excess being paid by the employee. Other services to members of the association and their families are rendered by the clinic on an agreed fee schedule; for an employee, the association pays all charges, and for families, three-fourths, the family paying one-fourth. Hospital care of family members is not included. It is noted that this agreement is three-fold as to degree of financial responsibility on the part of the person eligible for the service: As an employee, he may receive office treatment at no cost to himself; as a contributor to the employees' fund, he is entitled to medical and surgical treatment and a limited amount of hospital service for himself; as a patient requiring care costing more than a maximum amount, he must finance part of his own medical care.

Clinic "E" includes eight doctors, in a city of 15,000 population. The arrangement in this case involves no financial risk to the clinic in rendering service. The Welfare Association of a local department store sends all members to the clinic for medical service. Regular fees on a case basis are paid by the Association from a fund created through monthly payroll deductions plus a general contribution by the company. Each employee is entitled to a maximum allowance of \$75 for medical care in any one year. The manager of the clinic states that the store first asked that the contract be made on the basis of a flat payment of \$100 per month, but there were objections to this plan. On the present basis, the average cost to the Welfare Association has been from \$400 to \$600 a year—considerably less than was anticipated; at the same time, the clinic has received its regular fee for each case.

Clinic "F" comprises 22 practitioners, in a southern city of 300,000 population. It has arrangements with various employee's associations to furnish medical care but not hospitalization at a maximum fee of \$1 per person per month, with the possibility that the cost to the association may be less than this amount. The work is done on a case basis according to an agreed fee schedule. If, for example, a patient undergoes an appendix

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operation the clinic charges the association for this service; if he requires merely one office call during the year, the association pays only for that one call. If the total charges do not reach the maximum figure of \$1.00 per person per month, the association pays only the actual amount charged. This arrangement was adopted as a means of preventing excessive demands for service. The manager of the clinic states that the plan has not been in operation long enough to demonstrate whether or not a large volume of business can be handled at these rates. The clinic is, however, taking the attitude that these fees are about all the association can afford, and is striving to make its medical and surgical costs meet the figures. The manager believes that when the clinic operates its own hospital, as it plans to do in the near future, costs will materially decrease. Services given under this plan exclude dentistry, maternity care, treatment for venereal diseases and for drug addiction.

Clinic "G" is a group of 10 doctors who own a 75-bed hospital in a city of 50,000 people. Seven years ago these same physicians were offering medical and hospital service at \$1.50 per person per month to several groups of employees. The plan was later discontinued because the County Medical Society adopted a special by-law prohibiting it. The clinic physicians, however, according to a statement of the chief of staff, still believe that the plan is "economically and ethically sound practice." This doctor says valuable lessons were learned from the experiment: the fee of \$1.50 per month was somewhat low for the character of service given; the bulk of the service tended to fall in the first year; the beneficiaries, including employers, liked the plan and protested its withdrawal; the local medical profession generally disapproved the plan as being unfair competition.

Clinic "H," in a large Pacific Coast city, consists of 14 doctors, and owns and operates a 200-bed hospital. It has agreements with employers to provide certain medical and hospital services to employees. The employer deducts \$1.50 per month from each

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employee's wages, consent to this procedure being a condition of employment. Five employers have entered into these agreements, covering from 250 to 1,000 employees each. All of the service is separate from, and in addition to, medical care given under workmen's compensation. It includes medical treatment and hospitalization (limited to 90 days), consisting of ward care in a general hospital. The usual exclusions are made of maternity cases, chronic conditions, venereal disease, insanity, etc.

Clinic "I," a group of 20 physicians in another Pacific Coast city, provides the most extensive and inclusive annual service found by Dr. Rorem in his study of this field. The clinic has agreements with a number of employees' associations, some of which offer as one of the privileges of membership, the right to be certified for medical care by the clinic. Deduction of \$2 per month for each eligible employee is made by the employer, and paid over to the employees' association, which in turn pays the clinic \$2 per month per eligible member. Not all members of the various associations subscribe for the medical service, but the percentage is said to be growing. The plan was inaugurated in 1929. In 1931 more than 5,000 employees and their dependents were covered.

Illustrating the scope of services included in this clinic's various agreements, one with a county employees' association is summarized by Dr. Rorem. Members of the association certified to the clinic receive medical care without further payment. This includes all medical and surgical attention by doctors, i.e., diagnosis, clinical and laboratory tests, X-ray examinations and treatment; surgical operations, professional consultations, and home visits; all medicines and drugs, except insulin; all dressings and splints; complete hospitalization, including "special services," in the ward of a hospital selected by the clinic. A charge is made for orthopedic appliances, eye-glasses, dentistry, crutches, or sick-room furniture. All classes of sickness and disease are treated, including mental cases, maternity, tuberculosis, and venereal disease. Hospitalization is limited to 3 months in any calendar year, and does

not include treatment after patients are transferred to state hospitals or tuberculosis sanatoria. The services of outside specialists, where necessary, are paid for by the clinic. The clinic maintains branch offices, and 24-hour telephone service. Patients must visit the offices for treatment, if able. For house-calls at a distance of more than five miles from a clinic office, a charge of not more than \$1 per mile is made. Members of the subscriber's family who live with and are wholly dependent on him, are entitled to the same services, but must pay the cost price of all medicines, drugs, dressings, splints, X-ray films, hospitalization, and outside specialists' services. When a member of the association leaves the employ of the county, he may continue to subscribe for and receive the services of the clinic, by paying \$24 per year in advance directly to the clinic. This clinic also carries on private practice, the doctors of the staff serving all patients without distinction, and usually without knowledge as to whether they are private or subscription patients. The clinic does not own or operate a hospital, but has staff privileges at several of the hospitals of the city, both proprietary and non-profit.

Dr. Rorem's conclusions from the reports submitted by the clinic managers are worth recording here: "The private group clinics represent a special type of organization of group medical service from the standpoint of the physician. It is significant that they should also be experimenting with plans for group payment by patients for their medical care. Service based on annual agreements is usually referred to by the clinic physicians and managers as 'contract' practice, a designation which emphasizes the certainty of revenue to the clinic. From the point of view of the patient the annual agreements are a type of medical care insurance through which the costs of medical care can be systematically provided for in his annual budget. The data which have just been cited, and the interest shown by clinic practitioners and managers in this type of service point to the need for further experimentation along this line."

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NON-PROFIT COMMUNITY HEALTH ASSOCIATIONS

The essential difference between the plan of medical care offered on a fixed payment basis by community health associations and that offered by community hospitals (to be described in the next section of this chapter) is that in the first mentioned type, the risk is carried by an organization separate from the hospital providing the service, whereas in the case of the community hospitals, the institution "insuring" the medical risk also provides the service that may be needed by the member. Two examples of medical care offered by independent community associations will be described. One is in operation in Brattleboro, Vermont, the other in New Bedford, Mass. The latter is, in fact, modeled in its general features on the former.²

BRATTLEBORO MEDICAL INSURANCE PLAN

The Brattleboro medical insurance plan provides for two kinds of service usually needed when the emergency of illness occurs, viz., (1) nursing, and (2) hospital service. There are two Associations: The Thompson Benefit Association for Nursing Service, established in 1926, and the Thompson Benefit Association for Hospital Service, established in 1927.

Brattleboro is perhaps unique as a community in having a foundation known as the Thomas Thompson Trust, created under a bequest some thirty years ago. The trustees of this foundation have been particularly interested in helping to develop the public health facilities of the community. Among these, besides the Brattleboro Hospital (non-profit), with 55 beds, there is the Brattleboro Mutual Aid Association, which provides bedside, visiting and public health nursing by graduate nurses, and attendant

² In Cooperstown, N. Y., a town of about 3,000 population, an experiment in hospital insurance on a community basis is reported to have been inaugurated on January 1, 1930. The Bassett Hospital Guild, for annual fees of \$25 for individuals, or \$100 for families of any size, is reported as agreeing to provide members with medical, surgical and hospital (ward) care, in the Mary Imogene Bassett Hospital. The hospital doctors determine whether the patient needs hospital care. Obstetrical cases are not included. Persons with chronic illnesses are not eligible for the insurance. The plan is still in the experimental stage, and no detailed information was available when this chapter was written regarding results.

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nursing under graduate supervision; prenatal and child welfare health service; dental clinics; school nurse; and a general health education program. The Thompson Trust, by means of the two Benefit Associations mentioned above, and through arrangements with the Brattleboro Hospital and the Mutual Aid Association, established a system of "benefit insurance" under which necessary hospital, surgical and nursing service can be paid for by the ordinary family without hardship.

Brattleboro itself is a town of approximately ten thousand, surrounded by a rural district of about ten thousand more, for which it serves as the business and medical center. The insurance plan originally contemplated the ultimate inclusion in its membership of all families in this area whose incomes may be considered to be "average or less." In practice, we are informed, the insurance is sold to all otherwise eligible applicants, whether of the well-to-do or the smaller income group.

AIM OF THE INSURANCE PLAN

The plan aims to provide protection at small cost for the entire family against certain of the expenses incident to sickness. It seeks to put the best service at the lowest cost within the reach of everyone, without resorting to free service. The plan is believed by its sponsors to be adapted to communities of moderate size, or to special groups. In both instances, a certain amount of personal knowledge of the participants would take the place of expensive administrative machinery, in selecting risks and adjusting claims.

The two Associations were inaugurated by the trustees of the Thomas Thompson Trust. For the Association for Nursing Service \$1,000 was set aside in 1926; for the Association for Hospital Service (1927) the amount set aside was \$1,500. As at present organized, the two Associations have no overhead or operating expenses, since these are borne by the Thomas Thompson Trust. The executive secretary of the Trust acts in a similar capacity for the Associations, and in addition "sells" the insurance. The funds of the two Associations are held in one of the banks of Brattle-

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boro, whose president serves as treasurer of both Associations. This officer issues the checks in payment of claims direct to the Hospital or to the Mutual Aid Association, upon submission of properly approved bills.

In the Association for Hospital Service no benefit is allowed until the member has paid the first \$30 of expenses. This requirement is intended to do away with all small claims, leaving the benefits to be applied on occasions of major expense.

While no physical examination is required for membership, applicants must sign a statement to the effect that to the best of their knowledge they are in good health and have no chronic disease.

Memberships are for either individuals or families. No attempt has as yet been made to arrange for the insurance of employee or other groups.

THE THOMPSON BENEFIT ASSOCIATION FOR NURSING SERVICE

This Association furnishes its members, through the Mutual Aid Association and under the physicians on the staff of the Memorial Hospital, with the services of graduate nurses at one-third of regular rates, and of attendant nurses at one-half regular rates. The "attendant" nurses are women specially trained by the graduate nurses of the Brattleboro Mutual Aid Association, to go into homes where sickness exists, but where expert professional nursing care is not required, and perform all such duties as may be needed to keep the household functioning, including keeping the sick person comfortable, assisting in housework and cooking, and caring for the children. The additional amount due the nurses for their services is paid to them by the Association for Nursing Service, and constitutes the "benefit" received by the member in return for his annual contribution.

If a member has to undergo an operation in the Brattleboro Memorial Hospital (or elsewhere as determined by the Hospital) and special post-operative nursing care is required, the Association for Nursing Service pays for this up to two-thirds of full charges

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for three days' nursing service, with two-thirds of nurse's board. In pneumonia cases also, one-half the expense of special nursing care in the hospital, including nurse's board, is paid by the Association. (This special post-operative and pneumonia nursing service was not a benefit under the original plan, but was added January 1, 1931.) Nursing care for maternity and chronic cases is not included in the plan. The maximum benefit payable in any one case is \$200.

The annual dues entitling members to the foregoing benefits are: single persons, \$2; married couples, \$3; children under 16 years of age, 50 cents extra.

The membership in the Benefit Association for Nursing Service on November 1, 1930, was 114 families and 96 individuals, an aggregate of 432 persons. The cost of protection to November 1, 1930, is shown to have been 8½ cents per capita per month. The total income of the Association from its establishment in 1926 to November 1, 1930, was \$2,420.51, which sum includes the \$1,000 set aside by the Thomas Thompson Trust in 1926 for the purpose of starting the Association. The total expense for the same period (i.e., the amount paid in claims; there is no "overhead," as previously shown) was \$767.60, leaving a balance of \$1,652.91. If the \$1,000 from the Thompson Trust is deducted, there remains \$652.91 balance from premiums paid in, plus interest earned.

THE THOMPSON BENEFIT ASSOCIATION FOR HOSPITAL SERVICE

The benefits offered by this Association are as follows: In case of surgical operations in the Brattleboro Memorial Hospital (after the first \$30 of all charges have been paid by the member) the Association pays all expenses including surgeons' and hospital charges, up to a maximum of \$300. In case of the need of other than surgical service in the hospital, the Association pays one-half of hospital charges (after the first \$30). The maximum amount in such cases is determined by the hospital directors or their committee, who decide whether the case is a "genu-

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ine emergency." Payments will not be made for any use of the hospital or nurses that is "chiefly a matter of convenience."

Surgical treatment must be furnished under the rules of the Brattleboro Memorial Hospital and by surgeons approved by its directors; all charges must be approved as reasonable by the directors. The directors, or their committee, may advise that the service required be rendered elsewhere than in the Brattleboro Hospital, if the case is one to which its facilities are not adapted.

The annual dues entitling members to the foregoing benefits are: single persons, \$5; married couples, \$7.50; children under 16 years, \$1 each extra.

The membership in the Benefit Association for Hospital Service on November 1, 1930, was 141 families and 142 individuals, comprising 550 persons in all. The cost of protection was 50.3 cents per capita per month. The total income of the Association from its establishment in 1927 to November 1, 1930, was \$6,120.78, which sum includes the \$1,500 set aside by the Thomas Thompson Trust in 1927 for the purpose of starting the Association. The total expense for the same period (i.e., payment of claims for doctors' services and hospital care) was \$5,736.16, leaving a balance of \$384.62. If the \$1,500 from the Trust is deducted, the Association's deficit on November 1, 1930, amounted to \$1,115.38.³

Any changes in the terms under which the benefits may be paid must be agreed to by written consent of not less than two-thirds of the "family units" entitled to benefits; a family unit is either: a single person; a husband and wife with or without children; or a parent and child or children under sixteen.

In studying the insurance plan worked out in Brattleboro, it will perhaps be noticed that the family doctor is not directly favored, except when he assists at an operation. The sponsors of the plan believe that he is indirectly benefited, since something is presumably left for his remuneration after the bills of the hospital, the surgeons and the nurses he has had to call upon, have been paid.

³ The Trust subsequently added \$1,000 to the Association's treasury.

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NEW BEDFORD MEDICAL INSURANCE PLAN

The New Bedford Health Association was organized in June 1929, and began taking members on July 1 of that year. On May 31, 1931, according to a letter received from the Association, it had 225 contributing members. (The population of New Bedford in 1930 was 112,597.)

The following extracts from the By-laws of the New Bedford Health Association indicate its aims and methods of operation.

Objects: "For the purpose of enabling residents of Greater New Bedford to receive hospital service or other medical care with less financial hardship, a committee of the Bureau called the New Bedford Health Association is hereby created by the Welfare Federation of New Bedford."⁴

Membership Requirements. "Only residents of Acushnet, Dartmouth, Fairhaven and New Bedford are eligible to membership in this association, and upon any one's removal from the four localities mentioned his or her membership shall immediately terminate. The trustees shall have the right to accept or reject any application for membership. They may terminate any membership at any time on any terms they see fit. They may require such physical examination of any individual either prior to membership or during the membership period, as in their discretion seems appropriate."

Application for Membership. Application for membership is made on a card containing the applicant's name, date and place of birth, residence and business address, and the name of the family doctor. The form of the application is as follows:

NEW BEDFORD HEALTH ASSOCIATION,
NEW BEDFORD, MASS.

ADULT APPLICATION FOR MEMBERSHIP

I, the undersigned, being in good health, hereby apply for Plan.....
..... membership in the New Bedford Health Association of New

⁴ Welfare Federation is the name of the organization which raises funds to cover the operating deficits of New Bedford voluntary charitable and health organizations. It is the local "community chest."

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Bedford, Massachusetts, a voluntary, non-profit organization formed to promote the general health of the community. I hereby agree to contribute a membership fee of \$1.00 when applying for membership and to contribute \$6.00 dues per year payable months in advance, to promote its general work. I hereby agree to be governed by all present and future rules of the New Bedford Health Association; and in case I apply for service, to accept the decision of the trustees as to whether I am entitled to, or shall receive, such service. In case I become over two months in arrears in my dues, I hereby agree that all my rights to service or benefits from the association shall be forfeited and that my membership shall end.

Signed this day of 19.....
Signature
Witness to signature

How Cost of Insurance Is Paid. Each member is given a small book of contribution tickets covering the twelve monthly subscriptions for the year. Membership dues may be paid at various local banks and trust companies. The membership book serves as identification in case of sickness or accident. If a member becomes over two months in arrears he forfeits all rights to service or benefit from the Association and his membership terminates.

Nature of Benefit. "The New Bedford Health Association will pay toward hospital accommodation, surgical, medical or specialist treatment in a hospital or elsewhere, for its members under the rules of the Association as follows:

"A member, if he pays the first \$30 of his sickness expenses, shall be entitled to the above service on terms and in the manner approved by the trustees up to a maximum cost to the association of \$200 in a case involving an operation, in any membership year; and in a case not requiring an operation, up to a maximum cost of \$120 in any membership year."

The member has absolutely free choice of doctor and hospital, the only requirement being that the doctor shall be a registered physician.

The Association contributes toward the expense of eye, ear, nose, throat, or teeth cases only when a surgeon's services are required.

No expense is assumed by the New Bedford Health Associa-

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tion until a medical examiner, employed by the trustees, determines that the case in question is an actual disability to which the Association should contribute. When the medical examiner certifies that a member is entitled to disability expenses, the treasurer is authorized to pay such medical bills for the member as the secretary certifies are correct.

The Association does not contribute toward expense growing out of the following cases: maternity, alcoholism, narcotic addiction, venereal disease, and progressive chronic diseases.

Administration. The New Bedford Health Association is administered by seven trustees elected by the Board of Directors of the Welfare Federation. The treasurer and secretary of the Federation are treasurer and secretary ex-officio of the New Bedford Health Association. In January of each year the trustees are required to render an annual report of the work of the Association during the past year, including a full and detailed financial statement.

Four trustees constitute a quorum. The trustees have full authority to change the rules and regulations of the Association. They also have power to negotiate agreements with hospitals, doctors, nurses and others to render hospital and medical care to members of the New Bedford Health Association, and to adopt such rules and incur such expenses as are necessary to carry on the work of the Association.

The trustees are not personally liable for any acts or omissions in the conduct of the Association.

The By-laws of the New Bedford Health Association provided that it was to continue for a period of two years from July 1, 1929, unless its reserves became so depleted that the trustees decided that the Association should be liquidated. If on July 1, 1931, the reserves were sufficient in the opinion of the trustees, they were empowered to continue the Association for a further period of four years. At the end of the four-year period the question of the continuance of the Association is to be referred to the Welfare Federation of New Bedford. The first experi-

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mental period of two years has been completed, and the Association is continuing operations.

On June 1, 1931, the balance sheet of the New Bedford Health Association showed as follows:⁵

Guarantee Fund	\$1,654.00	Expenses	\$ 239.87
Contributions	214.35 ^a	Claims	1,401.80
Membership fees	317.00	Investments	1,991.70
Dues	2,017.00	Cash on hand	709.21
Interest	16.90		
Dividends	123.33		
	\$4,342.58		\$4,342.58

^a Contributed by an individual to pay for "selling" the insurance. A young man does this in his spare time, receiving a commission for each new member he brings into the Association.

The possibilities of the community health association as a method of widening the application of insurance to the purchase of medical care cannot, of course, be deduced from the two experiments discussed above. Their success depends upon the degree to which medical practitioners will cooperate. One difficulty in this type of insurance plan stands out: the individual basis of membership. The expense of recruiting and retaining members on an individual solicitation basis necessarily reduces the total amount available for providing medical and hospital benefit. However, experience in Brattleboro and New Bedford may supply data for improvement in the present form of organization.

NON-PROFIT COMMUNITY HOSPITALS

Three examples of non-profit, community hospitals offering service to individuals, in consideration of a fixed payment in advance, have been found in the course of this investigation. One of these plans (Dallas, Texas) is relatively new, and to date does not offer much by way of experience with this type of hospital insurance. The hospital insurance plan in Grinnell, Iowa, has

⁵ Letter from New Bedford Health Association, June 5, 1931.

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been in operation since 1918; and that of Roanoke Rapids, North Carolina, since 1917.

BAYLOR UNIVERSITY HOSPITAL, DALLAS, TEXAS

In letters dated November 10, 1930, and February 10, 1931, this hospital writes that its plan for dividing the cost of the individual's hospitalization among the total members of a group was first offered to the public on January 1, 1930. In February 1931, there were about 3,000 persons participating in the plan, in groups as follows:

Public school teachers (largest group, 1,200 members); employees of three large banks; graduate nurses; city firemen; city police; employees of a daily newspaper. Only non-compensable disability cases are covered.

The annual fee is from \$6 to \$10 per person, according to the type of room desired, is collected in monthly installments by the group, and transmitted to the Hospital. The plan does not include the services of a physician, such as medical examinations, diagnosis office or home treatment, but only hospitalization for those members of the group whose physicians have sent them to the Hospital as patients.

From printed matter issued by the Hospital, the following information as to the services offered by the plan is taken:

Hospital service in Baylor University Hospital is assured when needed, including operating room service, anesthetics, and laboratory fees, for a period not to exceed 21 days in any 12 months. If further hospitalization is required, a discount of $33\frac{1}{3}$ per cent from regular hospital fees is made. The service does not include doctor's fees, either physician's or surgeon's, nor the services of a special private nurse; it does include all usual hospital services of nurses, internes and house staff, medicines, surgical dressings and hypodermics.

The service is given in wards or in private rooms, as previously agreed upon; if all beds of the agreed class are full, the assured patient is placed in a bed of a different price until one

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of assured price is available; if a higher priced bed is desired, membership rates are applied on the cost of such higher priced accommodation.

Membership in the plan ends if and when the person leaves his employment. The dues must be collected and paid as a group.

Obstetrical cases are not included in the plan, but a 50 per cent reduction on regular hospital fees will be allowed. Chronic mental and nervous disorders, tuberculosis, acute venereal infections, and contagious diseases, are accepted only for diagnosis.

Provision is made for times of epidemic or public disaster occasioning over-crowding of the hospital, by declaring that in such an event, the responsibility of the Hospital under the contract shall be discharged by the refund to the assured of twice the amount he has paid during the twelve months immediately preceding.

No patient can be admitted to the Hospital except under the care and upon authorization of some member of the Dallas County Medical Society; all members of the Society are eligible to use the facilities of the Hospital.

No information was available when this chapter was written (May 1932) as to the results with this experiment in hospital insurance.

THE GRINNELL (IOWA) HOSPITAL PLAN

The Grinnell Hospital has operated an insurance plan of hospital service since 1918. Under this plan, an adult is entitled to three weeks' hospital care during any one year, in consideration of the payment in advance of an annual membership fee of \$8. Husband and wife together may be insured for hospital service, for not exceeding three weeks for each of them in consideration of an annual membership payment of \$12. For an additional \$5, one child may be insured for a year along with the parents. Additional children are accepted at the rate of \$2.50 each per annum.

The insured member becomes entitled to hospital service fifteen days after payment of the annual fee. Unless the insurance is renewed by payment fifteen days before the lapse of one year,

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it expires. If then renewed, fifteen days must elapse before the member becomes entitled to hospital service.

Hospital service covered by the insurance includes room, board, and general nursing care. Medicines, X-ray and other special services, laboratory tests, operating room charges, and special nursing, are not included, and are charged to the patient.

In obstetrical cases, the period during which the insured woman is entitled to free hospital care is two weeks instead of three, plus \$10 per week and \$1 per day for the baby.

A member is admitted to the Hospital only upon recommendation of the attending physician, and upon presentation of the identification or membership ticket.

The remuneration of the family physician is not included in the insurance plan. His bill, as well as that of the attending surgeon in the case of an operation, is outside the insurance arrangement.

Dr. E. E. Harris, of Grinnell, in a letter dated December 10, 1930, states: "The plan originated in a meeting of the hospital staff in which we were considering ways and means of helping the Hospital in a material way. The coöperation of the doctors is very cordial in support of the insurance. . . ." Dr. Harris further stated that he did not believe the insurance plan could be extended to take care of the remuneration of the doctor and the surgeon, however desirable this might appear. He is convinced, however, that the insurance plan can take care of the running expenses of the Hospital and that the success of it is beyond question. He says, "I kept an accurate account of this for the three years I was in charge of the Hospital finances and I found only a single month in which we ran behind, and the amount was only \$3. Of course, the extras help out a great deal, but even these have such a great value to the patient that there is never any complaint of the extra charges. This is especially true of the laboratory service and also the X-ray."

The students at Grinnell College, according to Dr. Harris, are now being offered the opportunity of participating in the insurance plan. Those residing in the dormitories are required

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to take out a card at the beginning of the school year. The cost of the insurance service to them is \$5 per school year of nine months. In return for this annual contribution of \$5, the student gets practically the same care as is given the general public.

THE ROANOKE RAPIDS (N. C.) COMMUNITY HOSPITAL PLAN ⁶

Roanoke Rapids, N. C., reported by the 1930 Census as having 10,612 inhabitants, affords an interesting example of how a number of typical textile company plans of medical service to employees have developed into what is practically medical and hospital insurance for the entire employed population of the community.⁷

Employment in Roanoke Rapids and vicinity is provided chiefly by three cotton textile mills, one paper mill, one fiber-board mill, and an electricity generating station.

The Roanoke Rapids Hospital has 85 beds and is completely equipped for medical and surgical diagnosis and care; and for obstetrical work, eye, ear, nose and throat cases, etc. It has X-ray and physio-therapy equipment. The hospital ranks as Class A, and is accredited for nurses' training. A residence for nurses has recently been added.

The hospital staff consists of five doctors, two of whom are surgeons; three registered, and 30 pupil nurses. None of the doctors confines himself to a specialty, but each is interested in some special field: pediatrics, gynecology, surgery, etc. There is no specialist in eye, ear, nose and throat on the staff, but there is one in the town, who in return for the use of the hospital equipment for his private patients, gives his services free at the hospital for mill and charity patients. Dr. Long says that he is sometimes able to call on neuro-psychiatric and other specialists from other towns and institutions.

⁶ Information as to the Roanoke Rapids plan of medical and hospital insurance was obtained in connection with a visit to that town by a member of the National Bureau staff in December 1930. To Dr. T. W. M. Long, of Roanoke Rapids, the National Bureau is indebted for much of the following information.

⁷ See Chapter I (page 17) for a description of typical company medical service in the southern textile industry.

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The staff physicians are also the "company" doctors for the local industries. Their duties include physical examination of employees and of applicants for work; medical service to employees in their homes; surgical work to injured employees under the North Carolina Workmen's Compensation Act. (Enacted in March of 1929; effective July 1 of that year.) These physicians are free to engage in private practice to the extent that their duties to employers and employees leave them time. They are allowed the use of the hospital for their private patients.

The medical care to which employees of the local industries are entitled by reason of their periodic contributions includes complete care in the hospital in case they go there either as in-patients or out-patients. Medicines are furnished, as well as X-ray work if required. Obstetrical service is available to women contributors. Home care is available to contributing employees and dependent members of their families.

The following history of this enterprise has been given by Dr. Long: The industrial development of Roanoke Rapids began in the late '90s with the establishment of the cotton mills. The medical care began with the "company doctor" employed by these mills soon after their opening. The community was infested with malaria, 50 per cent of the people being infected with it all the time, so that the mills were always operating with debilitated workers. The typhoid and infant mortality rates were also excessively high. With the coöperation of the United States Public Health Service malaria and typhoid were eradicated, and the so-called "summer complaint," which carried off so many babies in their second summer, was abolished. Swamps were drained and oiled, surface wells replaced by driven wells, and open privies by septic tanks.

Meanwhile, endeavoring to provide more adequate care for the sick among the mill workers, Dr. Long and two colleagues opened a small private hospital in a vacant house. It had one nurse, eight beds, and such equipment as the owners could afford out of their resources. It was, of course, inadequate, but its pres-

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ence served to demonstrate the need to the mill owners, and convince them of the value of adequate medical care.

In 1914 Dr. Long proposed to the six local industries mentioned above that they build and equip a hospital large enough to serve the entire community, the cost to be divided among them *pro rata* to the number of employees of each. Dr. Long undertook to secure the coöperation of the employees in meeting the expenses of such a hospital through small, periodic contributions.

The idea was accepted by the local industries and in 1916 the hospital was completed. The employees also agreed to the plan, and in 1917 it was launched. A corporation was then formed under North Carolina laws to operate the hospital as a non-profit, eleemosynary non-taxable institution. To this corporation the local industrial concerns deeded the hospital, whose board of trustees is composed of the managers of the mills, the local physicians (both those engaged in industrial and in private practice), the Mayor of the town, and the Chairman of the Board of County Commissioners, *ex officio*. Apparently, the contributing employees are not directly represented in the hospital corporation. Up to the end of 1930 a capital investment of \$232,000 had been made on land, buildings, furniture and equipment.

The income of the Hospital is composed of (a) the periodic payments of employed contributors, deducted from their wages by local employers and turned over to the Hospital corporation; (b) fees paid by private patients; (c) a contribution from the Duke Foundation of \$1 per day for each "free patient day." Only actual charity patients, not mill patients, are counted in reckoning the amount of this contribution from the Duke Endowment. The teachers in the town also contribute as a group at the rate of 50 cents per person per week. Of this amount, 25 cents goes to the hospital and 25 cents to the hospital physicians for equal division among them. If there is a deficit in the operating expense of the hospital, it is made up by the local industrial corporations, *pro rata* to the number of their employees participating in the medical and hospital insurance scheme.

According to Dr. Long there had been only two deficit years

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prior to 1930. In all other years the Hospital had been able, by the exercise of close economy, to pay its way. How far the employee contributions fall short of meeting the cost of service to them is shown by the fact that in 1929 the cost of treatment to them amounted to \$62,071.30, while the amount contributed by them through payroll deduction amounted to only \$39,302.90.

For the year 1930 the following information has been kindly furnished by Dr. I. S. Falk, Director of Research of the Committee on the Costs of Medical Care, who has made a study of the Roanoke Rapids plan: "The total cost in 1930 was \$147,536, of which \$89,193, or \$20.10 per person eligible to receive care, was contributed by the mill corporations and their employees. Services covered home care, the care of the ambulatory sick in the offices of the physicians located in the hospital and in other out-patient divisions of the hospital, and all necessary hospital care for workers and their dependents. Home service included visiting nurses, as well as physicians. There were no limitations on the amount of care either in the home, in the out-patient divisions or in the hospital proper, nor were there any limitations with respect to the kind of care, with the exception of dentistry, pharmacy, and refractions and glasses. Major operations and similar services are all included. In 1930, the year to which these figures apply, the practice was that the employees contributed each 25 cents per week by check-off and this money went to the direct support of the hospital. The physicians were paid by the companies and this amounted to an equivalent of 25 cents per employee per week. In addition, the companies paid for the visiting nurses and made up a deficit of about \$10,000 in the operation of the hospital."

The Roanoke Rapids plan has not been immune from the effects of the prolonged business depression. Dr. Falk reports that although the local companies have managed to keep their plants in operation, there has been a considerable reduction in the size of the employed population, and drastic curtailment has taken place in the "welfare" activities of the industries. The financial basis of the insurance scheme has been radically modi-

fied as a result. As against the former weekly contribution of 25 cents, employed contributors now pay 50 cents. In other words, they are on the same contribution basis as the group of school teachers. Prior to 1932 the salaries of the hospital staff physicians (who are also the company doctors) were paid by the local industries. Now they are remunerated out of a fund created by allocating to them as a group 25 cents of each 50 cents collected.

Until July 1929, North Carolina did not have a workmen's compensation law. Prior to that time, therefore, employers were not under legal obligation to pay the Hospital for treatment of employees injured in the course of their employment. Dr. Long states that since the compensation law became affective, it has been the policy of the Roanoke Rapids Hospital to accept the amount paid by local industries to cover the operating deficit, in lieu of payment on a case-by-case basis from employers, for cases of accidental injury coming under the North Carolina Workmen's Compensation Law. These employers "self-insure" their compensation risk. Dr. Long states further: "The prolonged depression and unemployment has thrown a larger amount of free work on us than in the past, and the \$1 per day per patient from the Duke Endowment does not, of course, take care of this, so we are entirely dependent upon our local industries to make up any deficit that occurs."

Experience with fixed payment medical and hospital service in Roanoke Rapids naturally brings up the question of the effect of a long-continued business depression on this type of insurance scheme. What happens to the "insured contributors" when they cease to be entitled to medical care by reason of the cessation of their periodic contribution? Chapter I showed how the total number of employees in the mining, lumber and steam transportation industries participating in fixed payment medical service plans has declined during the past two years. No information is at hand as to how this particular group of unemployed persons now obtain medical and hospital care. This is a point concerning which it is important to have definite information. The same question arises, of course, under compulsory sickness insurance in

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the different European countries. The employed contributor is entitled to medical care from the insurance institution for a certain number of weeks after his employment has ceased. After that transition period is over, he must either pay for medical service or get it at the expense of the community as a "charity" patient.

MEDICAL BENEFIT CORPORATIONS

As far as has been discovered, this type of business concern operates only in the State of California. In return for a fixed periodic payment, the medical service corporation guarantees medical, surgical or hospital treatment to the contract holder in case he is disabled by accident or disease. Many of the contracts entitle dependent members of the contract-holder's family to medical and hospital service without additional payment. Medical service is provided on behalf of the corporation issuing the contract by physicians designated by the medical service corporation. Not having hospitals of their own, the medical service corporations arrange with independent institutions to provide hospitalization needed by contract-holders, in accordance with the terms laid down in the contract.

While the California medical benefit corporations endeavor to write group contracts with employers for the benefit of their employees, and while a small number of such group contracts have been written, the great bulk of this medical insurance is in the form of contracts between the corporations and individuals.⁸ Where group contracts are entered into with an employer, the latter collects from each employee electing to participate in the plan the monthly sum agreed upon. The employer does not match any part of the employee's contribution and assumes no responsibility beyond collecting the amounts authorized by employees and paying the total to the medical service corporation.

Six medical benefit corporations have come to our notice. No information is available as to the total number of contracts out-

⁸ The Insurance Department of the State of California has informed us that these medical benefit corporations do not come under its jurisdiction, since their contracts are considered as contracts of service, not of insurance.

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standing at a given moment; the total number of individuals who are guaranteed medical service; the number of claims paid; or the ratio of total claims paid to total receipts. However, there is nothing to indicate that the total numbers of persons covered by medical benefit contracts in California is more than an insignificant fraction of the total population of the state.

The nature and scope of the benefits offered by California medical benefit corporations is indicated in the following summary, prepared from specimen contracts.

Cost of Protection; Method of Payment. The customary method of payment is monthly, in advance. In the case of group arrangements, the employer collects the monthly fee, by an authorized deduction from the employee's pay, and transmits it to the insuring concern. The rate most usually quoted is \$2 per month per employee, for groups of ten to forty-nine employees. One concern quotes the following rates for larger groups: Group of fifty to ninety-nine, \$1.75 per month each; groups of one hundred to one hundred ninety-nine, \$1.65 per month each. In each group, provision is made for including family members and children, age twelve or under. For additional adult family members, the rate runs from \$1.65 to \$1.85 per person per month, depending on the size of the group. For each minor child, the rate is \$1 per month.

Most contracts contain strict provisions as to the payment in advance, and if payment is not made on the stipulated date, the contract ceases to be in force. Thereafter, payment may be accepted at the discretion of the medical benefit corporation. One contract allows ten days grace for payment of dues under an individual contract.

Convertibility under Group (Employer) Contracts. In case a person insured under a group contract ceases to be employed (other than temporary lay-off) he may convert his insurance interest under the group contract into an individual contract, by making application within thirty days, and paying the individual rate in advance. In case of temporary lay-off, the insurance re-

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mains in force until the end of the period for which payment has been made.

Cancellability of Contracts. "Falsity of any warranty contained in application" is the phraseology used in one contract. Other contracts stipulate that while the insured may cancel, the insurer may not, except for fraud.

Nature of Service Guaranteed. Certain contracts guarantee only hospital service, ordinary office or home treatment by physicians being excluded. The usual provisions, however, as shown by an analysis of several specimen contracts, are as follows:

Physician Service. Medical and surgical treatment, including major and minor operations, at the home of the insured, at the office of the attending physician or at the hospital. Members over 60 years of age are not entitled to continuous home or office treatment for more than 52 weeks. Some contracts limit treatment of home confining or non-confining illness to six months.

Medicines, Drugs and Dressings. The usual provision is that all prescriptions issued by approved physicians will be filled at designated pharmacies, at the expense of the medical benefit corporation.

Medical Benefit, so far as treatment at home or in the doctor's office goes, becomes operative immediately upon payment of the stipulated monthly fee in advance by the contract holder. The contract usually contains a provision that treatment under the contract shall only be given for diseases or non-occupational accidents occurring after the contract has entered into force.

Hospitalization. This includes room, board, regular nurse service, operating room charge, anesthetics, X-ray and other incidental expenses. Two contracts state that "all hospital service must be first approved by an officer" of the medical benefit concern.

Duration of Hospital Benefit. (Limitations on total expense.) The most usual provision is that hospital care shall not exceed 12 weeks in any one year. Some contracts increase the period of hospital care after the insurance has been in force for two years, without lapse. One contract limits the amount the Company will pay for regular hospital services to not exceeding \$6 per day.

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Another contract stipulates that "the Association will pay the Hospital for the member's hospital service as provided, in cities where it maintains offices, as ordered by a physician or officer of the Association (a) at regular hospital rates not to exceed \$50 per week; (b) not to exceed a period of eight weeks for any one sickness or accident, subject otherwise to terms and conditions of this certificate."

Waiting Period Before Hospital Benefit Becomes Operative. Most contracts provide that hospital benefit shall not begin until the fifteenth day following the issuance of the contract.

Ambulance Service. Contracts include ambulance service within city limits, or within a certain distance of the hospital to which or from which insured may be transported.

Maternity Care. Contracts usually exclude maternity care, but make the special condition that after two years of continuous membership on part of both husband and wife, maternity care will be provided.

Dental Care. Contracts provide for a semi-annual examination and cleansing of teeth, but include no dental work beyond this.

Optical Care. Annual examination and "treatment" of eyes are included as benefits. Apparently this does not include cost of new glasses.

Types of Medical Care Excluded. The contracts analyzed exclude medical, surgical and hospital treatment in connection with occupational accidents already covered under the California Workmen's Compensation Act; rest cure in a sanitarium; treatment for venereal disease; obstetrics (except when both husband and wife have been members for 2 years); "diseases not common to both sexes"; dentistry; injuries self-inflicted, or due to temporary insanity. One contract excludes treatment for "injuries received while participating in aeronautics."

Organization for Furnishing Medical Care. None of these six medical benefit corporations has its own clinic or hospital. A list of approved hospitals is given the insured member. Upon entering the hospital he is supposed immediately to notify the concern

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in which he is insured. As far as our information goes, only one of the medical benefit corporations mentioned above has its own staff of full-time employed physicians. Ordinarily, a list of "approved" dentists, physicians and pharmacists, is maintained.

Procedure by Which Member Gets Medical Care. Contracts usually provide for a special identification card to be given the member. In the case of illness or non-occupational injury, he is supposed to call in an "approved" physician. The identification card serves as authorization to the latter to render his bill to the medical benefit corporation. In case of emergency, any licensed physician may be called for the first treatment. After that, the member must utilize an "approved" physician.

Remuneration of Physicians, Dentists, Pharmacists, and Hospitals. The usual practice appears to be for the practitioner or hospital to render a bill to the medical benefit corporation. One concern states specifically: "Doctors are not paid a salary or hired by the year or month. They are paid for each visit they make. We pay them for calls at their office or at the client's home, according to the compensation rates as made by the State of California."

NEWSPAPER MEDICAL INSURANCE

A recent development is a special agreement worked out between one of the larger medical benefit corporations and a Los Angeles newspaper. As an inducement to become subscribers, readers of the newspaper are offered the services of the medical service corporation at reduced rates. A year's subscription to the paper, and \$1 registration fee, makes the reader a member of the "League". He may choose either of two services. Under Service No. 1, he and all members of his family are entitled to receive, at special reduced rates, the medical, surgical and hospital service provided by the medical corporation; under Service No. 2, the member himself, by payment of \$1.35 per month (a reduction on the regular monthly rate) is entitled to complete service without further charge. If the member ceases to be a subscriber to the newspaper, his dues automatically increase to

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\$1.80 per month; if he is using Service No. 1, he and his family are no longer entitled to the special reduced rates for services rendered by the corporation. Each member receives a regular certificate of agreement, or contract, from the medical service corporation, and the medical, surgical and hospital service guaranteed is the same offered to all clients of the corporation.

CONCLUSIONS

In concluding this summary of experiments at present under way with fixed payment medical service in urban places, it may not be out of place to examine them critically from the standpoint of insurance. The essence of insurance is risk, and any insurance contract involves an undertaking on the part of one party, called the insurer (or carrier) to pay a sum of money (or its equivalent in goods or services) to another party, called the insured, in the event of the happening of the contingency insured against, called the risk, or hazard. In the case of commercial accident and health insurance, the contract can be carried out by the payment of a stipulated sum of money. In other words, the risk is quantitative. Thus, a policy of health insurance ordinarily undertakes to pay to the insured a certain amount of money for a certain number of weeks, in case he is incapacitated by a cause covered by the policy. Where the policy includes medical or hospital benefit, the undertaking is to pay to the insured a stipulated sum of money in case he has incurred expense in connection with any one of several specified ailments. The difference between ordinary health and accident insurance and employers' liability insurance is that under the latter there is an undertaking on the part of the insurance carrier to provide the amount and kind of medical, surgical and hospital care to which an injured employee is entitled under the workmen's compensation law of his state. In other words, the risk under this type of insurance contract is qualitative. The same thing is true of the types of medical and hospital insurance which have been discussed in this chapter. It is plain, therefore, that for these forms of insurance to be successful, they must be based on

adequate experience with respect to the frequency and duration of illnesses of different kinds. Such data are at present meager. Data as to costs of treating various types of illness are, of course, indispensable. Such data, to be reliable, must in turn be based on adequate cost accounting systems, both in hospitals and in the offices of private practitioners. Such accounting systems do not as yet exist. Among the useful data which the experimental plans of private group clinics, community health associations and non-profit community hospitals could yield are figures as to costs of various kinds of illness under different types of medical and hospital treatment. A certain degree of standardization of fees for medical and hospital service is also essential to the successful operation of any insurance scheme. Some progress in this direction has already been made through the working out of what are called "fee schedules" for medical and surgical services in connection with workmen's compensation.

From the foregoing description of fixed payment plans of medical service, the reader will have noted that in any insurance plan there are two distinct functions: (1) the function of risk carrying; (2) the function of providing medical service. In the case of the private group clinics and the non-profit community hospitals, both functions are discharged by the same organization. In the case of the community health associations and medical benefit corporations, the risk is carried by one organization and the medical service is provided by another. In these two types of medical service plan, the medical practitioners and hospitals may demand remuneration from the association or corporation on the regular basis of payment for a specific service rendered.

The question arises from a consideration of the plans of fixed payment service offered by private group clinics and community hospitals, whether it is wise for the medical service organization to also assume the insurance risk. The Judicial Council of the American Medical Association has recently voiced apprehension on this score in the following language: "The members of the Judicial Council doubt that it is wise to lead the people in any community to believe that all necessary medical and hospital service, even though chronic diseases and obstetrical care be excepted, can be

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provided for the average family at \$35 a year. In the cases presented to it the Judicial Council has advised against adoption of such plans by community hospitals because it is believed they are not economically sound, in that they may be unfavorably affected by conditions entirely beyond control, under which contracts cannot be fulfilled."

The significance of the combination of group medical practice with group purchase on a fixed payment basis cannot be overestimated. The group principle of medical organization is here to stay; and if a satisfactory basis for providing medical treatment on the insurance principle can be developed out of experiments which several private group clinics have under way at present, a wide extension of fixed payment service may follow. Hitherto, the unwillingness of the medical practitioners to undertake the provision of service on a "contract" basis has been an obstacle to the development of medical insurance. With an increasing number of physicians and surgeons voluntarily adopting the group principle of organization, the way is now open for organized groups of would-be purchasers of medical service, e.g., employee mutual benefit associations, local trade unions, etc., to approach organized groups of medical practitioners with a view to some mutually satisfactory arrangement for the group purchase of medical care on the insurance basis.

Since this chapter was written, information has been received that in Dallas the Methodist Hospital has instituted an insurance plan similar to that of Baylor Hospital. The major difference is that whereas Baylor Hospital contracts directly with employee groups, the Methodist Hospital provides service under an agreement with the National Hospitalization System, a business organization which solicits the contracts, collects the fixed periodic payments and pays the hospital. Of the annual membership fee of \$9, the System retains \$3. About 4,000 members were under contract on March 31, 1932. It is reported that a similar plan has recently been instituted by the System in hospitals in Fort Worth, Texas, Louisville, Ky., and Shreveport, La.

In Rockford, Ill., we learn that a hospital association, similar to the one in Brattleboro, Vt., has been in operation for some years.

In Little Rock, Ark., Trinity Hospital and Clinic has agreements with groups of employees to furnish complete medical and hospital care for \$2 per month per member. House calls are charged extra. Six weeks is the maximum of hospitalization allowed.