ALAMEDA COUNTY PLAN

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ONE of the foremost topics of study and discussion today is the sociologic and economic aspect of the cost of providing adequate, efficient, and satisfactory medical care to persons of moderate income.

BASIC OBJECTS OF THE ALAMEDA PLAN

Therefore the Alameda County Medical Association undertook the study and development of a plan which it was believed would solve the problem of medical care and hospitalization for:

1. The indigent;
2. The individual of moderate means; and
3. Those who can properly finance all their medical problems to the entire satisfaction of the medical profession, the hospital, and the community.

Preventive medicine is left to the properly constituted health authorities: federal, state, and municipal.

In developing their plan, the members of the Alameda County Medical Association have been mindful of:

(a) The undesirable schemes of the commercial organizations which render medical and hospital service for profit;

*Read at the second general meeting of the California Medical Association at the sixty-second annual session, Del Monte, April 24-27, 1933.*
(b) The necessity that the relationship of patient and physician shall remain as it has always been—the patient having choice of his medical attendant from the membership of the Alameda County Medical Association; and the

(c) Desirability of a plan of hospitalization under which the beneficiary would pay a small sum to a central organization, which would be conducted by a nonprofit organization controlled by officers of the medical association and executives of those local hospitals having accredited standing from the American College of Surgeons. This plan would guarantee payment to the hospital, and leave the beneficiary in a position to finance his obligations to his physician.

To keep the cost of laboratory service, roentgen ray and medicine in the same ratio as the cost of medical service, the pharmacists' association, roentgen ray and pathological laboratories were embraced in the Alameda County plan.

In this plan we believe that we fulfill most of the recommendations of the Committee on the Costs of Medical Care.

FORMER CONDITIONS IN ALAMEDA COUNTY

It may be well to review the situation which prevailed in Alameda County prior to beginning this study and which has helped to make the adoption of this plan possible.

In 1918 there was established in Oakland, through the initiative of Miss Annie Florence Brown, a clinic for the medical care of the indigent sick and persons of moderate means. This was accomplished with the approval of the Alameda County Medical Association, after a thorough study of the problem. The organization, an eleemosynary corporation, was named the Public Health Center of Alameda County.

In this connection one may be reminded that even in 1918, fifteen years ago and long before even the most pessimistic had foreseen the present economic cataclysm, public attention had been directed to the need for a public health service of this sort.

Alameda County boasted several clinics (in Berkeley, Alameda, and in rural districts) but they operated as independent, unrelated units with no central control. Each received assistance from the Community Chest and the County Board of Supervisors. Patients who had tuberculosis were cared for by the Alameda County Tuberculosis Society.

About July, 1917, the supervisors had established the Alameda County Institutions Commission; its purpose, to take entire charge of the operation of all county institutions wholly supported by county funds and designed for the care of the indigent sick. Its jurisdiction did not extend to clinics.

THE ALAMEDA SURVEY MADE IN 1930

The picture now shifts to the year 1930, with the problem of medical care becoming more and more acute. In this year several health organizations, cognizant of the critical situation, requested a county health survey. The request was carried to the State Board of Health by the Board of Supervisors. It was granted and the survey was made by J. W. Mountain, a surgeon of the United States Public Health Service, the expense being defrayed by the Alameda County Tuberculosis Society.

Doctor Mountain's report embraced two main sections:

1. Prevention of disease and promotion of health; and
2. Care of the sick.
The report recommended that the treatment function of health centers (clinics) be assumed by the County Institutions Commission. This involved control over appointments, budgets and accounts and, where desirable, the ownership of property.

The Mountain report gave the supervisors a clear picture of the problem of the care of the indigent and near indigent. In August, 1932, resolutions were adopted in accordance with the report’s recommendations. On September 1 a new set-up went into effect, and thus all the pay clinics went out of existence with one stroke. Thereafter only those citizens who were indigent could receive care at any of the clinics in Alameda County operated by the County Institutions Commission.

Meanwhile, under the direction of the commission and the supervision of the county medical director, Dr. Benjamin W. Black, the following public hospitals and sanatoria were operating:

1. Highland Hospital, a modern institution of 450 beds.
2. Fairmount Hospital, a convalescent hospital with 900 beds.
3. Arroyo Sanatorium for citizens with tuberculosis; and

Economically and efficiently conducted under Doctor Black, each of these institutions has its superintendent, except the preventorium, which is in charge of the superintendent of the adjacent Arroyo Sanatorium.

HOW ALAMEDA COUNTY MET ITS NEW PROBLEMS

Even before these changes went into effect, Alameda County had maintained a staff of county doctors who had served patients in their homes on a fee basis. Under the new set-up the county physicians were made regular county employees on a salary basis covering part-time service.

These changes left in the hands of the Alameda County Medical Association the problem of caring for the low-income group, who in the new arrangement were now without medical care.

Concluding an extensive and exhaustive study of the problem, the Alameda County Medical Association at a meeting in October, 1932, adopted the following resolution:

WHEREAS, It has come to the attention of the Council of the Alameda County Medical Association that certain changes have taken place in connection with the work performed by the county doctors, its county physicians, and the consideration that they have given to the “indigent sick” and “dependent poor”; and

WHEREAS, Public Health Centers have up to this time cared for certain patients from whom certain fees have been taken, and who appear to be not eligible for care at the expense of the public, under the Indigency Act of the State of California; and

WHEREAS, The county profession realizes the importance of maintaining a service for patients that are not able to pay a full fee; now therefore be it

Resolved, That it appears to be necessary to establish a plan whereby certain patients formerly cared for at health centers, who do not technically fall under the term “indigency” and at the same time require attention at the hands of reputable physicians, and whose care should be assumed at a fair price within the ability of the patient to pay; and be it further

Resolved, That the Alameda County Medical Association agrees to establish a list of physicians who will volunteer to accept calls for such classes of patients and to render service when called in cooperation with the established official county agencies and centralized social service, as established in Alameda County and according to such additional plans as may be adopted.

It was gratifying to note that the call for volunteers met with practically 100 per cent response.
Numerous problems were met with in putting the plan into effect, and one of the first was the re-rating of patients. Where formerly the ratings of applicants to clinics were A, B, C, D, and E, depending on the applicant's financial rating, the new schedule fixed the ratings simply A and R, the first meaning "without resources" and the second "with some means to pay for medical services."

Thus all applicants were automatically divided into two definite classes: those without resources and therefore dependent upon county aid, and those able to pay to some extent but who cannot be classed as indigents under the law. These latter patients are being served by the members of the Association, and are given proper care whether able to pay one dollar or only fifty cents.

Physicians on the volunteer list are listed alphabetically, geographically, and as to specialty; and they are called in rotation. The physician makes the original call, supplies the necessary professional services, and charges the patient a fee that he is able to pay. The fee is paid at the time the service is rendered.

NECESSARY ELEMENTS IN THE PLAN

Necessarily the carrying out of this plan requires the fullest cooperation of the various clinics. Where a family applies to a recognized charitable agency and the family is not known to the agency, the call is referred to a physician in the same manner through the central social service agency.

If the doctor who has been sent on the case can work out the financial problem with the patient, then he is retained on the case by the patient and the case becomes a part of his own private practice. If he determines it to be an indigent case, he may refer the patient to the clinic operated by the county, to a hospital operated by the county for charity cases, and/or to the county physician who is paid by the county to care for indigent patients.

For each patient the doctor makes out a report, the form of which was adopted by the Alameda County Medical Association. Brief but comprehensive, this report describes the financial and social status of the patient and indicates the disposition of the case by the doctor. Filled in by the doctor, the report reveals the total family income per month, the length of time the income has been received, the number of persons supported on the income and whether adults or children; debts, savings, nationality, whether the home is owned or held by equity—mortgage, rent or payments on home—whether patient is a war veteran and length of residence in the county. For reference it bears the name of the agency by which the case was referred, name of the social worker, medical diagnosis, and probable duration of illness.

On the reverse of the report the patient signs his name below a printed paragraph which says the patient has made the foregoing representations for the purpose of securing necessary medical and hospital service, being unable to pay in full or anything, as the case may be. He consents that the report may be furnished to the Health Department of Alameda County and to the various charity agencies, and agrees to pay for the medical services specified at the part-pay fee schedule of the Alameda County Medical Association.

As a component element of the Alameda County Plan there was formed an obstetrical group, the members of which will accept any patient referred to it by the social service at a reduced fee. The money collected from such patients is deposited
in a central fund which, after the visiting nurses are paid, is divided equally among the members. The purpose of this plan of division is to avoid the possibility of Jones consistently receiving more than Brown for his services, or vice versa. Jones might have a run of five-dollar cases, while Brown was getting five times that sum for each case. The division plan, however, tends to solve that problem.

Cooperating with the Association in carrying out the plan, the established pathological laboratories have agreed to render services within the means of the individual to pay. To illustrate: If the specimen is sent to the laboratory, one-fourth of the regular fee is charged. If it is necessary for a laboratory representative to call at the house of the patient, one-half of the regular fee is charged.

The x-ray laboratories have likewise agreed to perform the service required of these part-pay patients at 25 per cent less than their established rate, while similar cooperation was given by the Alameda County Pharmaceutical Association, members of which have agreed to provide standard drugs at low prices to part-pay patients.

Finally, an arbitration committee has been appointed to which shall be referred any question of policy or complaint of member, and a decision of the committee shall be final.

HOW THE PLAN AFFECTS THE PHYSICIAN

We now see the individual physician working under this plan as the master of his own private clinic rather than a worker in a public clinic for the low-income group. Conditions which prevail today indicate that the patient of low income is entitled to a lower fee consideration, but it is quite possible he may presently graduate into the higher economic classification, fully able to finance his medical problems at the standard fees. The physician, therefore, through his generous cooperation, will have added to his practice and in the meantime has received something for his services. As for the patient, he has maintained his self-respect by avoiding indigency and paternalism, and thus may also have escaped a pernicious habit, destructive of his morale. Moreover he has been given good medical care, which, from his standpoint, is perhaps the most important consideration of all.

While it is desired to avoid unduly hasty conclusions, it now appears that the plan, operating since January 1 of this year, has been eminently satisfactory to both the physicians and the patients. During the month of February, 151 patients were referred to private physicians on the volunteer list, and the total since the plan went into operation is 506.

CREDIT RATING AS APPLIED TO THE PLAN

Oakland is the headquarters for the Retailers' Credit Association of Alameda County, a merchant-owned bureau of 500 members, with 350,000 names in its files, and with state and national affiliations. With this bureau the Alameda County Medical Association has entered into an agreement by which the credit bureau has established a medical file containing a complete record of all patients on the books of its members. The names of the patients are furnished to the bureau by individual doctors, who in turn are entitled to full credit information on any person listed in the medical file.

For this service each member-doctor agrees to pay an initial membership fee of five dollars and thereafter the sum of one dollar monthly. In addi-
tion to an unlimited number of telephone reports on information contained in the medical file, he is entitled to reports on information contained in the bureau's master file. Full standard written reports are furnished for seventy cents each.

Obviously this service will at present be used principally in connection with names not acquired under the part-pay plan, but the margin of difference may be small in some cases, if any exists at all. Therefore the bureau has agreed to furnish a rating on any part-pay patient, or indigent, whom the doctor believes may have emerged from the low-income group and is able to assume his medical obligations on a normal basis. The bureau undertakes to obtain and deliver the facts in the case, for which service a fee of one dollar is charged.

COÖPERATION GIVEN BY OTHER GROUPS

Important to the efficiency of the Alameda County Plan are the liaison relationships established between the Tuberculosis Association of Alameda County, the Alameda County Medical Association, and the County Institutions Commission. The first named, which is purely an eleemosynary organization deriving its support from the sale of Christmas seals, assists the county in its tuberculosis problems by providing a full-time social worker in the county clinic to supervise and coördinate all of the tuberculosis social work; a physician devotes half-time to the clinic care of the tuberculous indigent; and two physicians in general practice pursue postgraduate study in the clinic. The latter two serve for a period of one year and their places are then filled by others in general practice, compensation for services being $25 a month.

In the establishment of this liaison, complete coördination of existing facilities was sought and obtained. While no new major developments were found necessary, certain revisions in authority were made, and the superintendent of Arroyo Sanatorium, Dr. Chesley H. Bush, was placed in charge as chief of the tuberculosis clinics throughout the county.

In order that this plan of coöperation may smoothly dovetail with the Alameda County part-pay plan, those patients who are not entitled to county care are referred to the executive secretary of the Tuberculosis Association, who is also a trained social worker. He, in turn, refers these patients to one of the physicians on the volunteer list. Before referring the patient he explains the importance of the examination of all contacts. In return it is required that, for statistical purposes, the Tuberculosis Association shall request report on the skin test, and if this is positive, on the findings of the chest roentgen ray. This insures proper examination of the contacts. A definite appointment is made with the physician to whom the patient is referred and the family notified of such appointment. In this manner accurate results can be tabulated, and through the various health departments such further supervision can be given as may be indicated.

Under this procedure the physician retains the patient, the family receives the necessary care at a proper fee, and the health department also receives accurate information.

HOSPITAL SERVICE ON PERIODIC PLAN BASIS

In endeavoring to meet fully all of the numerous problems encountered in formulating a comprehensive plan for complete medical care, the medical profession must of necessity give careful
consideration to the major problem of hospitalization. Numerous plans for medical care separately, hospital care separately, and the two combined, have been put into practice, but the task of combining the two successfully has more often than not proved an insurmountable hurdle.

Adopting the premise that neither can of itself stand complete, and likewise that only a nonprofit group supported equally by the medical profession and the hospitals can render effective service to a large portion of the people of moderate means, the Alameda County Medical Association is now projecting an organization for the furnishing of hospital service on a periodic payment basis. This is being done with the aid of the Department of Public Relations of the California Medical Association, through Dr. Walter M. Dickie, Director, and Mr. Hartley F. Peart, General Counsel of the California Medical Association, who are cooperating with the council and officers of the county association.

This organization will be called the East Bay Mutual Hospitals, and will embrace in its membership every accredited hospital, other than county institutions, in Alameda County. The members of the East Bay Mutual Hospitals will select their directors from their own number, and the directors will select a medical director who shall be a member of the Alameda County Medical Association. All members of the Association will be eligible for appointment on the staff of the East Bay Mutual Hospitals.

Hospital service contracts will be issued at a cost to the holder of about $12 per year, payable quarterly. A contract will entitle the holder to service in a member hospital of his own selection, the necessity for hospitalization to be determined by his attending physician, a staff member of the East Bay Mutual Hospitals.

The board of directors will be composed of representatives of the hospitals with which East Bay Mutual Hospitals holds contracts, and of members of the Alameda County Medical Association.

In formulating this plan it was borne in mind that unless all hospitals in good standing in a given locality are embraced within the scheme, it will not prove satisfactory in the long run. When all hospitals in the community are working under identical conditions there is no chance for undue competition or underbidding, nor is the freedom of choice of physician or hospital in any way affected.

Details of the plan are now being completed by a committee of doctors and hospital representatives in cooperation with the Department of Public Relations of the California Medical Association; and the articles of incorporation, by-laws, staff rules, hospital service contract, and the application for beneficiary contract are now being prepared.

IN CONCLUSION

Such is the Alameda County Plan, presented in brief, designed to solve the pressing problem of adequate, efficient and satisfactory medical care and hospitalization to persons of moderate income; and we believe that it fulfills most of the recommendations of the Committee on the Costs of Medical Care.

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DISCUSSION OF PAPERS OF DOCTORS REINLE, HOLDEN AND BROWN

R. G. Leland, M. D. (535 North Dearborn Street, Chicago, Illinois).—To those who have an uncontrolable desire to disorganize the time-proved methods
of medical practice and to reorganize on the lines of big business, mass production methods of commercialism, the description of the organization of both the Alameda County and the San Diego Medical Society proposals must have been a disappointment. It is worthy of more than passing notice that both these proposals seem to be little more than a closer coordination of the community's existing medical facilities, and the physicians who have perfected the details of the plans have, thus far, not deemed it necessary to incorporate the feature of big business acquisition, viz., solicitation—a feature which is prominent in most of the schemes advocated by the medical revolutionary enthusiasts.

During the past one or two years the American Medical Association has been frequently and not too tenderly criticized for failure to bring forth for the entire United States a master plan to be used by county or state medical societies for a reorganization of medical practice. A careful examination of such a proposal should convince any fair and open-minded physician that it is utterly impossible, impracticable, and unwarranted for the American Medical Association to adopt such a procedure. To adopt, publish and recommend "a plan" would be to infer that a change is necessary in the tested and proved methods of medical practice, and the arguments in support of the necessity for such a change have thus far been unconvincing. To assume that "a plan" devised to illustrate a "model or typical or master method" of practicing medicine is utterly absurd. The several sections of the United States differ widely as to population, industry, age, customs, traditions and many other features. To urge a single new method and thereby to infer that the present methods are unsound and should be discarded or altered would be to hasten or precipitate that sovietization of medicine which the medical profession is seeking to avoid. All advocates of commercial medical schemes, involving complicated, top-heavy overhead organization, expensive administration, and unethical solicitation should be required to present their true credentials to indicate the nature and extent of their extra-professional interests and affiliations and the manner in which they expect to profit financially, politically, or otherwise in the promotion of these fictitious, artificial and economically and ethically unsound proposals.

There never has been a time in medical history when certain obligations upon the medical profession have been more clearly defined. One of these duties is, obviously, to resist all efforts to commercialize medicine. Commercialization of medicine means a deterioration of medical service and a disruption of medical organization. The evils and effects of commercial mass production methods are as inimical to the welfare of the public as they are to the advancement, freedom, and independence of medicine. The history of medicine records an enviable record of brilliant achievements and the application of numerous humanitarian measures almost entirely devoid of the element of personal aggrandizement and individual monetary gain. During the past several decades the medical profession has advanced tremendously in its ability to cope with scientific problems. It is unbelievable that a profession which has demonstrated such ability in the scientific field will now, because of the pressure of profit-seeking propagandists and the exigency of a general economic unrest, surrender the control of the practice of medicine just when professional control is most necessary. The medical profession can and must cling to and defend, for the public good, all those elements of medical practice which demand a high quality of medical care and an ethical conduct of its members.

Although I respect the ability represented in perfecting an organization such as that described by Doctor Brown of Santa Barbara, I cannot agree that the medical group which he has perfected is representative of the average medical group throughout the United States. I regret that so much space and time has been devoted to the details of the business, property holding arrangements, income and purely personal or professional advantages of a group arrangement. Our primary consideration should be, rather, to direct our efforts to the development of the superior service, if any, that can be provided to the public and, secondarily and incidentally, the guarantee of personal or group financial security. If a medical group, no less than an individual physician, is able to justify its existence and methods on the basis of quality of medical services, with fairness in its dealings with patients and honorable ethical conduct with those phy-
sicians not members of the group, the financial security can usually be arranged quite naturally and normally.

A report of group practice will soon appear in the Journal of the American Medical Association. I hope this report will receive careful study by all who may be interested in that method of medical practice.*

I am firmly convinced that the American public wants its family physicians rather than any highly organized complicated form of medical combination. The family doctor of average ability can successfully care for about 90 per cent of the illnesses in any American family. The allegation that a large section of the American public is suffering because of the paucity of medical facilities is unconvincing when one knows the nature and habits of the medical profession. I venture to predict that few, if any, physicians, even in these troublesome economic times, have refused medical care to any person regardless of his ability to pay. To be sure the political subdivisions of our states should pay for the care of the indigent sick; but it has not yet been demonstrated that commercial schemes which reduce the value of the medical dollar of the low-income group by 20 to 75 per cent can be justified even on the ground of spreading the cost over a large population group.

It appears that the writing of "medical plans" has become a fetish, and the profession is told that inaction in this matter will be fatal. Action in any direction is never justified solely to satisfy the desire to be doing something. Change is never justified unless the advantages which that change introduces are superior to the conditions which the change supplants. Our faith to detect the changes that must be made in the methods or administering medical care, if and when necessary, must be placed in the medical profession itself and not in profit seeking, commercially minded promoters.

In the study recently completed by the Bureau of Medical Economics less than 15 per cent of the 224 groups which answered the inquiry had adopted any arrangements for a flat rate charge for any type of medical service.

The comments of many indicated that the physicians doing group practice are not in favor of insurance arrangement for meeting the costs of medical care. A flat rate monthly payment plan such as that to which Doctor Brown referred, if adopted by a medical group under whatsoever pretext would at once give that group an unfair commercial advantage over the other physicians in the community and would both directly and indirectly set in motion a very undesirable form of public education. If the public is led to believe that for a small monthly payment medical care can be secured for all or most of the human ills, the natural and unavoidable inference will be that regular medical fees are unfair and exorbitant.

The fees derived under such an artificial and unnecessary scheme, applied during an abnormal economic period, will have become frozen when normal or prosperous conditions return and an upward revision of medical fees can then be made only with the greatest difficulties.

Insurance schemes do not sell themselves; they must be sold. This sales element involved in the distribution of medical services under insurance schemes constitutes a violation of the principles of professional conduct and the practice of medicine which for thousands of years have proved their fairness, soundness of doctrine and faithful adherence to the best interests of the public. Those who are promoting these commercial schemes during a temporary financial exigency are not only breaking faith with the thousands of honest and devoted physicians who have established and striven to keep unsullied the high ideals of the medical profession but also are encouraging the public to lose confidence in the medical profession to which it has always looked for honest, unselfish, personal service.

Not all of these promoters of unsound schemes are found among the lay business propagandists. Many professional promoters are urging that the principles of ethics be changed so that they may have some "new" and "modern" principles to protect them as they "put over" these recently conceived pilfering plans.

To lessen the standards of the principles of ethics would be to cheapen and reduce the quality of medical care. To change the principles of ethics to satisfy

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* Report referred to was printed in The Journal of the American Medical Association, issues of May 20, May 27, 1933.
certain conniving cliques would be to sell out to commercialism. To lower the standards of medical conduct would be to allow medicine to become a mere trade.

The principles of medical ethics are neither antiquated nor obsolete. These principles must govern in the practice of medicine now as never before. I believe that most physicians concur in the value and the interpretation of the principles of ethics in medicine, and it is this majority who must compel their general application.

If medicine be at the crossroads, then surely the medical profession and not commercial conjurers must select the correct course. And this selection will be made in the interests of the public no less than for the continued freedom, independence and self-respect of medicine itself.