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THE STORY OF BLUE CROSS

On the Road to Better Health

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BY LOUIS H. PINK

WHAT BLUE CROSS MEANS TO YOU:

Prompt hospital care when you need it.

The best of care in approved hospitals.

No hospital bills — peace of mind.

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THE STORY OF BLUE CROSS

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By LOUIS H. PINK

An Idea Is Born

In 1929, a group of teachers in Baylor, Texas, were faced with the fact that *as individuals* they could not save enough to pay hospital bills in an emergency. Millions of other Americans had found themselves in the same plight without doing anything about it. But these Baylor teachers did something about it. By a little figuring, they found that *as a group* they could easily pay all the hospital bills they were likely to incur. So they persuaded the University Hospital at Baylor to agree, for $3 each school semester, to

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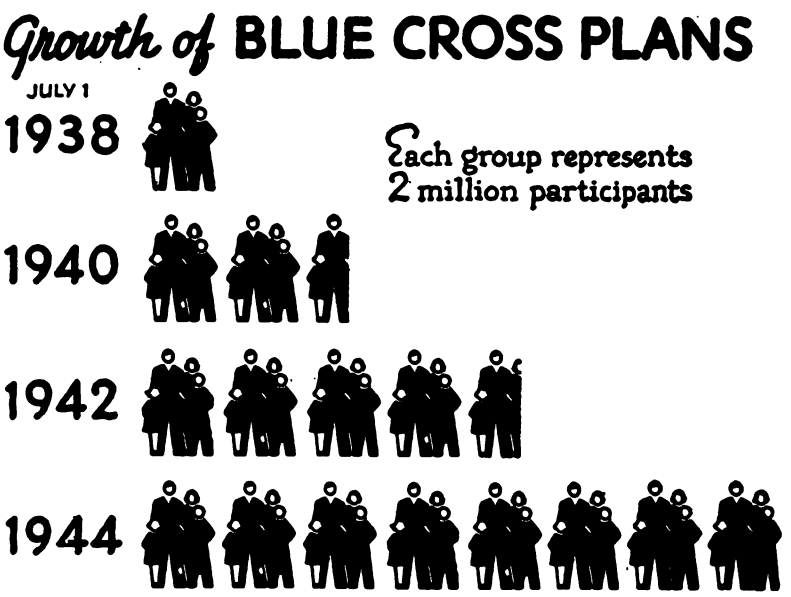
provide twenty-one days of hospital care to any one of them who needed such care. When the experiment proved successful, others besides schoolteachers asked to be included in the plan. Other hospitals learned about it and



followed suit. But in cities having more than one hospital, overlapping and competitive difficulties arose. It became clear that to be really successful, any plan would have to include nearly all the hospitals in the area and permit the patient to choose the one he wished. This was the beginning of Blue Cross.

The First City-Wide Plans

The idea was tried out with a group of hospitals in Sacramento, California, in 1932. The following year a similar plan was started by the Hospital Council of Essex County, New Jersey, which includes the city of Newark.

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This experiment developed so rapidly that after six months the working capital which had been advanced by a commercial agency was returned and the hospitals took over the management. The Essex County plan was successful and now operates throughout the state of New Jersey. The hospital plans at St. Paul, Minnesota, and Durham, North Carolina, came next. The largest of all—that of New York City—was established in 1935. Ten years later, it had a membership of 1,700,000. The hospital plans at Cleveland and Detroit, spurred on by large industrial organizations, and the state-wide plan in Massachusetts have grown more rapidly in recent years but have not as yet topped New York's.

Today there are seventy-five Blue Cross Plans scattered over the United States. In addition, there are five in Canada, and one in Puerto Rico. In all, there are nearly seventeen million subscribers. The plans differ in some respects as to the amount of protection offered and the method of operation, but in general, they follow a common pattern.

What Blue Cross Means to You and Me

All of this means a good deal to your health and to mine. Hospital care has improved vastly in recent years. New inventions, techniques, and drugs—plus the increased skill of physicians and surgeons—have made many dread diseases less dangerous to mankind. This has added vastly to the expense of hospital care. Since hospital bills have to be paid promptly, the problem which confronts us when serious illness comes is a difficult one.

Blue Cross, by the use of small, regular payments, makes hospital care possible for all of us—without financial worry, depletion of savings, or the necessity of borrowing from friends.

Blue Cross helps the *subscriber* because it assures prompt hospital care and pays the bill. By eliminating financial worry, it helps speed recovery.

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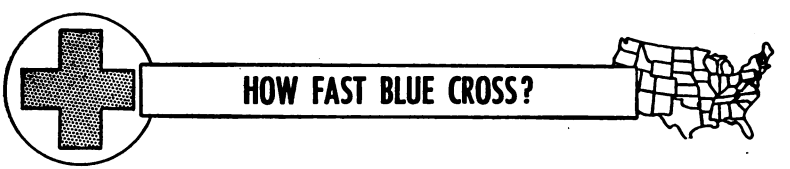
The *employer* doesn't have to pass the hat or make a contribution after an employee falls ill; his employees have peace of mind and freedom from worry—a valuable asset.

The *hospital* gets its money on the line and doesn't have to worry about the patient's credit; collections do not involve bookkeeping expense. Blue Cross membership encourages hospital use whenever it is needed.

The *doctor* benefits because when a patient's hospital bill is paid by Blue Cross the patient can more readily pay his doctor.

Blue Cross not only lightens the financial burden of the individual but it also helps the hospital and the local government, for it pays for many who would otherwise be entitled to free or part-free care. Prompt hospital care and adequate service are Blue Cross's contribution to the *community.*



EIGHT years ago, the membership was only half a million. Blue Cross now has nearly seventeen million subscribers after sixteen years of existence. Seventy thousand people join Blue Cross each week, and the annual income is $100,000,000. This record is a remarkable achievement. It testifies to the appeal which its social usefulness makes to the public.

At the present rate of growth, Blue Cross may double its membership and thus protect more than 35,000,000 subscribers within a six-year period. While the present membership is about 12 per cent of the population of the United States, in many localities a much larger proportion of the people have become members. In Rochester, Cleveland, Minneapolis, St. Paul, Duluth, Flint (Michi-

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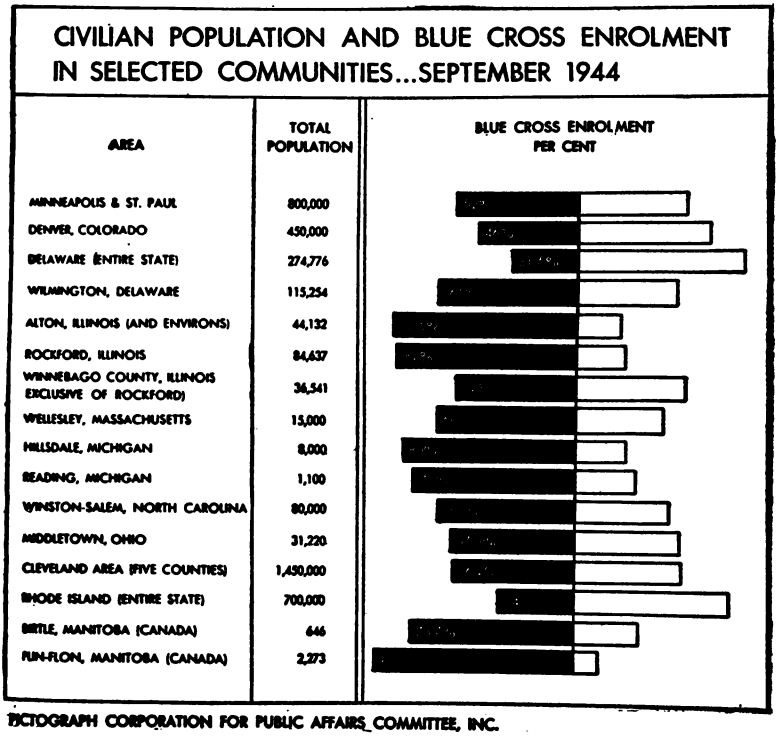
gan), Winston-Salem, and Rockford (Illinois) more than 50 per cent of the population has been enrolled. In the city of Rochester, as distinguished from the area served by the plan, about 70 per cent of the population is covered. The chart shows what a number of other communities have accomplished.



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Many forms of health insurance protect only the worker on the job. Blue Cross has now more family participants than single subscribers. In 1938, 60 per cent were individual subscribers, and 40 per cent were members of family groups; today the situation is almost reversed Single or individual subscribers account for 46 per cent of the total enrolment, and family subscribers for 54 per cent.

Although women and dependents require more hos-

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pitalization than men and are therefore more costly to insure, the Blue Cross Plans have been able—in the face of rising costs—to increase payments to hospitals, constantly expand their benefits, and give better service to subscribers.



PROBLEMS OF ENROLMENT



PRIVATE insurance is usually sold by agents who canvass in the office, the factory, and the home. Experience shows that it does not sell itself. Consequently, commissions are offered to encourage the sale of insurance. But commissions are illegal for nonprofit hospital and medical insurance in many states. Blue Cross protection is usually offered through salaried employees. In some places such as Cleveland, where there are many large industries, not even a paid sales force is necessary; the employers come to the plan. In New York, where there are many small industries, it is necessary to maintain about thirty salaried representatives to call upon employers and conduct enrolment campaigns among employees. The other plans vary between these two extremes. Enrolment expenses rarely exceed 3 per cent anywhere, and in some cases scarcely exist.

Group Coverage Easiest

Most of the people in a community can usually be reached as groups of employees, which make up 95 per cent of the business of hospital service plans. Not only is it easier to get a large number of subscribers by the group method, but it has been found that plans are more apt to get the "average subscriber" by accepting many persons in a common office or employment at a time. The

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acceptance of a group protects the plan against "adverse selection," or too many poor risks. Group enrolment cuts down clerical work and bookkeeping expense, thus permitting a greater return in benefits for the subscriber's dollar. Most plans now accept groups as small as five—and even smaller units in rural districts. Group enrolment with payroll deduction is obviously the easiest and cheapest method of building membership. Where the employer will not provide collection facilities, it is often necessary to appoint one of the employees to make collections and look after the interests of the group. There are at least 100,000 of these group representatives, most of whom serve without pay. But if Blue Cross is to provide adequate security for the public, it must go beyond employed groups.

Individual Membership

The Hospital Service Plan Commission has recommended broadening the base of Blue Cross membership. The Commission also urges plans to accept individuals who are self-employed or who for one reason or another cannot join a group. Some thirty plans have experimented with this type of subscriber, but as yet there is little individual enrolment anywhere except in some rural areas and in New York City, where there are over 75,000 non-group individual and family subscribers.

In New York, the experience in recent years with persons who cannot join through employed groups has been good. The practice has been to accept people on the basis of a medical questionnaire similar to that used by life insurance companies. Maternity benefits are usually given only to group subscribers. Some of the plans will accept people without medical questionnaire during certain fixed periods, on the theory that most of the people who join during such a period will be in normal health. New York City, for example, is experimenting with a simple form of enrolment without medical questionnaire, during a limited period.

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Community Enrolment

One way of getting broader group coverage that has worked out particularly well is "community enrolment." A campaign is made to secure as members at least half the population of a village or town. This type of membership is not considered broad enough to be wholly desirable unless approximately 50 per cent join. In order to get such a large proportion, the aid of the mayor and local officials, local banks, the Grange, civic and health organizations, women's clubs, and other associations is enlisted. Although insurance experts say that the best cross-section is obtained from employee groups, nevertheless, lodges, churches, societies of professional people, all of the doctors or dentists in a locality, all of the people residing upon a given street, or working in a large office building, may also be considered as a satisfactory group. Out of the many experiments now under way, the answer will be found as to the means of enrolling with a minimum of red tape, the self-employed, members of small establishments, farmers, domestics, and others, many of whom are not now covered by Blue Cross or even by the old-age and survivors' insurance.

Reaching the Farmer

It has always been hard for farmers to get satisfactory medical or hospital care. There are not nearly enough hospitals in rural areas, and farmers are independent and tend to avoid hospitals—especially when there are none nearby. Farms are widely scattered and the cost of collection and administration is therefore high. Living conditions on many farms are poor, and illness is more prevalent than in villages or cities. Yet farmers who lack money should be cared for just as well as the poor in cities.

Blue Cross is now making a serious effort to help country people get the hospital care they need. This is accomplished through cooperation with the Grange, the farm

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bureau, the union, the cooperative, the local bank, local mutual fire insurance companies, newspapers, creameries, and other marketing associations. More than twenty Blue Cross Plans are now actively trying to enroll families who live on farms and in villages. Even the poorer farmer is included. Hospital care has been made possible for many of those whom the Farm Security Administration aids in the purchase of the farm or equipment. The FSA has helped by enrolling the farmers, collecting the money, and turning it over to Blue Cross. This has made it easy for the individual farmer and for the Plan. The Farm Security Administration also attempts to provide medical care for its families through medical societies and medical plans. Altogether, Blue Cross farm enrolment approximates 500,000, and in addition, over 500,000 members of needy farm families are provided with medical care through the Farm Security Administration, Blue Cross, and medical prepayment plans



Provision for Negroes

Negroes, like farmers, have been difficult to bring into the Blue Cross Plans. Their incomes are low. And in many localities they are not accepted in private or semi-private rooms. An effort is being made in New York to overcome this latter obstacle by the setting up of an interracial hospital. Such experiments, unfortunately, care for only a small part of the Negro population. Considerable advance has been achieved in making use of Negro physicians

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and, more particularly, Negro nurses in hospitals. Some progress has also been made in admitting colored patients to private and semi-private accommodations, but the hospitals and the public will have to become more democratic before Blue Cross coverage can be extended satisfactorily to our Negro citizens, except in some parts of the South where there are special hospitals for colored people. In a few such Southern areas, Negro members predominate.



AT present, both private and semi-private hospital accommodations are fully occupied almost everywhere. This is due in large part to the war. Under present conditions many people can afford to pay for better accommodations. And Blue Cross Plans enable many people who were formerly dependent upon philanthropy, and would in the natural course of events go into wards (as multiple-bed rooms are called in the East), to pay their own way in private or semi-private rooms. The charge for ward accommodations is usually about a third less than semi-private. Also, when hospital care is available as a prepaid benefit, many seek this care who would otherwise forego hospital treatment—a factor of tremendous significance in hospital financing and in the health care of the nation.

Although more people are using hospitals than ever before, multiple-bed accommodations have not been so full as in normal times. Some people foresee the gradual disappearance of such accommodations. But this cannot happen until the country has become more prosperous and the standard of living has been considerably increased. Unless full employment continues after the war, the minimum-cost rooms will again receive their cus-

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tomary quota of patients. In any event, the Blue Cross Plans ought to provide ward benefits so that everyone, even those with low incomes, can receive the benefits of modern care and treatment without appeal to charity.

There are now thirty-seven plans which offer multiple-bed room care in addition to their semi-private coverage. In some parts of the South, there are no private or semi-private rooms at all. The ratio of Blue Cross minimum-cost patients to semi-private patients varies from 4 per cent in Wilmington (Delaware), to 43 per cent in Canton (Ohio), and 45 per cent in Portsmouth (New Hampshire) and Detroit. Six of the seventy-five plans offer no benefits in private or semi-private rooms, but only in minimum-cost accommodations.

Rates and Benefits

Rates for Blue Cross coverage differ slightly from plan to plan. They differ also depending on whether the subscriber has the membership fee deducted from his monthly pay check by his employer, or pays directly to the plan. In general, the charges for semi-private accommodations range from $8 to $10 a year for an individual and from $18 to $24 a year for a family, regardless of the number of children under eighteen years of age.

The benefits given also differ somewhat, but follow a general pattern. Some provide more days of care than others, and some allow more special services. Practically all provide full benefits for from twenty-one to thirty days in a year or for each admission. Most plans allow an additional period during which the subscriber receives half benefits. Bed, board, general nursing care, and customary drugs are provided without extra charge in semi-private accommodations.

It is important that the provisions be made the same, not only for the sake of national businesses where employees of a single firm are often scattered over many states, but because health needs are, after all, the same.

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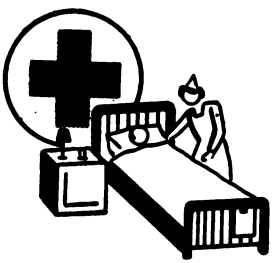
A proposed uniform contract has been drawn up by the Hospital Service Plan Commission. It makes liberal provision for the use of the operating room, laboratory examinations, plaster casts, special equipment, and oxygen therapy, as well as for X-ray examinations, anesthesia, and use of the delivery room.

Private-room Service

The original pattern of Blue Cross service was quite properly semi-private care, but in populous communities it is important to provide minimum coverage for those who cannot afford semi-private care. It is also desirable, though less urgent, to provide a service contract for subscribers who elect private rooms. At present, in many plan areas, those who go into private rooms do not receive service benefits but a cash allowance based upon the cost of semi-private service. Where there are extra charges for special facilities, this bears heavily upon the private-room subscriber, who is not always a person of means. In some areas, the hospitals object to a private-room contract because higher charges are often made for X-rays, laboratory, and other special services to those in private rooms. The hospitals insist that this practice is necessary to meet the deficit from cheaper accommodations where the full cost is not collected.



Gifts to hospitals for endowments appear to be decreasing. They will have to look to their patients to bear the major load. The present method of hospital finance which charges private-room patients more than cost and compels them to extend charity to those occupying inferior accommodations may be necessary but is hardly equitable. As the cost of hospital care rises—particularly of the special services—there will be increased opposition to this.

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At present, a considerable proportion—sometimes as high as 25 per cent—of semi-private subscribers choose private rooms—some because they prefer them and can afford them, some because no semi-private rooms are immediately available, and others because the doctors urge it because of the nature of the illness. Many are not people of means and select private rooms at considerable financial sacrifice. If government agencies would pay the hospitals adequately for the indigent, and if those who want to pay their way but cannot afford semi-private care would obtain minimum-cost coverage in the Blue Cross Plans, the charges to all paying patients could undoubtedly be reduced.



BLUE CROSS is technically owned by its members. Actually, it is very difficult for the individual policyholder in a large insurance organization or a member of Blue Cross to have much influence. Most policyholders do not want to be bothered about management so long as the business is run efficiently and honestly. The provision in the statutes for control of mutual companies by policyholders is to protect them in case of mismanagement and possible loss, rather than with the expectation that the thousands of policyholders will take an active part in running the company.

A Community Enterprise

Some people argue that Blue Cross Plans are merely agencies of the hospitals. While it is true that in the beginning many were started by hospital administrators and trustees, they have, in fact, become community enterprises. The plans must be fair both to the hospitals which

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make them possible and to the public which supports them financially. Since both the public and the hospitals are interested primarily in health, any dispute over ownership should be academic. Granting that the Blue Cross Plan is primarily a public institution, belonging to subscribers and to the community, how can Blue Cross Plans be operated on a democratic basis? Direct control by the subscribers is impossible, even though desirable. The New York plan, for example, has 17,000 different employee groups which include most of the 1,700,000 subscribers. No practical method for electing the board of directors by a popular vote of the subscribers has as yet been devised. Consequently, as in the case of the life insurance companies, the board of directors must be, in fact as well as in theory, trustee for the policyholders and subscribers. If board members are trustees in the highest sense, there will be little difficulty about control. It is undoubtedly wise to include among the directors not only representatives of the hospitals and of the medical profession, but of labor unions, civic organizations, subscribers, and employee groups. Broad community representation characterizes the board of the typical hospital plan.



Complete peace of mind is yours when you have joined the BLUE CROSS PLAN.

Some experimentation has been made with advisory committees of subscribers who are invited to keep in close contact with the work of the plan and make constructive suggestions and criticisms. This has been particularly effective in the case of the Cincinnati plan. Supervision by the state insurance department is also a real protection

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for the public. It insures against serious abuse and affords an important check upon managerial policies. The problem is the same as that faced by the hospitals themselves. It is not practical for patients in hospitals to elect the boards of trustees and yet the voluntary hospital is considered one of the most important of our democratically administered community enterprises.

Relationship to Hospitals

The United States has more hospitals in proportion to population and provides better hospital care than any other country in the world. Yet, in some areas, particularly in the South and West, there are sparsely settled regions without hospitals, and many other regions where hospitals are scarce and far between. Some hospitals are better administered than others; some have modern buildings and equipment, while others are old-fashioned. But on the whole, standards are high, largely because voluntary hospitals, which provide for most of those who are not institutional mental or tuberculous patients, are administered by boards of trustees composed of the civic, business, and professional leaders *of the community*. Each hospital in itself becomes a demonstration of local and democratic administration. With a competent medical staff, proper equipment, and close cooperation with the medical profession, the voluntary hospital offers a firm foundation for the building of a sound health structure.



The growth of the Blue Cross movement was so rapid that, in the interest both of hospitals and the public, the American Hospital Association felt that it was desirable to set up definite standards. In 1933, the Association recommended seven requirements which are still in force, and which must be complied with by the various Blue Cross Plans.

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The standards set for both new and existing plans bind together the plans, the hospitals, and the community. There must be adequate representation of the entire community—hospitals, doctors, industry, labor, and welfare—in the governing bodies of the plans. Service to subscribers is strongly emphasized. All plans must be strictly nonprofit. Free choice of hospital and physician must be assured. Although the plans do not require large reserves and surpluses (since their obligations are for short periods and because the hospitals agree to render service to subscribers even if not fully paid), sound financial policies, adequate reserves, and records are very important.

The Hospital Service Plan Commission

The American Hospital Association also helped set up the Hospital Service Plan Commission, which acts as a general coordinating body for all the Blue Cross Plans. Although it has no legal authority, the Hospital Service Plan Commission has standing, because of the voluntary support and allegiance of all the plans.

One of the most important duties of the Commission is to make sure that the plans are financially sound and maintain adequate reserves, that their expense ratio is neither too high nor too low, and that they conform to all the essential standards. Differences between plans as to territory, and other conflicts, are brought to the Hospital Service Plan Commission for decision.

The Commission maintains a central office in Chicago which is in constant touch with all the plans, gathers statistics, arranges for administrative and educational meetings, conducts publicity campaigns, and assists the Commission in enforcing the approved standards as to both new and existing plans.

In addition to passing upon the qualifications of new plans for incorporation into the Blue Cross movement, the Commission helps see to it that all plans justify their existence by increasing their membership so that the move-

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ment may become a really effective public service. In some areas, there are too many plans, some of which ought to be merged; in undeveloped areas, new plans should be established. In a few areas, the plans do not provide services for all of the items of care for which the public ordinarily pays the hospital. A plan can attain its full growth in the community only if the extent of hospital care is comprehensive and if the plan itself satisfactorily serves the community. The Blue Cross Plan should and usually does provide all that the hospital customarily gives. The exercise of regulatory functions is a delicate and difficult one and can be effective only if the hospitals, their administrators, and trustees assist the Commission in securing higher standards and improved service.



STATE SUPERVISION

BECAUSE the Blue Cross Plan was unique, there was no legal provision under which it would fit. It was not practical to incorporate as an insurance company because this would have meant an advance of considerable capital which the hospitals could not undertake. However, the deficits of Blue Cross Plans, if any, are guaranteed by the hospitals which are obligated to give service to the subscribers whether they are fully paid or not. This eliminates the need for a large amount of capital or surplus to protect subscribers. It is not so much the nonprofit feature that distinguishes Blue Cross from mutual companies, which are also operated without profit for the benefit of

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their policyholders, as the underlying responsibility of the hospitals for service.

To make it possible for the hospitals—and later, as interest in medical plans increases—for physicians to organize nonprofit plans to serve the community, some of the states enacted specific legislation providing for the incorporation of these organizations.*

There has been in the past considerable difference of opinion as to whether Blue Cross Plans are insurance organizations as defined by the statute or whether they are merely corporations engaged in distributing the service of the hospitals. This difference of opinion has not entirely disappeared, but officials of most of the plans are now agreed that they should come under the insurance departments of their respective states so that they may have the benefit of state supervision. It is not so important whether the plans are or are not strictly insurance so long as they are well-run and managed, properly supervised, compelled to give reports, and to maintain adequate reserves.

Most of the state enabling acts provide for supervision by state insurance departments. These departments examine the financial status of the plan at periodic intervals, receive any complaints, and help to assure solvency and quality of service. But some of the plans still operate without any special supervision as membership corporations. Others are under the general supervision of the welfare department. The Hospital Service Plan Commission has prepared a model incorporation law which it has submitted to a committee of the National Association of Insurance Commissioners in the hope that all states may be encouraged to adopt uniform regulatory laws, providing for supervision by the insurance departments.

*California, Connecticut, Delaware, Maine, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Vermont, Virginia, West Virginia are the states which adopted enabling acts before 1945 under which nonprofit plans can be organized. In Indiana, Blue Cross is now incorporated under the mutual insurance law.

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Blue Cross and Private Insurance

Rivalry might be expected between the Blue Cross Plans, which have gone so far with hospitalization and are now giving very practical aid to affiliated medical plans and the mutual and commercial insurance companies. Strangely enough, that is not the case. Blue Cross has aroused interest, organized educational support, and instead of harming the business of the insurance companies has increased it by materially stimulating public demand.

Blue Cross as a nonprofit enterprise receives tax exemption to encourage hospitals and doctors to carry on this work. But the main advantage of Blue Cross over ordinary insurance is that it grants service benefits in member hospitals. In most cases, Blue Cross pays the entire bill. It does not merely provide a fixed sum regardless of the size of the bill. This service feature is made possible by the backing and cooperation of the hospitals, and largely accounts for the success of Blue Cross. But there are other important advantages as well.

Blue Cross tries to provide hospital care "wherever you are." Individual plans accept transfers from others with a minimum of formality and red tape. When the subscriber moves from one area to another he is accepted in the local plan and is given credit for the period of former membership in computing waiting periods. Most plans accept applicants up to age 60 or 65. Once a subscriber, no one need lose the benefit of his hospital contract because he becomes old or leaves his employment. Once a member, one may always remain a member if he pays his dues. Family protection is stressed and encouraged in every way, and in most cases the large family pays no more than the small. Commercial insurance and industrial medicine usually protect wage earners only while they are employed.

Through cooperation between the plans, coverage can

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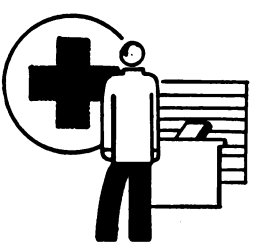
be arranged for employees of a national employer, having branches in many localities. But because of the rapid growth of large industrial and business corporations in the United States, Blue Cross cannot serve the nation effectively unless it becomes more than a group of purely local organizations. It must offer its facilities in compact form to employees in plants scattered all over the United States. It is difficult to sell different types of coverage at varying rates of payment to a single employer with branches in several plan areas.

Blue Cross is in the process of adopting a national contract so that it can offer uniform coverage to large employers, which will protect their employees everywhere. This contract will not take the place of the local coverages; that would be too difficult, and local conditions sometimes call for special arrangements. The national contract would be utilized only for the employees of those establishments which have branches in a number of plan areas.

Blue Cross is working on a plan whereby service benefits will be provided not only in the member hospitals of a local plan but in the member hospitals of any other Blue Cross Plan. If a Blue Cross subscriber becomes sick while away from home, his local plan will arrange with the plan where hospitalization takes place to give the service benefits provided in that locality.



Another much-needed national agency is a nonprofit company, affiliated with Blue Cross, that can provide medical and surgical coverage on a national basis. This is now under consideration and plans are being worked out. If Blue Cross is to continue its rapid growth and is eventually to care for the public on a voluntary basis, effective national agencies for hospital, medical, and surgical care must be perfected to supplement and cooperate with the local plans.

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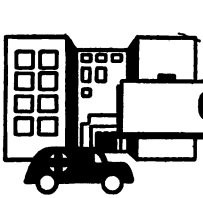

COOPERATION WITH MEDICAL PLANS



SINCE the hospital is an institution where medicine is practiced, it is unfortunate that there seems to be so much conflict between the hospitals and organized medicine. Some physicians fear that the hospitals are going more and more into the practice of medicine. Every extension of medical service in the hospital is apt to be opposed by special medical groups. No clear line can be drawn between hospitalization and medical care; they are part of the same thing. If disputes were resolved by determining what is in the public interest there would be no serious conflict.

What About the Doctor's Bill?

Blue Cross has found that as the demand for adequate health protection grows, it is not enough to offer hospital care. People say: "What about the doctor's bill? Who will take care of that?" An increasing number of employers, pressed by their employees and the unions, want to provide surgical care when they accept the Blue Cross contract. Outside of Michigan—where there are more than 750,000 subscribers, and where the medical plan has been largely backed by organized medicine, large employers, labor unions, and the Blue Cross Plan—the sale of medical coverage has been surprisingly small. Not counting industrial health insurance plans, some of which include families, the total number of subscribers in prepaid plans probably does not exceed two million. The Ross-Loos plan, which is based on group practice, and the California Physicians' Service, in which compensation to the doctor is based on services rendered each patient, are two of the largest plans outside of Michigan. Some of the group

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plans have been going for many years but have not acquired a large number of subscribers. The National Opinion Research Center took a poll upon the various phases of health insurance. One of the most interesting conclusions is that the public is still far more receptive to prepaid hospital insurance than to prepaid medical care. Ninety-two per cent of those interviewed thought hospitalization insurance a good idea; 4 per cent were opposed. But when asked if they wanted a similar type of insurance to cover medical care for themselves, only 55 per cent responded affirmatively; 38 per cent were in favor of paying the doctor direct. A majority, however, favored a national health plan through extension of the Social Security System.

It has been found by experience that many excellent doctors are poor businessmen, and too often do not understand public relations and the need for more aggressive public leadership. Many of the physician-sponsored plans have been too costly and have not offered benefits sufficiently appealing to the public. Medical societies have therefore turned to the Blue Cross, which is already established and can provide the business management and selling ability at a minimum of trouble and expense.

Blue Cross Medical Plans

There are now nineteen medical plans which are affiliated with Blue Cross organizations. In most of these, the management and selling are in the hands of the Blue Cross while the policies are made by boards of directors controlled by physicians. The idea of prepaid medical care has been endorsed by both the American Medical Association and the American Hospital Association.

The American Medical Association is opposed to group plans. It favors free choice of physician and the payment of a fee to the doctor for the service rendered, so that the doctor may control his practice and fix charges. Most medical prepayment plans are organized upon this basis.

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The medical profession has as a rule favored a financial arrangement that gives individuals more purchasing power without in any way binding the doctors. Under such an arrangement, the physician would carry on much as at present. If the medical plans were organized on *a service basis* similar to Blue Cross hospitalization, on the other hand, the medical profession would be able to provide more adequate medical care for the great mass of the people. Where such plans are established, the chief controversy is how high the income of the subscriber may be and still entitle him to service without extra charge. To subscribers having incomes higher than the ceiling, physicians are permitted to make an additional charge. In some states, the medical profession has been unrealistic about this and has made the income ceiling so low that there is no popular appeal.

Medical organizations have passed many resolutions favoring nonprofit medical plans. But outside of Michigan, California, and a few other states, they have not set up new health programs of their own. If compulsion is to be avoided, there will have to be greater cooperation on the part of organized medicine with other health agencies. And the plans must meet the public's need. Blue Cross can effectively market medical coverage to a large segment of the population through its existing organizations, but it must have something worthwhile to offer. Much educational work is still to be done to make people realize the necessity and values of medical care.

Mayor LaGuardia's proposed broad health plan for municipal employees and other large employee groups in New York City has stimulated a great deal of interest and is educationally valuable. Medical plans which provide home and office care, the service of specialists, X-ray and laboratory services are difficult to administer and are subject to abuse. But it is obvious that medical plans must find some means for providing broad medical coverage as well as surgical protection. Some interesting experiments

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are now underway. The American Medical Association could be very helpful to the public and to the Blue Cross movement if it assumed more active leadership in developing medical prepayment plans with comprehensive coverage and preventive as well as curative features.



SO far, Blue Cross has not been able to find a way of preventing illness, except by giving people the opportunity to go promptly to the hospital. X-ray, laboratory, and other important diagnostic services are usually provided only to bed patients in the hospital. But hospital plans encourage prevention in some areas by cooperating with medical plans which pay part or all of the surgeon's bill, and there is public demand for broader medical coverage which provides for home and office care.

The cost of Blue Cross service is so small that it cannot include periodic diagnostic check-ups. The lack of diagnostic clinics for the middle-income groups is one of the most glaring defects of the American medical system. There are few hospitals or clinics which provide complete diagnostic service for a limited fee. Those at Johns Hopkins in Baltimore, and Mt. Sinai in New York, are notable examples of what can be done. They charge $35 for a complete examination, but they will not accept people of means. There is a similar diagnostic clinic at the Medical Center at Columbia, but at the present time it is able to provide service for only about a hundred people a year.

It would be a great help to the family doctor if there were fine diagnostic clinics to which he could send his patients at moderate cost. Every well-equipped hospital is in a sense a diagnostic clinic because it has experienced specialists on its staff and the most modern apparatus. If

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Blue Cross can find a way, it ought to go farther than it does in providing diagnostic care for subscribers who are really ill but do not know what the trouble is. Blue Cross might pay a portion of the charge for diagnostic service for ambulatory as well as hospital patients who actually need it, but this would undoubtedly arouse opposition on the part of medical specialists who fear that the hospitals are infringing upon their practice.

Another possibility would be to establish diagnostic centers in populous areas under the control of the specialists themselves. Eventually, as we progress towards a more comprehensive health program, this important preventive agent should be made available to all subscribers. Diagnostic service is obviously expensive and subject to abuse, but it is probable that in the long run it would pay for itself by the early discovery of disease and by shortening the period of hospitalization. Anything which improves the general health of the community means ultimately less hospitalization and expense in providing hospital care.

The larger Blue Cross Plans might well join with hospitals, the medical profession, foundations, and other welfare agencies in the financial support of these diagnostic centers. If 1 per cent of their income were devoted to preventive medicine, the expenditure would be justified as a practical deterrent to illness and hospitalization.



WHEN the hospital plans started, the benefits were restricted to bed and board, floor nursing, and such other limited services as were customarily provided by hospitals without extra charge. But most Blue Cross Plans now provide more because the hospitals themselves give much wider service than formerly. X-ray, laboratory, and other

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special services have become a part of hospital care, and new techniques have come into common use. But the hospital care offered by Blue Cross—broad as it is—does not completely fill the public need. The advance of social security and the extension of medical science, together with the educational efforts which have been made to promote public health, have increased the demands of the public for more comprehensive service.

The public is coming to demand, as part of the same program, not only surgical care, but comprehensive medical protection which includes home and office visits, and preventive medical services. In the near future, when we have found out how to do it and how to pay for it, dentistry and home nursing through visiting and public health nursing associations will undoubtedly be added to the health package. In Great Britain, the public has come to demand that eyeglasses and ophthalmic services be provided as well. That may also happen here because such a large proportion of our people have eye defects. Gradually, as we progress in public health, all these related protections may be added to the hospital contract.

In Great Britain, under national health insurance, the services of the doctor have been provided to employed workers, although not to their families; but in the contemplated revamping of the British social security plan now under discussion, there is every indication that a much broader health program will be adopted. The British proposal calls for free choice of patient and doctor. Provision is made for general medical care through a system of group medical practice together with a separate general practice. In addition, this proposal embraces hospital service, specialists and consultants, maternity and child welfare services, and home nursing. Plans are also being made to extend the provision of drugs and medicines and to include dental and ophthalmic services as soon as arrangements can be made. The new British scheme contemplates setting up health centers under local control.

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All of us must agree with the statement of Dr. Thomas Parran, Surgeon-General of the United States Public Health Service, that "the hospital of tomorrow should be an instrument of total community health—an institution for the facilities and skills necessary to promote health and prevent disease, as well as to treat the sick."

A Challenge to Blue Cross

Blue Cross obviously must be concerned in seeing that a sound health program is made available to the great mass of the people. Additional services can be provided only if there is some practical method of paying for them. As education along health lines progresses, people may become more willing to pay for such obvious necessities. If the level of living rises, increased income will make it easier for people to provide protection for themselves. But it will also be necessary for the employer to pay a portion of the cost. It is to the interest of the employer to provide a comprehensive health program; it diminishes absenteeism and pays in dollars as well as good will.



SOCIAL security never goes backward. One of the most important problems before the people of the United States is the form which the extension of social security is to take. Although there is much to be improved in old-age and survivors' insurance, unemployment insurance, compensation insurance, and other present forms, no one proposes that they be discontinued. Public opinion is undoubtedly in favor of the gradual and sound extension of social security. There are many persons not provided for by even the existing types of social insurance. The decision as to what kind of nation-wide health insurance, if any, we

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should have, has not yet been made. And apart from unifying all the hospital and medical services in the United States, much needs to be done in improving, broadening, and extending the existing services. No rigid program which will make change and improvement difficult should be considered while there is so much still to be done to enrich hospital and medical care. Whatever pattern of health care is adopted in the United States, every encouragement must be given for research, experimentation, education, and local control—both governmental and through voluntary agencies.

A broad national health program operating through community control would undoubtedly improve the people's health. The federal government has an important place in the development of health programs in financing, providing standards, and encouraging state and local effort. Great strides have already been made by the United States Public Health Service in assisting states and communities in the control of tuberculosis, venereal diseases, and other widespread illnesses. In the field of housing, the federal government has helped to finance fit dwellings for low-income people and the clearance of slum areas by the local housing authorities throughout the nation.

The partnership between the federal government and the local housing authority suggests a practical plan for cooperation in extending health facilities upon a national scale. There has been little friction in public housing and no undue encroachment by the central government upon the localities.

Dr. Parran, the Surgeon-General, has declared that, in his judgment, "a grant-in-aid program such as has been authorized for nursing education, for venereal disease control, for tuberculosis control, and for other public health problems would be preferable to a federally operated program. Under this type of program, federal aid would be given to the state, and through the state to the community in proportion to the need."

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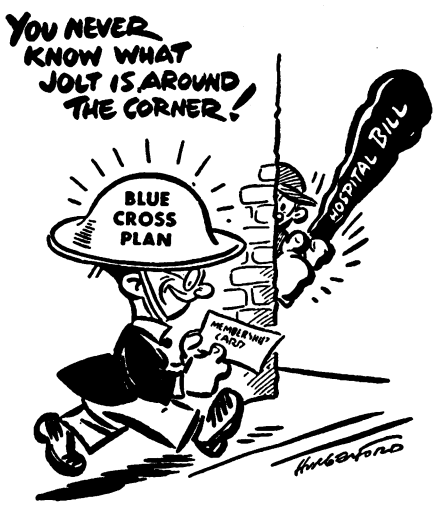
As a step in this direction, the federal government might make grants-in-aid to the states for the encouragement and assistance of voluntary insurance efforts, such as the Blue Cross Plans. Such an effort might begin in states in which health facilities are least satisfactory. Federal assistance should be used to enrich hospital and medical care in every respect, both in the provision of facilities and encouragement of methods for financing the care. Many of our progressive laws have been first tried in the states and, when found successful, extended from state to state. Through federal grants-in-aid, hospital and medical care can be improved in every direction, and those areas which are insufficiently served can be provided with the necessary facilities.



Few people seem to realize that the American people are already committed to one of the largest experiments in government medicine yet seen in the world. We are to provide complete, free hospital and medical care in the hospitals for from twelve to fourteen million service men and women in veterans' hospitals staffed by salaried physicians. The cost is met from taxation. Veterans receive complete hospital care with the service of physicians. Although originally intended for service-connected disabilities, the language of the statute makes the test for ability to pay for nonservice-connected illnesses only a formality. No attempt is made to collect from the veteran unless he has insurance coverage, in which case an effort is usually

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made to collect from the carrier. In practice, the government pays. Proposals have recently been introduced to remove all reference to the financial status of a veteran seeking care.

This huge program in state medicine will have a great effect upon the future of hospital and medical care. Will it prove efficient? Can it be operated without serious abuse? Can government medicine attract the best professional talent, and encourage industry, experiment, research, and progress in medical science? Will the American people be satisfied with physicians and hospitals they have not chosen?

Further national effort should be directed mainly toward the enrichment and spreading of medicine under local control with federal leadership and financing. Those who oppose a federal health system, because of the dangers of centralization and rigidity, must provide something better. A policy of mere negation is not sufficient. It is an old saying that "you cannot beat something with nothing." But you can beat something with something better.

A positive program is also called for which encourages the rational extension of preventive and curative medicine consistent with American traditions and local and professional control. This implies a working partnership between federal, state, and local government and all efficient and well-directed voluntary efforts, such as medical schools, dental clinics, research institutions, medical societies, Blue Cross Plans, voluntary hospitals, visiting nurse associations, and fraternal, social, and educational bodies, with which this country is richly endowed.

In such a partnership, the federal government must exert leadership, encourage high standards throughout the nation, and see that such things as the following are provided:

Dental clinics for children
Maternity benefits for women in low-income brackets
New hospitals

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Medical and health centers
Diagnostic clinics
Modernization of existing hospitals (voluntary, state, and municipal), medical facilities, and equipment
Encouragement and expansion of medical education
Assistance to states for the provision of scholarships to medical schools
Financial encouragement for a limited period to induce doctors to locate in rural or industrial areas where it is now difficult for physicians to earn adequate compensation
Assistance to states which may wish to sponsor or initiate some form of health insurance, voluntary or compulsory
Closer cooperation in providing adequate preventive measures and care for mental and tuberculous cases
Day nurseries

There is a great deal of controversy as to what ought to be done to secure better health for the great majority of people, many of whom are not equipped to provide adequately for themselves. There is controversy as to how it shall be done. But at least we have reached a point where we recognize that health is a community problem and that it pays to prevent disease and to care for it adequately when it occurs.

The Blue Cross movement is a vital and democratic link in social security. It emphasizes public service, but utilizes private initiative. It allows for intelligent, voluntary action by the people, which, with proper encouragement and guidance from federal, state, and local government, may go far to provide the necessary health service for our citizens. Under such a scheme, the Blue Cross Plans and all other effective voluntary efforts will play a very important role in the development of a healthier and happier America.

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