C. Rufus Rorem, probably more than anyone else, helped shape and define group prepayment health services insurance plans as we know them today. Blue Cross-Blue Shield, commercial insurance plans, prepaid group practice arrangements have all benefited from the wisdom and foresight of Rufus Rorem.

Rufus was an Iowa farm boy, born in 1894. He left the farm to attend Oberlin College. He simply appeared one day at the college registrar's office with tuition and a reference letter from his high school principal in hand, and he was admitted. His major was political science. Not much that he studied in college prepared him for his later career as a medical economist, a C.P.A., an expert on financing of hospitals and medical care, or a university professor of accounting. He was graduated with a B.A., cum laude, and was admitted to Phi Beta Kappa.

Following college he had brief employment in the office of the Goodyear Tire and Rubber Company. He remained there until World War I broke out and he served for a short time with the YMCA before taking officer's training to become a second lieutenant in the U.S. Army Ordnance Corps.

After the war he worked a few months as a reporter on the Mason City (Iowa) Globe Gazette until he could get a job as a traveling salesman for Goodyear in a new territory in South Dakota.

Rufus has remarked that this new Goodyear sales job was characteristic of jobs held later. From this time on he always entered jobs in which he was not following someone else, but was the first to work in that particular situation, and for which he had no experience or special training.

After three years of traveling about the Dakotas for Goodyear, Rorem tired of living in hotels and being away from his family most of the week. (He had married in the meantime.) He decided he would like to be a

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teacher, but discovered he could not qualify for teaching in a high school because he lacked college credits in education theory and practice.

His next attempt to become a teacher culminated in an offer from Earlham College, a small Quaker school in Richmond, Indiana, to teach business courses and accounting the following year. Rorem agreed to teach everything but accounting, in which he had no training or experience. The college said it had to be all business and accounting courses or nothing. Faced with this ultimatum, Rorem accepted the position and said he would report the following September prepared to teach all the courses. He quit his job with Goodyear and enrolled at the University of Chicago for study that summer, taking beginning and advanced courses in accounting simultaneously. In September he began teaching accounting and all the other subjects he had agreed to teach at Earlham College.

During the three years he was at Earlham, Rufus also taught night school courses in the public schools of Richmond including one course in income tax accounting, which, again, he had to learn on his own before teaching it. It was during these years that he passed the examination to become a Certified Public Accountant in Indiana.

After three years at Earlham, Rorem wanted to move on to something better. The obvious route was through graduate study. The University of Michigan offered him a tuition scholarship but he needed both a way to study and to support his family. The University of Chicago made a better offer: graduate study and an instructorship in accounting. (There were few, if any, persons in the United States entering graduate school with a C.P.A. in 1924.)

During the next five years Rorem was busy. He finished the work for his master's degree and doctorate; he taught accounting courses and advanced to Associate Professor and to Assistant Dean of the School of Commerce and Administration at the University of Chicago.

Then, as often happens, a stranger appeared who became a life-long friend and colleague, a person who had a lasting influence on Rufus Rorem's life. Dr. Rorem describes it this way:

In December 1928 during my last year of teaching as Assistant Professor of Accounting, when I was working also as assistant to the Dean as sort of an adviser to students, I was called upon by Michael M. Davis, Ph.D. He was a medical economist who had just become Director of Medical Services of the Julius Rosenwald Fund in Chicago. He also was a member of the executive committee of the Committee on the Cost of Medical Care (CCMC). This committee had been organized in 1927 to study the cost of medical care from the standpoint of the general public, the individual patient, the institution, and the professional personnel. The CCMC had been gathering statistical data and general facts
about the organization and administration and resources for health care. They were beginning to explore the financial aspects of hospitals and wished to add to staff a person familiar with accounting and administration, particularly with respect to capital investment and costs of maintenance.

Dr. Davis asked me to recommend someone with competence in the field of social statistics. After some discussion he offered me a temporary part-time appointment with the committee, which I accepted, to work with him at the offices of the Rosenwald Fund in Chicago. He informed me I would not be a regular member of the staff but would work on a specific study, for which money was available from the Rockefeller Foundation. The study would be of the amount and nature of the capital investment in the hospitals of the United States. No such study had ever been made, no such estimate had ever been compiled, and no specific information was available in the libraries. If I were to accept this assignment, I would perform the task in my own way and find out whatever was available.

The opportunity appealed to me as I had been active in some aspects of public finance and nonprofit corporations. Under my direction, several master's degree students had prepared theses on trade associations. I had also served on a federal committee to develop uniform statistical terms and definitions for various units of social service such as clinic visits, patient days, and "free" service at health agencies.

The Committee was composed primarily of sociologists, businessmen, and physicians. I agreed to take the job at the end of the academic year, meanwhile working on a part-time basis through the summer of 1929. I went on the full-time payroll of the Committee on the Cost of Medical Care, January 1930, and moved to Washington, D.C.

My first study of the cost of medical care, financed by the Rockefeller Foundation, was published in November 1930 by the University of Chicago Press with the title, The Public's Investment in Hospitals. This title was used because the preliminary findings showed that hospital capital had come from public sources (rather than from private investors) which expected neither repayment of the original capital nor a return in the form of interest.

Investor-owned hospitals, at that time, represented about 10 percent of the national total, as the estimates were finally developed—a percentage that still remains. The money invested in the hospitals in the United States has increased twentyfold, but the ratio of investor-owned hospital remains the same—about 10 percent of the national total. The capital of the other 90 percent at the time of the study was equally divided between philanthropy and taxation.

The Committee on the Cost of Medical Care conducted a program
with many subdivisions. My own studies were limited to business operations, or to the fiscal and administrative side of medical care production. Consequently, after I was nicely started on the effects of hospital capital and its relations to hospital costs, I conducted a study of group practice among private physicians, a trend which had been developing for at least 40 years—having its roots in the Mayo Clinic of Rochester, Minnesota.

The first study, *The Public's Investment in Hospitals*, was issued in November 1930 by the University of Chicago Press, which was the official publisher of the Committee on the Costs of Medical Care. A second study, *Private Group Clinics*, was published February 1931.

Some broad conclusions came to my attention, at that time, which appeared to be important. The primary problem facing society in providing medical care was the effective utilization of capital investments in facilities and personnel. At that time the average hospital had an investment of about a million dollars. The average public investment in a physician was approximately $10,000. The average investment in a nurse was zero, since she worked her way through nursing school, making a personal investment from the day she entered the institution's premises.

An interesting part of the capital investment study was that many facts and data were obtained by personal visits to institutions. I would ask each hospital for a copy of its financial statement. During the winter of 1928-1929 the first hospital I visited was the Huggins Memorial Hospital in Wolfeboro, New Hampshire which had 24 beds, and second was the Massachusetts General Hospital in Boston which had 24 operating rooms. At neither place was there any record of capital investment. For purposes of insurance, some records were maintained, but neither hospital kept a plant ledger, and management was surprised that anyone should ask for such information.

After a few weeks, and after visiting a dozen more institutions, I found that instead of asking questions I was answering questions. This was a field in which I knew very little, but in which the hospital representatives knew nothing. Within a month I became an expert on capital investments in hospitals and began writing on the subject. There was no literature. If I wanted to read something about capital investment, I had to write it myself.

An illustration of how little I knew about hospitals was that I did not know that attending physicians at hospitals were private practitioners using the institutions to carry on their practice. I did not know that very few deans of medical schools in the country received cash salaries for their work. They donated their services for the most part, and made their living from serving private patients in their spare time.

For example, a statement from the Presbyterian Hospital in Chicago, the teaching institution for Rush Medical College, revealed that the
medical school paid $500 for the services of Dean of the medical school, Dr. S. E. Irons, who later became President of the American Medical Association.

I said to him, "I find everything in the statement but your salary."
"That's it."
"That $500? You can't live on that."
"Of course I can't. That's just for office expenses."
"Well," I asked, "how do you make your living?"
"I have a private practice on the side."

The Committee on the Cost of Medical Care was disbanded during the summer of 1933. Meanwhile (1931), I had moved to Chicago to work on a full-time basis with the Julius Rosenwald Fund, acting as Associate Director of Medical Services under Michael M. Davis.

Although the Rosenwald Fund paid my salary and expenses, I still remained a member of the staff of the Committee on the Cost of Medical Care. I was one of the three joint authors of the final report of the Committee called The Costs of Medical Care. The authors were Isadore S. Falk, Ph.D., C. Rufus Rorem, Ph.D., C.P.A., and Martha D. Ring. Dr. Falk was the primary author; I wrote the section dealing with financial and organizational matters; and Miss Ring served as editor and coordinator of the volume as a whole.

During the latter years of the work of the Committee I was the author of a volume titled The Municipal Doctor System in Saskatchewan. I also was co-author with Robert P. Fischelis, D. Pharm., of The Costs of Medicine, dealing with the pharmaceutical industry and the use of prescription drugs and over-the-counter products.

The Committee on the Costs of Medical Care was the first public body to approach the entire problem of producing, delivering, and financing health services to the American people. The project began during a time of high wages and low prices. The Committee concerned itself with prevention, treatment and financing phases of personal care and public health. The study cost a million dollars, which was spent over a period of five years. Since that time, many millions of dollars have been spent annually to discover and rediscover some generally known facts including the following:

1) No one can tell when he will be sick or injured, or what his care will cost.
2) The total costs of medical care needed by a group of individuals during a period of time can be estimated with reasonable accuracy.
3) During any given time period some individuals will require no health care, some will require a great deal.
4) It isn't the cost, it's the uncertainty that gives rise to most criticism of health service.

5) Prevention is cheaper than cure—and less exciting.

6) Some accidents will happen that require health service.

7) Man's best friend is himself. Most of his health service consists of following a doctor's advice.

8) Many of the best things of life are free—moderation, rest, etc.

9) Elderly people have more sickness and less money than others.

10) Present methods of producing and financing health care tend to increase the total and per capita expenditures for all groups of the population.

11) Medical practitioners and institutions can provide better and more service through cooperation than competition.

12) Medical practitioners and institutions have a vested interest in maximizing health services and stressing their complexity and mystery.

13) Many doctors "overwork" themselves by performing services and giving advice which can be equally well provided by nurses and supervised assistants.

14) Hypochondriacs often request, and receive, care which health practitioners consider unnecessary. A patient would often be better served if a doctor were paid to refuse services or drugs which a patient thinks he needs.

15) It has been suggested that an insurance plan should require patients to pay deductibles or partial fees, thus to reduce the amount of unneeded care. This would constitute the practice of medicine by arithmetic rather than by professional judgment.

16) The average individual American is not capable of dealing with his own economic problems of health care. Legislators have recently discovered what had long been obvious to the average American.

17) Most of present research and experimentation is unnecessary to accomplish the avowed purposes, namely: (a) to determine whether any specific method of delivering service would be cost effective; and (b) to determine whether a new method of financing health care would be more equitable to individuals who require service.

Rorem's most significant contribution in health care delivery came after he left the Rosenwald Foundation and joined the AHA as an as-
sociate director to head an effort to develop prepayment plans, to set guidelines and standards for their operation, and to spread the word about them throughout the nation. This was the true beginning of the Blue Cross movement. Rorem describes those days:

Health care insurance, taxation, or some form of group payment appeared necessary to achieve equity of the financial burden and appropriate distribution of care.

Hospital care insurance originated as a device by which an individual hospital would be guaranteed specified revenue, and would assume responsibility for specific services for groups of people who paid money to the institution. They were eligible to receive specified care at that institution without extra cost at the time of illness.

The most publicized health insurance program was one initiated in Dallas, Texas by the Baylor University Hospital. It enrolled members of the Beneficial Association of School Teachers at the city of Dallas in a program in which each one would contribute 50¢ a month regularly. For this amount each individual was entitled, if necessary, to 21 days of hospitalization each year.

The program was initiated by Justin Ford Kimball, D.D., who was Vice President of Baylor University and administrative officer of the medical school, dental school, and other health-related professional activities in Dallas. He persuaded approximately 1600 of the 2000 teachers, many of them Baptists, to join the program and pay the money into Baylor University Hospital.

Many individually sponsored health programs had been established before. The Baylor program was the first institution to start a program of health service benefits, as opposed to cash indemnities toward the hospital bill. The service benefit principle is the feature, and probably the only distinctive characteristic, which explains the rapid growth of the insurance principle in paying hospital bills. One weakness of the Baylor Hospital plan was that the benefits were available in only one hospital, a Baptist hospital, therefore the plan was not widely acceptable to people of other religious beliefs.

During the time that Baylor Hospital was expanding its coverage from approximately 1600 to 6000 beneficiaries in the city of Dallas, two other hospitals established similar and competing programs. One was a Catholic hospital, the other a Methodist institution. Both of these hospitals ultimately enrolled approximately 5000 beneficiaries who paid 75¢ a month through a promoter for exactly the same benefits as at Baylor. Each hospital received 50¢ a month for each person enrolled by the promoter. The enrollment in the Methodist and Catholic programs was not deterred by the fact that their fee was $9.00 a year while the Baylor program was available at only $6.00 per year. Any reluctance to partici-
part arose from disbelief in the programs in their entirety.

I found out later when interviewing business executives about enrollment of employees that none of them objected on the grounds that family coverage was not worth $24.00 a year. They doubted whether the contract was worth anything. They just did not believe in the program at all.

Originally, people were required to choose one hospital at the time they joined the plan. It soon became apparent it was necessary to allow people to choose their hospital at the time of illness rather than at the time of enrollment. This meant, of course, that effective group insurance for health care should allow free choice among several alternative institutions. Dallas and the state of Texas were among the last areas of the country to have a free-choice, areawide plan. Ultimately the single hospital plans which had been formed at Dallas, Houston, and Fort Worth were merged into one plan, the Hospital Services Association of Texas. Except for the principle of providing hospital service benefits, Dallas (and the Baylor Hospital) cannot be considered the instigator of community-wide health services prepayment.

The earliest plan to provide service benefits in several institutions appeared in the city of New Orleans where the Baptist Memorial Hospital joined with the Jewish hospital, Touro Infirmary, in establishing a citywide program with service benefits at the two institutions and modest case benefits elsewhere.

The first full-blown, community-wide, free-choice hospital service organization—still group hospitalization—was at Newark, New Jersey. It was introduced in 1933 by Frank Van Dyk, who later moved to New York (1935) to become director of the New York City plan. In Newark, the areawide plan covered approximately one dozen hospitals, each of which agreed to provide stated benefits for a stated amount expressed in terms of dollars per day.

Another important and early plan of citywide group hospitalization developed in 1934 in St. Paul, Minnesota where Mr. E. A. van Steenwyk, a 29-year-old former real estate operator, conceived the ideal of free-choice benefits among all the institutions in St. Paul. He also introduced for the first time the principle of dependents' benefits. Other programs had been for employed persons only, with no coverage for wives or children. The Minnesota dependents' coverage did not start as a full-benefit program. For an additional 25 percent of the $1.00 per month charge to employed individuals, coverage would be allowed for dependents.

For some time in the United States it was customary to charge an additional amount for each dependent. Within a few years the law of averages indicated that it would be practicable from a statistical point of view to have a standard family rate regardless of the size of the family. In
other words, one uniform rate for a one-person family, male or female, and a uniform rate for a family of two or more persons regardless of number of dependents.

It became my responsibility while working for the Rosenwald Fund to visit, upon request, many areas throughout the country. In the course of several years I visited at least 40 of the areas where plans were established. In several of these I had the pleasure of being able to recommend individuals to serve as the original executive directors of plans. These directors were recruited from many fields: finance, industry, accounting, sales, hospital administration, social work, and education.

The Rosenwald Fund decided in 1936 to discontinue its program in medical economics, although there was widespread interest among the general public. (Julius Rosenwald had died in 1932.) Some board members of the Fund were embarrassed by personal criticisms from their family physicians who objected to change in medical service organization. As a result, early in the year of 1936, the medical economics section of the Julius Rosenwald Fund was voted to be discontinued at the end of the year. (Certain other work in Negro public health and education continued for some time longer.)

The Rosenwald Fund faced the problem of what should become of the medical economics staff, Michael M. Davis and C. Rufus Rorem. Separate amounts were voted: a total of $150,000 for Davis, and $100,000 for Rorem, to be paid in four years of equal installments. The problem then arose as to what agency should sponsor their activities, since the Fund was required to restrict its donations to nonprofit organizations eligible to receive grants.

Michael M. Davis decided to move to New York City to establish a nonprofit corporation called the Committee for Research in Medical Economics. It was headquartered in New York City for several years until he moved to Washington, D.C. to continue his interest in health economics on a personal basis.

My grant was offered to several agencies. My first suggestion was that the money be granted to the Twentieth Century Fund, which had been interested in medical economics, particularly group practice. The Twentieth Century Fund decided not to accept the grant, since it would mean the addition of a stranger to their division of medical economics, and might embarrass their present staff.

I then made the suggestion that the National Association of Community Chests might consider a program of this type. The director of that organization considered this program as outside its sphere of interest, which was charity and public services to be financed by donations from individuals and groups. He recognized that group hospitalization was a
way people collected their own money for services for themselves—an organization to administer funds as though it were an insurance company. Furthermore, he foresaw that such programs could become area-wide or even statewide, and would not fit into the programs of local community chests and their charitable activities.

The third offer was made to the American Hospital Association, which promptly accepted the grant with the understanding that I would become a part of their staff but be paid from the money granted by the Rosenwald Fund.

Beginning January 1, 1937, I organized the Committee on Hospital Service of the American Hospital Association and I moved my offices from the Julius Rosenwald Fund to 18 E. Division Street in Chicago where I became the third male employee of the American Hospital Association. The others were Dr. Bert W. Caldwell, Executive Secretary of the Association, and an individual who served as janitor. By the vote of the Trustees, I was given the title of Associate Secretary of the American Hospital Association, and Executive Secretary of the Committee on Hospital Service of the American Hospital Association.

I assumed no duties or responsibilities for the activities of the Association as a whole, was not invited to the meetings of the Board of Trustees, and was not dependent on the Association for travel expenses or any other costs of the Committee on Hospital Services.

Two primary objectives comprised the program of the Committee: (1) improvement of hospitals through the development of uniform accounting according to a standard program which had been developed in 1933-1935 under my chairmanship while still in the employ of the Julius Rosenwald Fund; and (2) development of group hospital insurance for the payment of hospital bills on a community, state, and national basis.

I want to mention at this point in our discussion of the Committee on Hospital Services that I took part in the activities at the annual conventions of the AHA during those years following 1929, and that many of those activities had some bearing on the development of group hospitalization.

Programs of the annual conventions of the American Hospital Association (in 1929 at Atlantic City, and in 1930 at New Orleans) included references to my forthcoming book, *The Public's Investment in Hospitals*. The first mention was in 1929 by Winfred H. Smith, M.D., a member of the Committee on the Cost of Medical Care and superintendent of the Johns Hopkins Hospital, Baltimore. The mention in 1930 at New Orleans was by Julius Rosenwald, who quoted widely from the galley proofs of the forthcoming book.

At the 1931 annual convention of the American Hospital Association
in Toronto, a paper on "Group Hospitalization" by Dr. Justin Ford Kimball was presented in absentia, by an unidentified volunteer. The paper described a contributory insurance program for 1500 Dallas, Texas school teachers who, for 50¢ per month, were guaranteed 21 days of care (annually) at the Baylor Hospital of Baylor University. Dr. Kimball had been city superintendent of schools, and had become (about 1925) vice-president for medical affairs of Baylor University.

While the group hospitalization paper was being discussed, I was elsewhere in the convention. At one meeting I described the "Middle-Rate-Plan" for controlled physician fees for semiprivate patients at the Massachusetts General Hospital in Boston. At another session I presented a formal paper advocating improved and uniform accounting entitled "Cost Analysis—An Aid to Hospital Financing."

Beginning with the Detroit 1932 convention, the developing voluntary hospital insurance was the subject of considerable discussion. The movement was called by various names, such as hospital insurance, group budgeting, prepayment plans, group purchase of hospital care, and group hospitalization. The Blue Cross symbol and name were not mentioned, inasmuch as they were developed two years later by Mr. E. A. van Steenwyk of St. Paul, Minnesota.

During the period 1932 to 1936 I had served as consultant to the American Hospital Association Council on Community Relations and Administrative Practice although my headquarters was located at the Rosenwald Fund. The Fund paid my salary and other expenses during the four year period.

It was customary to report to the annual convention of the American Hospital Convention. My first presentation to the national meeting in Milwaukee in 1933 included the following:

As long as hospital bills are unpredictable as to amount, people will complain about them. It is impossible to silence a popular, present day criticism of hospitals by explaining that hospitals are efficiently managed, or that hospital bills are reasonable...

The function of group hospitalization is not to make easier the problems of the superintendent, but to solve the problems of the individual and of the public who own the hospitals...

Group hospitalization, by way of definition, is a device by which people pool their resources by fixed and equal periodic payments, the total being used for the payment of hospital services to members who require such care. Group hospitalization plans are not primarily for the benefits of hospitals . . . but for the benefit of people.

The experience of the last several years . . . has demonstrated that the people can and will budget their hospital bills if given an opportunity . . .

The Council on Community Relations and Administrative Practice
(following the action of the trustees endorsing the principle of group hospitalization) has specified certain characteristics (or criteria, or essentials, or points) which would characterize successful and ethical group hospitalization plans. Let us examine them now and test their validity, both by logic and experience.

The first principle is that a group hospitalization plan should place primary emphasis upon public benefit and secondary emphasis upon hospital finance . . . Group hospitalization is a method by which people pay their bills, not a product to be sold by a hospital executive, although the public will require the active cooperation of hospital directors in outlining the administering of their plans . . .

The second essential is that group hospitalization shall be limited to hospital services. The term "hospital service" is purposely not defined, but it means merely that the plan should include only those services which the hospital regularly provides . . .

As one man said to me in Boston: "What is the objection to including the physician's bill?" I merely replied, "I have no objection, and the public has no objection. Whenever physicians want medical bills included, some arrangement can be made."

The third criterion is that it should involve participation by all hospitals of standing in the community. This policy avoids competition among individual hospitals.

The fourth point is that plans should be economically sound. The rates should be sufficient to cover the costs of services and payments to the hospitals, and payments to the hospitals should be sufficient to remunerate them for the care rendered on behalf of sponsorship.

The fifth point is that group hospitalization should have community sponsorship. A group hospitalization plan should be established for the people and by the people. The initiative may come from hospital superintendents, professional groups, industrialists, social workers, unions, or people in the various trades.

The sixth and last characteristic is that it should be promoted on a noncommercial basis. No intermediary group should be allowed to take the position of promoter or sponsor with the idea of a net profit or a net loss made from the success of this plan.

The foregoing criteria were ultimately developed into 14 standards which served as the basis for formal approval of Blue Cross Plans by the American Hospital Association.

I held the position at AHA for 10 years (January 1937 to December 1946) during which time the Committee on Hospital Service changed its character in several ways. During the second year (April 1978), an approval program of Blue Cross hospital plans was developed according to standards I had drafted, and which have been amended from time to time.

During the second year, the name of the Committee was changed to The Hospital Service Plan Commission. After another year the term
"Blue Cross" was introduced and the sponsoring group was known as the Blue Cross Plan Commission, which was the forerunner of the Blue Cross Association.

At this point, mention may be made of the origin of the term "Blue Cross" which was used to identify nonprofit hospital service plans which had gained the approval of the American Hospital Association. The term "Blue Cross" was first introduced by Mr. E. A. van Steenwyk who used this title to identify his plan in St. Paul, both as a design on the literature and as a term to describe the organization which was registered by the State of Minnesota—not as an insurance organization, but as a hospital service plan association.

The Blue Cross was widely adopted, with or without permission, by various plans being formed throughout the United States. In the Spring of 1949, a list of "approved" plans was issued. These plans were allowed to identify themselves by a Blue Cross on which the seal of the American Hospital Association was superimposed. This granting of the seal to indicate approval by AHA came about through formal action of the Association's Trustees, approved by the Association's House of Delegates and membership.

During several years of the period when I was serving with the Blue Cross Plan Commission, each approved plan paid annual dues to the Association based on the number of subscribers in the plan at the end of the calendar year. Each approved plan became an associate member of the Association. The greater portion of the dues was used for the activities and expenses of the Blue Cross Plan Commission.

Before the establishment of membership dues, there had been other changes in the management of its successors, the Commission on Hospital Services, and the Blue Cross Plan Commission. One was the temporary election of six hospital administrators, chosen as "advisers" to the Plan Commission.

The original Committee on Hospital Service consisted of five persons with voting privileges and final authority over resources and program. They were appointed by the president of the American Hospital Association. The five persons were as follows: Basil C. MacLean, M.D., Superintendent of Strong Memorial Hospital in Rochester, New York, Chairman; S.S. Goldwater, M.D., Commissioner of Hospitals of New York City; Rev. Maurice F. Griffin, a Catholic clergyman of Cleveland, Ohio; Robin C. Buerki, M.D., administrator of the Wisconsin General Hospital, Madison, Wisconsin; and C. Rufus Rorem, Ph.D., C.P.A., Executive Secretary and voting member of the Committee.

As of January 1947 I resigned from the Blue Cross Plan Commission to accept the job of Executive Director of the Hospital Council of Greater
Philadelphia, covering five counties in southeastern Pennsylvania and three across the river in New Jersey with a population of approximately five million people and a membership of about 60 hospitals.

Since Dr. Rorem was one of the first and most practical of the medical economists it is natural that he should comment on the present scene. He said:

Some persons point to the economics of medicine and ask if that's what may be keeping the doctor seeing as many people as he can. That's where it all starts. The doctor is practicing medicine to yield the greatest possible return. It's amazing when you consider what society has done to itself. We give physicians the legal authority to keep others from competing with them, legal authority to serve anybody they wish to, legal authority to charge whatever the traffic will bear, and legal authority to refuse to serve any patient they choose to turn away. You add all that together and it's a wonder that a physician is honest at all. All these factors tend to make him do what is best for him economically, rather than what is best for the patient hygienically.

One of the most debated features of the economics is the way the doctor gets paid. Most of them work on the fee-for-service plan rather than on a salary. The fee-for-service system is all right in a delicatessen. If you don't want the commodity the store sells (if the price of peanut butter goes up from 50¢ to a dollar a pound), you just don't buy it, or you eat less of it. You can't do that with medical care. That's where we came in. The economic differences between medical care or health services and ordinary commodities are legion.

We'll all accept the fact that a person is entitled to health care if he needs it, without regard to his ability to pay. Second, we believe a person should keep as healthy as possible, be careful, and eat properly. We know that two people with the same amount of money may require health services that vary in magnitude of 100 to 1. One person may need nothing in a particular period; the other will need more than he can pay for in a lifetime.

However, buyer and seller are not on equal terms. The physician may know what's wrong with you, but it's obvious the patient doesn't know what's wrong. So they are not on equal terms. It's not a situation with an informed buyer and an informed seller where you safely can let the buyer beware. Add all those things together and you'll find that the fee-for-service ideal is pretty ridiculous.

You may ask: How do you work on that? Not, in my opinion, by
putting "caps" of costs of things and services. There is need to change the method of reimbursement. I think a doctor of medicine should be paid by as professional a method of compensation as a clergyman or a teacher. He obviously should make a good salary. I wouldn't make it too small. I would say a top specialist should have a salary the same as a United States Senator. When the Senate salary reaches $100,000 that becomes the rate for the doctor. It should go to the man the public thinks is entitled to it, not to the man with the best sales personality.

The real problem is that you can't protect yourself as a patient. You don't know what illness you've got. You don't know what should be done for it. You have to trust somebody. Why not pay the person who represents mankind, and has your interest at heart? If the doctor gets the same fee when he sends you home with a smile and a pat on the back as when he writes a prescription or performs surgery, it would be different. There isn't any doubt in my mind that the fee-for-service system interferes with the quality of medicine.

Of course, it's always a matter of dollars. Probably most of the physicians would not be prepared to settle for a United States Senator's salary.

About the second week after I began a study of capital investment I developed a one sentence questionnaire which I put to every doctor I met, wherever I was—at a party, in business, in a hall, on the street, accidentally. I asked the same question: "Doctor, what do you think of the idea of physicians working on salaries?"

They all gave the same answer: "What salary did you have in mind?"

They always said that, never a flareup as to it being undignified, improper or a trend toward Communism. A simple, practical answer: "What salary did you have in mind?"

That was at a time, 1929, when the average income of the American holder of the M.D. degree was $5,000 a year and when 40 percent of them made $2,000 or less. There were some who made $1,000 and some who made $100,000.

At that time, when the average doctor's income was $5,000, I suggested that interns get full room and board and a $100 a month for incidental expenses. The second year I'd like to have it go up to $200 a month, the third up to $500 a month until a person was certified, then have it go up until it was up to $10,000 in a couple of years, and, after the adjustments, to tenure with a salary of $15,000. Anything beyond $15,000 would only be for special items, for rare specialties, for research, or something equally important.

Some said: "Well, if that's what you have in mind, I think it would be all right." Not $100,000, I stopped at $15,000.
They said it was fine. You understand with this plan a person is going to get his salary no matter how hard he works—or he can loaf. One might say that if you pay all doctors the same, everybody will want to go to the best doctor. That’s what patients want to do now, anyway. Each physician gives you the impression he is the best doctor for you. Naturally, he can still do this, but, if money is not the object at the time, and he is going to be paid a salary anyway, he may say: “I don’t like to operate more than three times a day.” There isn’t one surgeon in a hundred who operates three times a day every day.

I think salary reimbursement would save the lives of physicians, it would make them better tempered, it would give them some respect for humanity. Doctors have their respect for humanity challenged every time they meet a person or a patient who acts like a child. I think it’s a wonderful thing that doctors are as honest as they are.

I have met some—they are not necessarily prosperous, they are doing well, they are in the Buick class. Did you ever see this magazine that came out of AMA, the *AMA News* I think it was? It was chit chat, about gossip—a weekly newspaper for physicians, at any rate. The General Motors Corporation bought a page ad captioned: “When You See A Buick at the Door, You Know the Doctor Has Arrived!” Why AMA didn’t rebel at that, I don’t know. I think they were proud of it. Now it would be another car. It would be a Cadillac or a white Lincoln.

*Rorem told an anecdote which illustrated a circumstance in which politicians and public service can get into confusing situations. His story related particularly to VA hospitals.*

The hospitals, for a long time, spoke of themselves as a public service industry. As I said, this position puts them at a disadvantage in dealing with politicians. I don’t know just what the politicians think of hospitals, in fact I don’t know what they think about their own Veterans Administration hospitals, or of state hospitals. I would say, however, that politicians don’t know much about the concept of public service.

Speaking of VA hospitals, my first contact with the Veterans Administration was when I was with the Rosenwald Fund and I was a consultant to the American Hospital Association. This was about 1932, just when we were wending our way out of the Depression.

The question being considered was whether veterans should be taken care of in existing voluntary, county, and city hospitals, or whether we should build new ones for them. The American Hospital Association was against building new hospitals for the veterans. They wanted veterans to
go to existing hospitals and pay regular rates. They would get regular
doctors and pay them.

I was hired to look into this. I was introduced at a meeting by Paul
Fesler, who said: "Rufus Rorem is going down to Washington to prove
that it would be cheaper to take care of veterans in private hospitals than
it would in government hospitals."

I had to stop him. "No, Paul, I am going down to see whether it's
cheaper."

I got in to see Congressman Wright Patman. (He recently died. He
was chairman of one of those important committees for a long time.) I
told him what I was doing there.

He said: "What side are you on?"

"I am not on any side. I have come to find out whether in the public
interest it is better to use the voluntary and local government hospitals or
to have new ones built."

"I know. Which side? Do you want us to build them, or don't you?"

I said, "I am trying to find out which."

The conversation never passed that stage. He just couldn't believe
anybody would come to see him who didn't either want to start something
or stop something.

The interesting result of that investigation (to which nobody listened)
was that I came to the conclusion that it would be much cheaper to build
veterans hospitals in metropolitan areas—not in rural areas—with
salaried doctors paid, not $5,000 a year, but $25,000 a year, than it would
be to use nonfederal hospitals.

No one took the trouble to read the report.

Rufus Rorem has retired successively from positions in Philadelphia,
Pittsburgh, New York City, and as a consultant to the President of Blue
Cross Association since he resigned from the American Hospital Associa-
tion in 1946. He never stays completely retired for he is sought out for
advice and counsel. Someone has remarked that no matter where Rorem
goes there are always many young persons among those who come to talk
with him. This certainly indicates that after a long career his thinking is
still relevant to today's problems.

NOTES

1. Unless otherwise indicated, Dr. Rorem's words are quoted directly
from C. Rufus Rorem: In the First Person, (c) 1981 by Lewis E. Weeks.