COOPERATIVE AND GROUP HEALTH PLANS - GROWTH AND EDUCATIONAL NEEDS

by Robert E. Van Goor, General Manager
Group Health Association of America

I. Introduction

There are now four basic necessities of life. To the old stand-bys of food, shelter, and clothing has been added good health.

The scope, complexity, and rapid growth of medical knowledge, combined with a significant increase in the cost of health care, present a problem for both the production and distribution of high quality medical care available to consumers at reasonable cost.

This problem is one requiring wide opportunity for experimentation with various organizational structures for providing care and with forms of payment. Such structures and forms of payment should make it possible to control the quality and cost of service produced in the interest of consumers, and should provide producers (doctors) with the opportunity to practice good medicine freed from business worries and concerns over the consumers' ability to pay for services needed.

II. Health Insurance Industry is Big Business

The population covered by some type of health insurance in the U.S. in 1959 was: 128 million persons with hospital insurance; 117 million persons with surgical insurance; 82.6 million persons with in-hospital medical insurance and some out-of-hospital coverage; 21.9 million with major medical expense insurance.

Hospital insurance covers nearly three quarters of the population. The fastest growing insurance is major medical expense or catastrophic insurance.

In 1959 in the U.S., $18.3 billion was spent by private citizens for health care. This was 5.4% of disposable income. Of the $18.3 billion: $13.2 billion came directly from consumers; $4.4 billion came from health insurance plans. $.7 billion was the cost of operating the prepayment plans.

Health insurance paid only 25% of the total health care bill paid by private citizens.

Average per capita expenditure in 1959 was $105.00, distributed in the following way: $32 for hospital; $29 for physicians; $21 for medicines; $11 for dentists; $7 for appliances and $6 for nursing home care.

Insurance companies and Blue Cross-Blue Shield plans cover the overwhelming majority of persons for health insurance. Insurance companies provide cash payments or indemnities according to a fee schedule for hospital expenses, surgery, in-hospital medical care, and occasionally some type of out-of-hospital medical care. In the 1950's, insurance companies introduced major medical expense or catastrophic insurance policies. These cover drugs,

out-of-hospital care, and other services not usually found in basic health insurance policies. After a deductible amount ranging up to $500 and $1,000 payable by the consumer, the insurance company pays 75 to 80% of the remaining bills up to maximum amounts ranging from $5,000 to $15,000. The consumer pays the additional 20 or 25% above the deductible not paid by the company.

In many Blue Cross plans, which cover hospital benefits only, the bill is paid in full or nearly so, with a small amount paid by the consumer. Blue Shield plans pay cash indemnities for surgery, many times for in-hospital medical care, and occasionally for out-of-hospital medical care. As with the insurance companies, these cash payments or indemnities usually do not cover the total bill except where doctors have agreed to accept Blue Shield's fee schedule as full payment for families within certain income ceilings. The consumer pays the balance.

My comments will not be directed primarily toward insurance company and Blue Cross-Blue Shield plans. Nor will I be discussing the important development in Canada where the Federal government and the provincial governments have worked out a hospital program for all residents. Instead, I will discuss a third type of voluntary health program operative primarily in the U.S. It is called group practice prepayment. Such plans cover approximately 4 million people.

III. Group Pracitice Prepaid Plans---What They Are

Three general definitions or statements:

1. Dedicated physicians called group medical practice a way of life.

2. When contrasted with the usual pattern of solo practice, fee-for-service medical care, the group practice prepaid health plan movement is a social evolution, a basic reorganization in the method of providing and paying for medical care.

3. In these plans, groups of consumers agree to pay a certain group of doctors stipulated amounts of money each month for which the doctors agree to provide all services they are qualified to render and which are spelled out in a contract.

Here are the basic elements in a group practice prepaid plan:

1. Prepayment: Consumers pool their risks and resources and budget for the cost of their health care needs through payment of monthly dues or premiums. In most instances, no additional professional fees are charged, although in some plans, a small service charge may accompany certain procedures or services. Consumer sponsored group practice prepaid plans are non-profit.

2. Group medical practice: This is the medical team approach to health care. Family doctors and specialists work together in clinics or medical centers, sometimes in a hospital of the plan owns its own hospital or if all doctors on the plan's staff have privileges at the same hospitals. The plan's doctors pool their experience and income, and share facilities, services of technicians and other personnel. The doctors are paid salaries

and not on a fee-for-service basis. In group practice prepaid plans, staff doctors are assured of an annual income, and in addition receive the following types of remuneration and opportunities: paid vacations, sick leave, and study leave without fear of losing their patients; many evenings and weekends free except when on call; social security, group life insurance, and other forms of insurance; opportunity for research, especially in the larger plans; and professional growth from daily contacts with colleagues in the clinic or medical center. Through such arrangements as group medical practice, particularly in consumer group practice prepaid plans, physicians have the opportunity to practice medicine with a good income and other benefits, without the worries and concerns of a businessman. The latter responsibilities for facilities, equipment, enrollment, dues, income, etc. are assumed by qualified lay administrators and the enrollees of the plan.

3. Comprehensive care: The scope of services rendered is usually broad, including preventive (physical examinations, immunizations), diagnostic (lab, x-ray), and therapeutic services, and occasionally a beginning in rehabilitation services. Services are provided in the health center, hospital, and home when medically necessary. Plans without their own hospital have enrollees covered by Blue Cross or an insurance company, or else the group health plan itself insures for hospital expenses.

4. Enrollees select doctors affiliated with the plan, unless referred by one of these doctors to an outside physician. The basic or primary choice by the consumer is free choice of health plan or system of medical care. After the consumer chooses group practice prepayment, the plan selects competent doctors according to standards adopted by the Board of Directors of the plan. The consumer need not make an unintelligent choice of some solo practice physician recommended by friends or others not necessarily competent to judge the qualifications of a doctor. Once the group practice prepaid plan is selected by the consumer, he selects from its staff of doctors the one who will be his family physician.

5. Goals of these plans: To promote health, keep enrollees healthy and out of the hospital unless such care is essential. Hospital costs are very expensive and a major item in the medical care price index contributing to the high cost of medical care. Consider thses statistics on hospital utilization: In 1960 the Blue Cross hospital plans provided 1,060 days of hospital care for each 1,000 enrollees. Kaiser Foundation Health Plans, Group Health Cooperative in Seattle, Group Health Association in Washington, D.C. and Health Insurance Plan of Greater New York, all group practice prepaid plans, provided 550-650 days of hospital care for each 1,000 enrollees. In two studies contrasting hospital utilization of Health Insurance Plan of Greater New York with that of Blue Shield members and Group Health Insurance members in New York City, HIP enrollees used the hospital 20% less than the enrollees in the other two programs. The goals of group practice prepaid plans contrast sharply with insurance company and Blue Cross-Blue Shield plans which are really sickness insurance programs to help meet some of the cost in the effort to make the patient better after he gets sick enough to be hospitalized.

6. Health Education: Printed material, films, and member meetings are used to provide health education. Many plans hold specialmeetings for enrollees with particular health interests or categories of health need, such as heart ailments, obesity, pregnancy, etc. Educational activities are also carried

out to help enrollees make intelligent use of the plan and help lay and doctor staff carry out their jobs efficiently. Little, if any, educational activity is carried on to promote the cooperative movement.

7. In consumer sponsored plans, particularly, the orientation of the staff is toward the interests and concerns of the enrollees. In cooperative plans, control over economic activities resides in a member elected board of directors.

IV. Diversity of Sponsorship is the Rule

French immigrants in San Francisco in 1851 initiated this type of program. The French Hospital is in existence today. Other fraternal, particularly nationality groups, have set up similar programs in other sections of the country.

Railroad hospital associations were started in 1869, serving primarily employees only on a prepaid basis. Approximately 30 to 35 railroad hospital associations are functioning today.

Mining and manufacturing companies in the late 19th and early 20th centuries organized group practice prepaid plans. Many of these are still in operation.

Doctor-sponsored group practice prepaid plans appeared in the 1900's on the Minnesota Iron Range. A doctor-sponsored plan was organized in Los Angeles in 1929. Enlightened doctors have started several other plans post World War II.

The International Ladies' Garment Workers' Union organized the first labor-sponsored group practice prepaid plan in New York City in 1913. Since World War II, primarily, 50-60 labor-sponsored health centers have come into existence. Many of these programs provide diagnostic and ambulatory care only and use insurance company programs or Blue Cross-Blue Shield for additional benefits. AFL Medical Service Plan in Philadelphia is an excellent example of a multi-union approach in organizing a group practice prepaid program. Here, thirty-three local unions pool their risks and resources and receive a wide variety of service from a team of physicians in a health center. The United Mine Workers of America Welfare & Retirement Fund is an example of an industry-wide labor-management health program utilizing not only group practice clinics but the services of individual physicians on a retainer basis as well as fee-for-service. In Detroit, the United Auto Workers sponsor the Community Health Association, a group practice prepaid plan available to a variety of groups in the Detroit Metropolitan area and not limited to labor unions. Participating groups will elect members to the board of directors of CHA.

Health Insurance Plan of Greater New York is one of the best examples of a community-sponsored group practice prepaid plan, with representatives on the board from various segments of the New York population. Kaiser Foundation Health Plans on the west coast and in Hawaii are the result of the vision and foresight of an industrialist like Henry J. Kaiser and are available to individuals and groups in the community.

Cooperative-sponsored group practice prepaid plans got under way in the 1930's. Organized in that decade were Community Hospital-Clinic in Elk City, Oklahoma and Group Health Association in Washington, D.C. Some twenty such programs are now in existence. Two of the latest ones to be started were Group Health Plan

in St. Paul and Tri-County Hospital Association in Deer Park, Washington. These two plans began to serve enrollees in 1957.

V. Four examples of cooperative-sponsored group practice prepaid plans

Name and Location of Plan	Group Health Assoc., Washington, D.C.	Community Health Center Two Harbors, Minnesota	Group Health Co-op, Seattle, Washington	Tri-County Hosp. Assoc., Deer Park, Washington
Date services started	1937	1944	1947	1957
Area Served	big city	small town and rural surroundings	big city	village and 3 rural counties
Benefits	comprehensive medical-surgical hospital care	comprehensive medical-surgical hospital care	comprehensive medical-surgical hospital care	comprehensive medical-surgical hospital care
Facilities	2 clinics no hospital new clinic planned	clinic nursing home share control of local hospital	3 clinics 173-bed hosp. 2 more area clinics planned	clinic and 35-bed hospital
Monthly dues for family of four	$ 24.20	$ 16.75	$ 23.00	$ 18.00
Membership fee and/or capital dues	none	$100	$100 fee and $100 dues	$100
Enrollees	47,000	3,500	61,000	approx. 2,000

IV. Why not more Co-op Group Practice Prepaid Plans?

1. Medical society opposition can make doctor recruitment most difficult. Competition from these plans is not wanted by many solo practitioners. Organized medicine, therefore, in many instances opposes new plans. Medical societies call such plans unethical because doctors are paid a salary instead of fee-for-service and enrollees must choose doctors from those selected by the plan itself (rather than any particular doctor a patient might otherwise select, determined usually be suggestions from friends and neighbors who usually are not competent to make such a recommendation). Canadian doctors, on the whole, have taken a much more realistic attitude

toward group practice prepaid plans. Three such programs are in various stages of organization in Ontario. These are labor-sponsored plans. The Ontario Medical Association accepts these programs although they do not like them. The programs do not contravene the medical code of ethics says the OMA.

2. Restrictive legislation in half the states and an unfavorable legal climate make it difficult for consumer-sponsored group practice prepaid plans to get started. In at least a half dozen instances, cooperative plans have established their legality through lawsuits settled by court decisions or outside of court. In each instance the right of consumer-sponsored non-profit group practice prepaid plans to organize has been upheld. In 1959 enabling legislation was passed in Ohio. Similar legislation is planned for several other states.

3. Capital financing is essential at the beginning and for expansion. Capital contributions from members and from interested organizations have provided funds from time to time. Commercial loans are usually difficult to get. Occasionally, a co-op insurance organization will extend a loan. The Group Health Association of America is now considering setting up a mortgage company it would control. Efforts are made each year to urge the Congress of the United States to pass legislation authorizing direct Federal long-term loans to such plans at reasonable interest rates.

4. Local leadership is essential. This leadership must be informed and patient in its efforts to set up a plan, considering the three points listed above and the need to educate the public on what good medical care is, how it can be obtained, and at what cost?

VII. <u>Group practice prepaid plans have demonstrated the following:</u>

1. Comprehensive medical-surgical-hospital care in the health center, hospital, and home at reasonable cost with quality and cost controls, can be made available for $17-25 per month for a family of four.

2. Such programs have brought the family doctor into prominence and in his rightful place in the medical picture.

3. Hospital utilization, the most expensive item in the medical care price index, can be significantly cut.

4. The legality of such programs has been established through successful lawsuits settled either in court or out of court, as well as by constructive enabling legislation in a number of states.

5. Educational activities in these plans center on health education and how to use the plan most effectively. Little, if any, effort is made to promote co-op education and co-op expansion into different kinds of services.

VIII. <u>Possibilities for the 1960's in Group Practice Prepaid Plans:</u>

1. A further but reluctant acceptance by the American Medical Association of these plans.

2. A concerted effort by some sections of organized labor to promote the development of more group practice prepaid plans. Hopefully, this will take the

form of setting up multi-union health centers, or health centers available to all groups in the community and not just union groups, or joining by labor unions of existing group health programs.

3. Groups of doctors actually engaged in group medical practice are showing more interest in working out contracts with labor union groups to meet their health needs on a prepaid group practice basis.

4. Expansion of benefits and of enrollment in existing group practice prepaid plans available to the community.

IX. What role should non-medical co-ops play in the group practice prepaid Movement?

Expansion is a cardinal principle for cooperatives. Meeting an unmet need is another such principle. Existing co-ops already have an organizational structure to work through and a population base on which to build. Rural areas, especially, are in need of better medical care.

Group practice prepaid plans offer the opportunity to get comprehensive care at reasonable cost. The role of co-ops in the group practice prepaid movement can be a major one. The initial decision is up to the management and governing boards of the co-ops, and finally, the members themselves. The Group Health Association of Association of America, through its panel of consultants and other services, is eager to help co-ops organize and promote group health care plans whenever and wherever possible.