APPENDIX J

*Excerpts from C. Rufus Rorem's Report on Group Hospitalization to the American Hospital Association's 1934 Annual Convention**

Group hospitalization is a way of putting hospital care in the family budget. It is not primarily a way of putting money into the hospital budget. The public has no particular interest in problems of hospital finance, but the ordinary citizen has a lively interest in the problem of his personal finance. Group hospitalization is a way by which people pay hospital bills and not a way by which the hospital pays its own bills.

Group hospitalization applies the principle of insurance, of removing the uncertainty of a large hospital bill and replacing it with the certainty of a small hospital bill . . . . No one can tell when he is going to be sick or what his sickness will cost him. If he could tell, there would be no discussion of group hospitalization.

The average cost of medical care is not high; the average cost of hospital care is not high . . . . But if a bill of $65 or $165 is presented to a patient, it is no comfort to the patient to know that hospitals are well managed. He is interested only in some plan by which he can pay the hospital bill.

It is sometimes said that if people would be as careful about budgeting their hospital bills as they are about keeping up their installments on the radio and automobile, we would not have all this talk about the cost of hospital care. This is true. But the individual's sickness is unpredictable. On the other hand, the sickness of a group of individuals can be predicted with reasonable accuracy . . . . It is possible for a group of people to do what is impossible for an individual, namely, to place hospital care in the family budget.

Group hospitalization, as officially endorsed by the American Hospital Association, applies to hospital bills only. The question of the inclusion of the physician's fee is often raised by members of the general public as well as by physicians. The question

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may be answered this way: "Whenever physicians want their fees included it will be done."

One-third of the population requiring hospital care for acute illnesses receives it at government expense or through philanthropy. In 1929 not more than five percent of the people were receiving relief for food, clothes, and shelter, yet a third of the people were receiving relief in the form of hospitalization. The standards of ability to pay for hospitalization are different from those for ability to buy economic commodities which can be budgeted.

How far down in the economic scale must you go before you find a person who cannot pay a hospital bill? One-third of the population is now receiving free hospital care. Who cannot afford to subscribe to a group hospitalization plan at five, six, seven, or eight dollars a year? Only the unemployed. . .

An acquaintance of mine who is on "relief" explains that he now rolls his own cigarettes. In this way he makes a 5-cent package last two days. Five cents every two days, two and a half cents a day, is about $9.15 a year more than the rate for a group hospitalization plan providing semi-private accommodations . . . .

I do not say that people should give up tobacco for hospitalization. I merely say that hospital care could be budgeted (and should be budgeted) along with sweets, chewing gum, and tobacco, without the aid of governments or philanthropy . . . .

The following characteristics of a group hospitalization plan are set forth as desirable features from the points of view of public welfare and hospital support:

1. Nonprofit sponsorship and control.
2. Provision of initial working capital and reserves . . . from contributions or loans, rather than from accumulation of subscriptions.
3. Lowest possible annual subscription rates. A low annual rate is desirable even if it requires limiting the subscribers' benefits to the use of the lower-priced hospital accommodations.
4. Widest possible coverage as to types of subscribers. Plans should ultimately be developed for membership by employees and families: large groups, small groups, individuals, women, children, unemployed dependents.
5. Greatest possible coverage as to special diagnostic and treatment services.
6. Minimum of exclusions as to cases accepted for hospitalization. Exclusions should be dictated by facts as to other coverage, such

as workmen's compensation or governmental provision for mental, tuberculosis, or communicable diseases cases. Subscription rates may well include services for maternity cases, without extra charge, or at discounts from regular rates.

7. Free choice of hospital service should be available in all hospitals of standing in the community, and to some degree in other communities.
8. Adequate payments to group-hospitalization employees, on a basis which will not jeopardize quality of service.
9. A uniform schedule for remunerating hospitals for the same types and classes of service. This may be accomplished by an all-inclusive day rate, or a schedule for each type of service, such as board and room, operating room, laboratory, X-ray, etc. The maximum liability of the association . . . should be stated in the agreement.
10. Admission for hospital care only upon recommendation of a medical practitioner and for treatment only while under his care.
11. Definite statement as to liability of participating hospitals or the hospital service association when "specific performance" of service is impossible.
12. Compliance with existing state legislation covering hospital service associations and insurance companies.

Interest in the periodic payment plan for the purchase of hospital care continues to grow. The widespread discussion among hospital executives which began two years ago, and which resulted in the official endorsement of group hospitalization by the American Hospital Association, has now spread to the medical profession and the general public.

Hardly a meeting of medical men occurs but the subject of the principle of insurance becomes one of the topics for presentation or debate. The offices of the American Hospital Association receive inquiries almost daily for the information on the development of group hospitalization throughout the United States, and I have been called upon frequently to explain or describe many of the problems of organization.

Examples of the types of organizations before which I have appeared are local, state, and county medical societies, state hospital associations, boards of trustees of individual hospitals, organizations such as the Chicago Conference of Personnel Managers, Kiwanis International, Illinois Parent-Teachers' Association, General Federation of Women's Clubs, and many others.

All of the city-wide group hospitalization plans which were in existence a year ago have continued to expand their membership . . . . In general, the single-hospital plans in cities

with more than one hospital have met with stubborn resistance in the enrollment of subscribers, even where there was no criticism of the financial stability of these hospitals or the quality of professional work. In several cities where competing hospital plans are in effect, the number of subscribers has been much smaller than might have been achieved if the institutions had worked together.

During the past year, city-wide plans have been introduced in a number of places, including St. Paul, New Orleans, Washington, D.C., and Durham, N.C. . . . An interesting development of the past year is the formation of the Elkin Mutual Aid Association in Elkin, N.C., a community of approximately 2,500 urban inhabitants and 2,500 farmers . . . . In Kingston, Ontario, a special type of plan reimburses the subscriber for the payment of hospital bills rather than make payment directly to the hospital for this service.

As a result of advice and suggestions from the offices of the American Hospital Association, the Youngstown Sheet and Tube Company has established a group hospitalization plan for its own employees, modeled to a great extent on that of the Goodyear Tire and Rubber Company.

Within the last year announcement has been made of group life insurance plans with the benefits for hospital care, issued by the Prudential Insurance Company and the Equitable Life Assurance Society of New York. The former has completed a contract with the 12,000 employees of the Firestone Tire and Rubber Company and the latter with the General Tire and Rubber Company.

There is a definite trend in all voluntary nonprofit group hospitalization plans toward the inclusion of service to dependents and the liberalization of the policy to cover more types of disease and more types of care . . . .

The question whether group hospitalization is "insurance" has been replaced by the question whether it is good for the public and for the participating institutions. Legislation has been revealed in the Ohio statutes which makes it unnecessary for nonprofit hospital service corporations to be organized under the laws of insurance companies.

During the past year, enabling legislation has been enacted in New York providing for special regulation of nonprofit hospital service corporations. In the public interest, it is necessary that group hospitalization plans receive the type of regulation which will protect the interests of both subscribers and hospitals. The regulations originally established for the control of life insurance companies are not necessarily those most appropriate for the control of nonprofit hospital service corporations.

Group hospitalization in some forms will probably continue to hold the imagination and interest of the public and will ultimately develop under some type of auspices. Whether or not the hospital will retain control of this development and keep it on a private, nonprofit basis will depend upon courage and prompt action. There is, to be sure, some financial

risk in inaugurating group hospitalization plans. But this risk is small compared to the costs daily incurred for rendering services to part-pay cases and giving free care to people who would be able to and eligible to participate in group hospitalization plans.

There is need for development in the United States of contributory schemes, based on the English principle, by which the subscription rates are intended only to cover a part of the cost, the balance to be paid through taxation or philanthropy. Such plans, which might be sold at rates from two to four dollars a year, would enable subscribers to pay from half to two-thirds of the cost of services which they are now receiving free, at the expense of philanthropists and taxpayers.

It is significant that in England at the present time (1934) the hospital contributory schemes have enrolled more beneficiaries than are entitled to the services of general practitioners under the National Health Insurance Act.

In the United States, where hospital care has been regarded as a commodity rather than as a charity, the movement toward group hospitalization cannot be regarded as complete until it reaches from 15 to 20 million wage earners. If this is not developed under the auspices of nonprofit corporations, it will ultimately be developed by private insurance companies or by a system of taxation which will rest directly upon the potential beneficiaries.

Some plans have been sponsored directly by the subscribers. The function of the hospital is merely to "take the money." The fund pays the bills, according to the agreement with the subscribers. The hospital renders the service and is paid from the fund. Such a plan, of course, makes possible free choice, because the fund pays bills in any approved hospital, and not merely in those hospitals which sign a contract. . .

It is the moral obligation of the executives and trustees of nonprofit hospitals to investigate carefully the economic and financial significance of group hospitalization plans from the standpoint of both hospital revenue and ultimate public benefits. If people of limited means are to utilize the voluntary hospital, they must develop some plan by which hospital care can be placed in the family budget. If this is not developed, encouraged, and experimented with by executives or representatives of hospitals, it will be developed by other bodies which may not be sympathetic to the problems of hospitals and may influence hospital policies in such a way as to interfere–for the time being, at least–with the quality of professional service.