APPENDIX I

*Excerpts from C. Rufus Rorem's Report on Group Hospitalization to the American Hospital Association's 1933 Annual Convention**

As long as hospital bills are unpredictable as to amount, people will complain about them. It is important 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 individual and of the public who own the hospitals.

Group hospitalization, by 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 the hospitals . . . but for the benefits 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 by experience.

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

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*Rorem presented this report in his capacity as consultant to the AHA's council on community relations and administrative practice.

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

The fourth point was 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 was 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.

[These criteria were ultimately developed into the standards which served as the basis for formal approval of Blue Cross plans by the AHA.]