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Prepayment health plans : including results of interviews with Kaieser Foundation Health Plan patients

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PREPAYMENT HEALTH PLANS
including
RESULTS OF INTERVIEWS WITH KAISER FOUNDATION HEALTH PLAN PATIENTS

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TABLE OF CONTENTS

INTRODUCTION

The medical profession and related services are in a state of forced transistion provoked partly by their progress and partly by society's demands. Society's demands seem to be due to the unrest over the economic status of present day medicine. Recently, this subject has become a political pawn in the United States; however, concern over this problem has been discussed seriously in Washington, D.C. for more than ten years.

January 18, 1954, President Dwight D. Eisonhower presented a health message to the House of Representatives, in which he stated, "Two of the key problems in the field of health today are the distribution of medical facilities and the costs of medical care." He continued to state that 10% of American families were spending over $500 a year for medical care and that the total medical bill of the Nation exceded $9 billion a year.[1] Since that time, this bill has greatly increased, and in 1958-59 the total medical bill of the nation was $25.2 billion.[2]

The expense of medical care in our nation is rising proportionately higher than other individual expenses during this inflationary period. 5.4% of the gross national product was devoted to health and medical care in 1959 compared to 3.6% in 1929.[2]

When medical expenses are broken into component parts, it is found that the proportion of the medical dollar going to hospitals has been growing the most rapidly. Since 1945 rates for room and board and general nursing care in a general hospital have more than tripled.[2]

In the attempt to provide financial coverage for medical expenses, various types of prepayment plans have been instituted including the voluntary private insurance plans, Blue Cross, the open panel and closed panel plans, and statuatory health insurance. This paper will discuss some of the aspects of these various prepayment plans with special emphasis given to the closed panel type of payment plan offered by the Kaiser Foundation.

DEFINITIONS

Group Practice

A. M. A.'s definition in 1948. The application of medical service by a number of physicians working in systematic association with the joint use of equipment and technical personnel and with central administration and financial organization.[2]

Definition in H.R. 7700 of 83rd Congress. A formal organization of physicians which meets the following criteria: (1) the organization must have more than one specialty of medicine represented; (2) joint use of office facilities and auxiliary personnel; (3) pooling of income;

and (4) formal organization for administration and financing with sharing of overhead with net payments made according to a preestablished plan.[3]

Open Panel Prepayment Plans

This term refers to a prepayment full service program, in which any physician may participate if he agrees to accept fees listed in a predetermined schedule of benefits. They usually do not include hospitalization benefits. Subscribers pay a monthly fee.[4]

Closed Panel Prepayment Plans

This refers to a prepayment full service program with or without hospital benefits. Physicians are employed on a salary, hourly, or on other contractual agreements. Subscribers may or may not have choice of physician within the group.[4]

Cash Indemnity

Plans designed to assist persons in paying the cost incurred for medical care. The insured may go to the physician of his choice. Maximum specified sums are not necessarily related to the insured's expense.[4]

Surgical Coverage

This self-defining term refers to coverage of in-hospital surgical expenses; operating room, anesthesia, surgeon's fee, etc.

Regular Medical Coverage

This includes the in-hospital physician's services. The Health Insurance Council includes some of the more comprehensive prepayment plans under this heading.[2]

Major Medical

Catastrophic coverage. It applies broadly to all kinds of medical care expenses over a specified amount; $1000, $500, $300, etc.[2]

Service Plans

These plans assure the members certain units of medical service, such as a day of general hospital care or specified surgical procedure. Some examples are Blue Cross and Blue Shield.[2]

Individual Plans

These are plans sold directly to the covered individual. It is usually more expensive than group insurance.

Group Plans

A large proportion (usually 75%) of employees of a firm, members of a union, etc. are enrolled in a plan as a group.[2]

HEALTH INSURANCE FORMS

The various forms of health insurance have developed with two different purposes. One purpose is to protect the insuree against the risk of large or unusual costs or losses,

and the other is to offer prepayment and the actual rendering of medical services. Insurance programs attempt to fulfill either or both of the purposes.[2]

Voluntary Private Insurance

The majority of private health insurance plans offer cash indemnities on a fee for service basis. They provide the opportunity for the insuree to select coverage for hospital benefits, surgical benefits, in-hospital medical benefits, and/or major medical coverage. The enrollee can select from separate benefit schedules certain assortments of coverages with varying rates.

The organization of the private independent programs varies with the individual company. They are usually autonomous groups with no direct connection with the physician. Their main purpose is to provide protection against great financial loss to the patient at an economic gain to the company.

The major medical coverage is a recent development in this field which was incorporated in an attempt to supplement the deficiencies in the compartmentalized schedules.[5] Another recent development in the voluntary health insurance area is the quaranteed renewable clause of policies. This resulted from the recent publicity concerning public care for the aged. In the testimony given on H.R. 4222, H. Lewis Rietz, president of Health Insurance Association of America,

stated that he estimated that 53% or 9 million people over 65 years have some form of voluntary health insurance compared to 26% or 3 million in 1952. More than thirty companies offered policies with the quaranteed renewable for life clause in 1961.[6]

Private health insurance enrollment has risen from 10% to 72% of the civilian population from 1940 to 1957.[2] (see appendix I) In the past three years there has been a continued growth in all the coverage groups of voluntary health insurance.[7,8,9] (see appendix II)

Blue Cross - Blue Shield

In the mid-thirty's the House of Delegates of the American Medical Association adopted principles for the guidance of medical service prepayment plans. These included that all features of medical service should be under the control of the medical profession; that third parties should not be allowed to come between the patient and his physician; and that free choice of physician should be allowed. Several state medical societies developed prepayment programs in the thirty's. The Council on Medical Services was established and a standard of acceptance was developed including the following: (1) approval by the local medical association, (2) responsibility of the medical profession for medical services included in the benefits, (3) free choice of physician, (4) maximum benefits consistant with sound financial operation,

(5) benefits in terms of service or indemnity, and (6) sound enrollment and administrative practice.[10]

In 1946 the Blue Shield program as it is known today was organized. The pattern is to assure its members certain units of necessary medical service, such as a day of general hospital care or a specified surgical procedure. Participating physicians agree to accept the insurance monies as full payment for the covered services, provided the annual income of the member does not exceed the amount permitted under their Blue Shield agreement. The organization is "non profit" and a large percentage of the collected funds return to the subscriber. (80 -90%)[10]

When first organized in 1946, there were nine plans with 1⅛ million members, and in December, 1960 there were 74 Blue Shield Plans with 45 million members. In 1958 the A.M.A. took action to recommend the development of special voluntary programs for the aged. At that time there were 2½ million enrollees over 65 years of age. 24 plans have developed new programs establishing coverage for senior citizens since that recommendation.[10]

Prepayment Plans

In the past years more controversial types of insurance plans have been formed, which are more comprehensive in nature. They include the principles of physician group practice either with the open or closed panelsystems,

and either with or without hospital service. These plans can be divided into industrial plans and non-industrial plans with subdivisions.

Some representative groups of the industrial plans are the Labor Health Institute, the International Ladies Garment Workers Union (ILGWU), and the United Mine Workers. The United Mine Workers Health Plan has been in operation for over ten years and has clinics and ten hospitals in Kentucky, Virginia, and West Virginia.[2]

The non-industrial groups can be subdivided by their differences in organization.

Groups, such as the Ross - Loos Medical Group in Los Angeles and the Palo Alto Medical Clinic, are controlled by the participating physicians. The Ross - Loos Group was started in 1929 and by 1959 had 131 fulltime physicians and 128,000 enrollees, of which 38,000 were non-group and 10,000 on a fee for service plan. The Palo Alto Clinic was organized in the 1920's by Dr. Russell V. Lee and is primarily for the Stanford University faculty and students. In 1959 there were 89 employed physicians. Only 15% of the enrollees are prepaid.[2]

Consumer cooperatives and community organizations are other forms of the non-industrial plans. The Community Hospital of Elk City, Oklahoma was originated in 1929 and

serves 1,600 families with annual dues ranging from $18 to $40. Other cooperatives are the Group Health Association of Washington, D.C. with 33,000 enrollees and the Group Health Cooperative of Puget Sound of Seattle, Washington with 51,000 enrollment.[2]

The last classification under the non-industrial plans is the community type which is sponsored both by physicians and the consumers. Examples of this type are the Kaiser Foundation Health Plan, the Health Insurance Plan of Greater New York (HIP), and the Group Health Insurance Plan (GHI).[2] The Kaiser Foundation Plan is described in detail later in this paper.

The Health Insurance Plan of Greater New York (HIP) was organized in 1947 to give prepaid care to New York City employees. In 1959 there were 550,000 enrollees with 60% being municipal employees. More than 1000 physicians are associated with the plan and are divided into 32 medical groups which receive annual capitation for each individual selecting that group. No hospital benefits are given in this plan, and the physicians are free to engage in private practice.[11,12,2] GHI is controlled by physicians and laymen equally with fee for service payment to the doctor. Group practice is not involved in this arrangement. In 1959 there were 575,000 enrollees, and 11,000 doctors involved.[2]

The prepaid medical care programs, as described above, have been and are a controversial subject among physicians and the laity. The objectives stated by proponents of these programs are to decrease the financial expense of medical care, to provide easier methods of paying for medical care, and to offer good medical care to enrollees.

Statuatory Health Insurance

Even more controversial in the United States, statuatory health insurance in one form or another has been established in almost all countries in the world. In 1848 to 1883 Bismarck introduced it into Germany; in 1911 it was established in England; and in 1928 in France. Public health insurance has remained almost totally absent in the United States, although political movements are attempting to change this position.[2]

A.M.A. and PREPAYMENT PLANS

The disapproval of the American Medical Association shown toward the closed panel prepaid health plans has become common knowledge of the laity. The main objections of the medical profession to such plans are the limitations placed on the patient's free choice of physician and the entrance of a third party (the plan and its organization) into the doctor-patient relationship.

The American Medical Association is a federation of state medical associations. These constituent associations may charter county or district medical societies. Each state medical association may select a certain number of delegates to the A.M.A. House of Delegates. The A.M.A. has its own constitution, bylaws, and code of ethics separate from the state and local associations, although all subscribe to the A.M.A. code of ethics. Since the A.M.A. is a federation, the state, county, and district societies have considerable autonomy.[4]

Closed panel health plans have been received with varying degrees of enthusiasm by the local societies in different areas of the United States. In the past several court cases have been filed against local medical societies, which have attempted to restrict membership in a particular society by barring physicians who participate in a closed panel prepayment plan. The laws of various states vary in the legality of closed panel plans, although a corporation may be involved, and/or the plan engages in advertising. Usually if the corporation involved is non-profit in nature, more leniency is shown to the plan by the court.[4]

There are four court decisions on record which demonstrate that medical societies can not deny membership to physicians or discipline members, because they render services for such a plan.

This is termed unlawful restraint of the business of the plan. In any such suit the society would have to prove that its action was reasonably adapted to maintain and advance the standards of medical practice and not to restrain the business of the prepaid plan. This type of legislation falls under the antitrust laws. Occassionally the Federal Sherman Act applies, if interstate commerce is affected. If either the medical society or the plan is interstate in dimension, this law becomes applicable.[4]

During the past few years the A.M.A. has become much more lenient and liberal in their consideration of the prepaid plans and group organizations, in general. There has been an increasing tendency for physicians to band together to form partnerships and other groups in order to decrease the expense of private medical care and to enable existing medical knowledge to be more easily reached by the patients and medical colleagues.

During 1956 - 57 the A.M.A. made a survey of 103 group practice medical groups ranging in size from 4 to 70 members, excluding the prepayment plans. At that time 37% of the physicians in group practice gave "providing better medical care" as their reason for selecting group practice. 29% gave "too heavy individual practice" as their reason, and 16% gave "more free time for study and recreation" as their reasons.[13]

At the same time this survey was taken, 56% of the doctors in the United States were in solo practice, 11% in an expense or space saving practice, 9% in a two man partnership, and 7% in a larger partnership or groups. 3% were in salaried assistantships (employed by groups), and 14% were in other salaried positions, such as hospitals, industries, universities, etc. This series excluded interns, residents, retired physicians, and military officers.[14]

In 1958 a survey conducted by the University of Chicago's National Opinion Research Center ran a questionairre to doctors asking, "Which one of these best describes your present practice?" and "Which one would you personally consider most desirable?"

	Present	Prefer
Individual practice	70%	41%
Individual with pooled facilities	12%	22%
Group practice	12%	24%
Small partnership	4%	7%
Salaried practice	1%	5%
Don't know	1%	1%

[15]

The trend of individual physicians seems to be toward group practice; therefore, the A.M.A.'s opinion (composed of individual physicians) is also becoming more favorable toward group practice.

The closed panel prepayment plans have been making progress more slowly. Most medical societies are now accepting their constituents as members; partly due to increased tolerance and partly due to legal pressures.

In January, 1959 the Commission on Medical Care Plans of the A.M.A. with Leonard W. Larson, M.D., as chairman, published a report on a three year study of various prepayment medical plans. The study included an analysis of 107 plans with a total enrollment of 3.5 million persons.[4] (See Scope of Commission's Study, Appendix III and III$_b$)

The conclusions and recommendations of this committee were quite conservative. Two of the more significant statements regarding the medical profession's attitude toward prepayment plans are as follows:

> "The A.M.A. and its constituent medical societies should increase their efforts to educate members as to the operation and function of medical care plans, in order that the entire profession may be conversant with all the problems involved."
>
> "An appropriate committee from the A.M.A. should sponsor national and regional conferences with representatives of all parties concerned. Guides for the relationship between the medical profession and these third parties should be considered and developed based upon recognition of the interests and obligation of plan members, physicians, and third parties. At such conferences, mechanisms and procedures should be agreed upon for resolving controversies which might exist between the medical profession and these third parties." [4]

During the 108th A.M.A. meeting, June 27, 1959, many important statements concerning the A.M.A.'s stand toward

closed panel groups were made following the distribution of the Larson Report in January.

1) "Free choice of physician is an important factor in the provision of good medical care."

2) "The A.M.A. believes that free choice of physician is the right of every individual and one which he should feel free to exercise as he chooses."

3) "Each individual should be accorded the privilege to select and change his physician at will or to select his preferred system of medical care and the A.M.A. vigorously supports the right of the individual to choose between these alternatives."

4) "There is no generally held opinion declaring that participation in a closed panel medical care plan would render a physician unethical."

5) "Medical profession and sponsored plans should seek to extend their number and coverage as a deterrent to the future development of closed panel programs."
16

In the fall of 1960 at the 13th Clinical Meeting of the A.M.A. an additional statement was added to clarify and strengthen the A.M.A.'s position on the issue of freedon of choice of the physician. "Lest there be any misinterpretation, we state unequivocally that the A.M.A. firmly subscribes to freedom of choice of physicians as being prerequisites to the optional medical care. The benefits of any system which provides medical care must be judged on the degree to which it allows or abridges, such freedom of choice and such competition."[17] According to some interpretations, this was determined as a partial withdrawal of the June statements.[2]

During the past two years, the Committee on Insurance and Prepayment Plans of the A.M.A. has almost ignored the subject of closed panel prepayment plans and very little controversy has been expressed in the A.M.A. committees. Local discrimination is still present in several areas. In December, 1962 a law barring discrimination by hospitals against doctors affliated with group medical plans was passed in Nassaw County, N.Y. This was the first such county or state legislation enacted in the United States. The bill provides for a three man board to review charges of discrimination by hospitals and to bring the violators before the New York State Board. This is the area in which HIP is active.[18]

KAISER FOUNDATION HEALTH PLAN

Origin

The Kaiser Foundation Health Plan traces its origin to the 1930's when an attempt was made to give medical care to construction workers employed by the Kaiser Industries. At that time Dr. Sydney Garfield, present medical director of the plan, organized a group of doctors to care for workers building the All-American Canal from Los Angeles to the Colorado river. The workers decided to give five cents a day from their wages to pre-pay the costs of treatment.

Just before World War II at the Grand Coulee Dam, Kaiser Industries contracted a four year project with 5000 workers.

Dr. Garfield and his staff provided medical care for the workers and their families on a prepayment basis on the project.[19]

In September, 1942 a more structured plan was formulated to meet the needs of workers in the wartime shipbuilding industry in the San Francisco Bay area. During the peak of the war years the membership rose to over 70,000, but at the end of the war in 1945 shipbuilding was discontinued, and the membership dropped to 14,500.[20]

In 1945 the membership was opened to the public with emphasis on industrial groups. By 1952 membership was over 160,000 in the Bay Area,[20] and in 1959 there were 675,000 enrollees in the San Francisco, Los Angeles, Portland, Oregon-Vancouver, Washington, and Hawaii areas. At that time, 6% of the total enrollment were Kaiser employees, and 94% were outside groups and individuals.[2]

Organization

There are four separate but coordinated organizations.

The Kaiser Foundation is a charitable trust which provides the facilities and funds for teaching, training, research, and charity. The Foundation consists of a board of directors with two members of the Kaiser family, two attorneys, and four executives in the Kaiser industry.[21,20]

The Kaiser Health Plan is a non-profit trust which enrolls members, collects payments, and keeps records of eligibility. The funds collected by the plan are divided proportionately between the hospitals and medical groups.[20,21]

The Kaiser Hospitals (12) are owned by the Foundation. A non-profit corporation operates the hospitals and medical centers securing its income from prepaid dues and a variable amount from private patients.[20] All hospitals are community hospitals, allowing independent doctors the use of the facilities.[2]

Kaiser Medical Groups are independent groups of physicians organized as partnerships. Each partnership contracts with the Kaiser plan to provide professional services to enrollees in its area.[20] In 1959 there were 40 such outpatient medical centers, involving some 650 physicians.[2]

Health Plan

The Kaiser Health Plan, as indicated above, is a closed panel program catering to industrial groups, but including individual subscribers. Subscribers pay a monthly fee with employers usually providing half the fee. This fee entitles the subscriber to outpatient medical and surgical care and full hospital coverage. The services are provided only at the Kaiser Foundation Hospitals and Medical Centers by teams of doctors affliated with the plan.[22]

The basic plan provides for the subscriber 111 days of hospital care a year for each illness or recurrance of it including room, board, nursing, and ambulance service within 30 miles; all operations, specialists' consultations, and other hospital treatment; doctor's care in the office at any time; home calls; and all drugs and medicines while hospitalized. For the subscriber's dependents, free hospital care is limited to 60 days for each illness each year and half private rates are charged for the next 50 days. Ancillary services, X-ray, etc. are covered for the subscriber and are usually one-half the private rates for dependents.[23]

Maternity benefits are provided for $60, if the subscriber has been a member for more than 10 months at the time of confinement. Maternity care after 10 months for dependents is $95.

All office visits are $1, $3.50 for home calls, and $5 for night calls. T & A's for the subscriber are $15 and $35 for a dependent. An additional charge per month is made for members over 65 years; $1.80 for a subscriber and $1.20 for a dependent. Registration fee is $2. Up to $500 per accident or emergency illness is provided, when out of the service area. Eye refractions are given with a $1 office visit charge.[2]

Exceptions to the inclusiveness of the plan are congenital conditions and conditions present at the time of joining the plan. Other diseases not included are mental illnesses, tuberculosis, epidemic or disaster illnesses, and contagious diseases requiring isolation.

In July, 1961 an individual subscription had monthly rates of $7.80, not including the registration fee of $3 and the medical review fee of $2. With one dependent the monthly fee was $14.20, and with two or more dependents was $18.35. The subscribing applicant may include his spouse and unmarried children under 19 years as dependents. The medical care given under the individual plan covers the subscriber and his dependents equally, offering each the same amount of coverage described as dependent's benefits under the basic plan.[24]

A typical small group plan has a fee schedule similar to the individual plan, but includes the same differentiation of benefits to the subscriber and his dependents as described in the basic plan.[25]

A larger group plan, arranged for the California State Employees Association, has a similar fee schedule as listed above, but offers the same benefits to dependents and subscribers as offered to subscribers in the basic plan.[26]

Many different groups are insured, and many variations in benefits are offered by the plan. The Kaiser Plan is only offered to a group, if they request it, and if two other prepayment insurance plans are presented at the same time. California Physicians Plan (Blue Cross) is usually one of the alternative plans.[27]

INTERVIEWS OF KAISER HEALTH PLAN PATIENTS

In the summer of 1961, 94 interviews of obstetric patients were taken at the San Francisco Kaiser Hospital, 2425 Geary Boulevard. The interviews were taken on the patient's second post-partem day. The interviewees were chosen at random with only one restriction, that all interviewees be married. All interviews were conducted by one person and had an average duration of 10 to 15 minutes. The number of the interviews accomplished was limited only by the time available to the interviewer. Permission for interviews was given by Mr. V. Brammer, Hospital Administrator, and Miss Kay Taylor, Associate Director of Nursing, at the San Francisco Kaiser Foundation Hospital.

A form was available, with which to conduct the interview, and was filled during and after each interview. The form covered the age of the patient, parity, marital status, occupation of the husband and patient, number of dependents, education of husband and patient, duration of Kaiser membership,

the anesthetic used, and any obstetrical complications. The latter two items were taken from the patient's chart. The patient was also questioned regarding the reason for joining the plan, previous medical experience, and their subjective feelings toward Kaiser's prenatal care, labor, and delivery. (See Appendix IV)

Kaiser's Obstetrical Management

The patients receive their prenatal care at the clinics available in their particular area. The patient may choose any physician on the panel and see him throughout the pregnancy or be seen by several doctors. The choice rests with the patient but may be limited by the doctor's schedule. Patients are advised to get early prenatal care.

The prenatal physician informs the patient that he will probably not deliver her baby and that the delivery will be the responsibility of the physician on call at the hospital. Prenatal records are sent to the hospital before delivery time. Only in special cases will the prenatal physician deliver the patient, such as an elective Caesarean section or coincidental scheduling. In most instances the patient is delivered by a resident or intern, although a boarded obstetrician is on call in the hospital at all times.

The postpartem obstetric department in the Kaiser Foundation Hospital has a 'rooming-in' arrangement, which allows the mother and baby to be together post-partem.

There is a small room between the mother's bed and the center hospital hallway, which contains a sink, bassinet, and cupboard space. The bassinet can be pulled into the mother's room if desired.

Post-partem hospitalization is routinely three days. During these days, organized classes in the care of the newborn, exercises by the physical therapist, and talks by the pediatrician are available on the obstetric floor for the mothers.

Results of Interviews

The interviewees' ages ranged from 18 to 43 years. Husbands' employment ranged from manual labor to professional work, such as lawyers and surgeons (private orthopedic surgeon). The duration of Kaiser Foundation Health Plan membership ranged from 0 to 13 years. One patient received the obstetric care as a charity patient, and another elected Kaiser Hospital for delivery but did not belong to the plan.

The anesthetics used were pudendal blocks, saddles, or locals, except in the case of C-sections, when the anesthetic was either a mid-spinal or a general anesthetic.

31 of the patients had had private deliveries in the past. Of these, 16 had a family doctor for the delivery, and 15 an obstetrician. The expense of the private deliveries in the California area ranged from $375 to $500, not including

the pediatrician for the newborn. One women reported a $1000 charge for a previous C-section and had just received a repeat section at Kaiser for $140 (higher than usual costs since she had been enrolled less than 10 months). Less costly deliveries were reported by women, who had recently moved to California from the East or had previously attended the clinics of the University of California or Stanford.

Health plan members, as explained above, were charged from $0 to $60 to $95 for their delivery above their monthly subscription rates. Extra charges were made for dismissal prescriptions, baby formula, blood transfusions, telephone in the hospital, vitamins, initial prenatal visit, and lab work. The additional charges averaged an extra $10. The woman, electing delivery at Kaiser Hospital and not belonging to the plan, was billed $346.

22 of the patients joined the plan through the union; 59 were offered it at their jobs; and 13 were enrolled on an elective individual plan.

The subjective feelings of the patients toward private medical care was favorable except for the economic factor. Of those interviewed, 40 had had a family doctor prior to Kaiser enrollment, and 30 had not. Of the 30, the majority had visited different specialists.

In the questions concerning prenatal care, 81 reported that they visited just one doctor, while 13 visited more than

one doctor. 86 felt that they had had good medical care; 7 were unsatisfied; and 1 was undecided. A similar ratio was found in those that had had private deliveries in the past. "Advice calls", questions answered by physicians at any time of the day, were made by 65, were not made by 14, and were encouraged but not made by 15. 63 felt that they had a personal physician during the prenatal care; 26 did not feel they had a personal physician; and 5 were undecided. The same differential was seen in those who had had a previous private delivery.

When questioned about the actual labor and delivery, 81 stated that they had confidence in the doctor that performed the delivery; 6 did not have confidence; and 7 were undecided. 24 of those with previous experience had confidence, but 4 did not (slightly higher percentage), and 3 were undecided. 82 felt that the doctor was interested in her and the baby; 10 did not feel so; and 2 had reservations. In 40 of the patients, the delivering doctor made 'postnatal visits' and in 54 no visit was made.

To the question, "Would you prefer to have one doctor care for your total obstetrical care?", 69 of the patients answered in the affirmative and 23 in the negative. Of those with prior experience, 23 answered yes and 6 no.

TABULATED INTERVIEW RESULTS

EDUCATION LEVELS

	Husband	Patient
Less than high school	18	14
High school diploma	31	40
High school - plus	15	25
B.A. or equivalent	18	12
B.A. - plus or M.A.	8	2
Professional degree	4	1
Total	94	94

PARITY

First delivery	21
Second delivery	27
Third delivery	31
Fourth delivery	10
Fifth delivery or more	5
Total	94

PRIOR MEDICAL EXPERIENCE

None	14
Clinics	6
Foreign	3
Army	1
Total	24

OBSTETRICAL EXPERIENCE

Private Deliveries	31
Clinics	13
Midwife	1
None	49
Total	94

	Total (94)	Priv. Del. (31)	Remainder (63)
Reason for joining:			
Offered through the union .	22	11	11
Elective on the job	59	19	40
Elective	13	1	12
	(70)	(31)	(39)
Subjective feelings toward private medical care:			
Favorable	57	25	32
Negative	9	4	5
Pos. & Neg.	4	2	2
Did you have a family doctor?			
Yes	40	16	24
No	30	15	15
Did you change doctors frequently?			
Yes	27	12	15
No	43	19	24

PRENATAL CARE

	Total (94)	Priv. Del. (31)	Remainder
Did you visit <u>one</u> doctor for prenatal care?			
Yes	81	27	54
No	13	4	9
Did you feel that you received "good" care?			
Yes	86	28	58
No	7	2	5
Yes & No	1	1	0
Did you make "advice calls" and were you encouraged to do so?			
Yes	65	20	45
No	14	5	9
Were encouraged but didn't	15	6	9
Did you feel that you had a "personal" physician?			
Yes	63	19	44
No	26	9	17
Yes & No	5	3	2

LABOR AND DELIVERY

	Total (94)	Priv. Del. (31)	Remainder
Did you have confidence in the doctor that delivered?			
Yes	81	24	57
No	6	4	2
Yes & No	7	3	4
Did you feel that the doctor was interested in you and baby?			
Yes	82	28	54
No	10	2	8
Yes with reservations ...	2	1	1
Did the doctor that delivered you make a postnatal visit?			
Yes	40	15	25
No	54	16	38

TOTAL OBSTETRICAL CARE

Would you prefer to have one doctor care for your total obstetrical care?			
Yes	69	23	46
No	23	6	17
Undecided	2	2	0

Conclusions

1. When interviewing a group of individuals enrolled in a program, there is a built-in bias towards the program.

2. Almost all patients chose this type of medical plan for economic reasons.

3. Individuals choosing the Kaiser Plan included a cross-section of society. It has been stated in various sources that lower income groups use this program more than the higher income groups, but in the interviews done on obstetrical patients, this was not the case.

4. Since this group of patients are young and of child-bearing ages, their previous medical experience is scanty.

5. When comparing the women who had had private deliveries with those that had not, there seems to be little significant difference except in the questions, "Did you have confidence in the doctor that delivered your baby?" and "Would you prefer to have one doctor care for your entire obstetrical period?" Those with prior private deliveries did not express as much confidence in the doctor delivering the child as those without prior experience. Also, those with prior experience expressed more of a desire to have one doctor responsible for the entire obstetrical care.

SUMMARY

This paper attempted to discuss some of the varied forms of health insurance with special emphasis on the closed panel prepayment plans. Also, discussed briefly were the voluntary private insurance programs, Blue Cross and Blue Shield, and statuatory insurance. The A.M.A.'s opinion and the medical profession's opinion in general toward the closed panel prepayment plans have become more liberal in the past few years; however, the plans are still far from being universally accepted.

Kaiser Foundation Health Plan is a closed panel prepayment plan. An enrollee pays monthly dues which entitle him and his dependents to out-patient care at clinics affiliated with Kaiser and hospitalization at the nearest Kaiser Foundation Hospital. Additional charges are nominal. The enrollee is restricted to physicians employed by Kaiser but may choose any of the physicians on the panel.

94 interviews were taken of obstetric patients at the San Francisco Kaiser Foundation Hospital in the summer of 1961. They were questioned concerning their subjective feelings toward the obstetrical care they received through the Kaiser Health Plan. Since there is a bias toward the program when surveying individuals already enrolled, the majority of opinion was favorable and indicated the presence of good physician-patient relationships. The majority of patients indicated

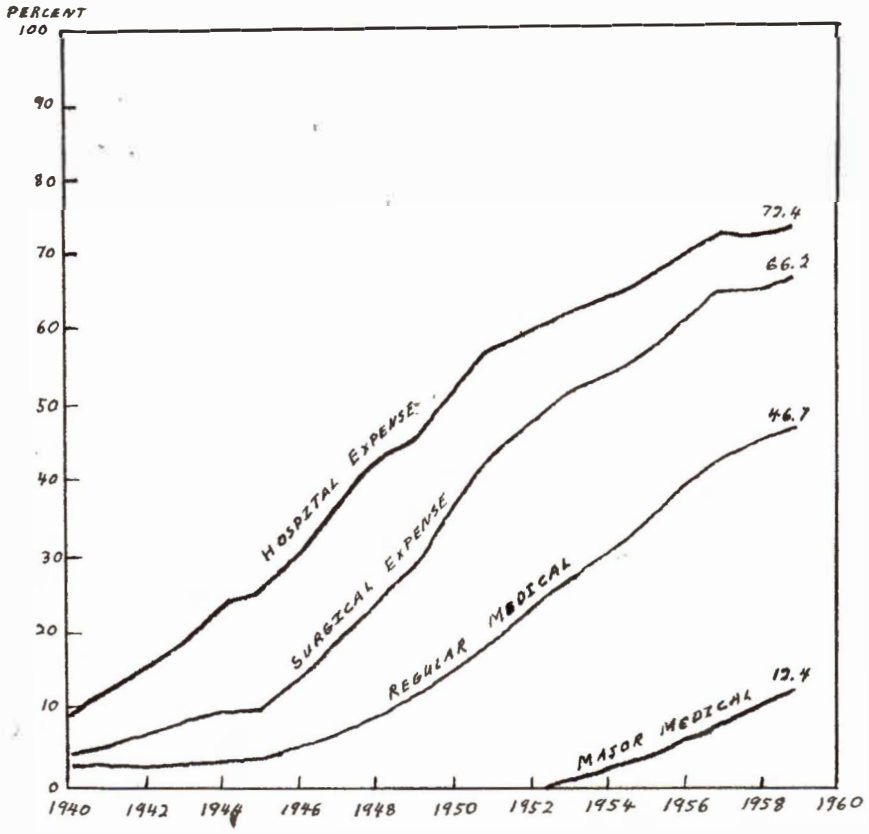
a preference for having one doctor care for their total obstetrical management. There was little significant difference when comparing the opinions of those with private obstetrical experience (31) with those without prior experience.

APPENDIX

PRIVATE HEALTH INSURANCE ENROLLMENT

Percentage of Civilian Population with Hospital, Surgical, "Regular Medical" and "Major Medical" Coverage,

1940 - 1959



APPENDIX

Growth of Voluntary Health Insurance Enrollment

Dec. 31, 1959	Total Enrollment	1 yrs. Growth
Hospitalization	127,896,000	..... 4.8×10^6
Surgical Expense	116,944,000	..... 5.5×10^6
Medical Expense	82 ,615,000	..... 7.2×10^6
Major Hosp. and Medical ..	21,850,000	..... 4.5×10^6
Dec. 31, 1960		
Hospitalization	131,962,000	..... 4.1×10^6
Surgical Expense	121,045,000	..... 4.1×10^6
Medical Expense	87,541,000	..... 4.9×10^6
Major Hosp. and Medical ..	27,448,000	..... 5.6×10^6
Dec. 31, 1961		
Hospitalization	135,042,000	..... 3.1×10^6
Surgical Expense	125,297,000	..... 4.3×10^6
Medical Expense	92,633,000	..... 5.1×10^6
Major Hosp. and Medical ..	34,138,000	..... 6.7×10^6
Dec. 31, 1962 (Estimated)		
Hospitalization	136,000,000	
Surgical Expense	126,000,000	
Medical Expense	94,000,000	
Major Hosp. and Medical ..	36,000,000	

7,8,9.

APPENDIX

SCOPE OF THE COMMISSION ON MEDICAL CARE PLANS' STUDY

Area of Study	Inception of Program	No. of Persons Involved	No. in Commission Study	Relationship of Patient to Program
In-plant non-occupational medical care programs	Late 1800's	15.0 x 10^6	1.4	No choice (majority of programs)
Miscellaneous and unclassified plans	Late 1800's	5.5 (app.)	3.6	Ranges from choice of physician to no choice(majority: choice of physician within panel)
Student health services	1861	1.0 (app.)	957 college health programs	Ranges from choice of physician to no choice(majority: no choice)
Occupational disability programs (workmen's compensation)	1911	40.0-45.0	0.8	Ranges from choice of physician to no choice (Majority: no choice)
Medical society approved plans (other than Blue Shield)	1939	3.5	3.0	Choice of participating physician
Blue Shield	1940	34.4	26.7	Choice of participating physician
Private insurance	1940's	39.0 (group) 22.5 (individual)	24.3 (group) 10.0	Choice of physician

APPENDIX

SCOPE OF THE COMMISSION ON MEDICAL CARE PLAN'S STUDY
(cont.)

Relationship of Physician to Program	Benefits Provided by Program
Salary, contract, fee for service	Ranges from first aid to comprehensive medical care
Salary, contract, fee for service	Ranges from diagnostic to comprehensive medical care
Salary, contract, fee for service	Ranges from first aid to comprehensive medical care
Salary, contract, fee for service	Ranges from limited benefits and duration to unlimited medical benefits
Fee for service	Surgical and medical
Fee for service	Surgical and medical
Fee for service	Surgical and medical

APPENDIX

KAISER INTERVIEW FORM

Age
P G
Marital status
Occupation:
  Patient
  Husband

Reason for joining:
  Union affiliation
  Other job
  Elective

Coverage code
Dependents
Education:
  Husband
  Wife
Duration of membership
Anesthetic
Complications

Previous Medical Experience:
1. Favorable
2. Unfavorable, how?
3. Change physicians often?
4. Family doctor?
5. Child delivered by private physician?
6. Expense of above delivery?

Prenatal:
1. Did you visit one doctor?
2. Best possible care or at sleast good care?
3. Advice calls?
4. "Personal physician?"

Labor and Delivery:
1. Confidence in your doctor?
2. Did you feel that doctors were interested in you?
3. Has delivery doctor made a postnatal visit?
4. If possible, would you prefer to have one doctor for the prenatal, delivery, and postnatal periods?

Comments:

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