

The remaining category for discussion of income distribution is the non-profit groups in which all of the personnel are employed. In the industrial group, all of the personnel are on a fixed salary basis including the medical director who acts in the capacity of the head of one branch of the company and reports to a vice-president. Generally, the type of care seen is one of routine character or emergency nature. But all complicated cases, or those requiring special consultation and management, would be sent to the local hospital. Safety, prevention, public health and rendering professional services to maintain optimum physical performance are the duties and aims of the industrial group.

In the consumer group, labor health center, or association cooperative, physicians receive a salary fixed by the lay board which has ultimate responsibility for management of the group. A bonus arrangement is also used. Professional matters are vested in the medical director appointed by the lay board. The medical director would be responsible to the lay board, and he would have considerable influence in the determination of the salary and bonus of each practitioner.

In the voluntary hospital group, physicians are on a straight salary. The medical director has considerable authority in the determination of salary of all employed personnel including the department heads. Salaries are, again, dependent upon the value to the group, seniority and volume of practice. Adjustments in salary may occur with increase in receipts by a department. While only the trustees have the authority for such matters, it is most often the medical director who determines salaries and raises subject to the confirmation of the trustees.

Economics of Group Practice—the Patient

Group practice may be financed in a number of different ways. The most direct method of patient payment is fee for service—that is, the fee is paid directly by the patient to the practitioner who renders the service. There is no intervening third party, and this method is considered to be the classical one in the administration of health services. Where a fee for service system is in operation in a group practice, the monies are pooled and redistributed according to some type of prearranged plan as those previously mentioned. To the nonprofit group practices (and only in some instances in rural communities) gifts, bequests and endowments are utilized when the group practice is clearly of such overwhelming benefit to the public. Perhaps the outstanding example of this is the substantial en-

dowment of the New York Foundation which, in 1945, enabled the Health Insurance Plan of Greater New York (HIP) to lay the essential groundwork for its establishment. The method of subsidy has very significantly and effectively been used to aid and promote group practice. Again, the aid and encouragement of the government of the city of New York played a most important role in the formative years of the HIP. However, as has already been indicated in prior discussions, the enormous growth of group practice occurred after the Second World War when the concept of prepayment was united with comprehensive health services to form so effective a team for the administration of health services. Therefore, the method of prepayment will occupy the major portion of this discussion.

Of the 368 group practices operating in 1946, only 56 were considered to be financed by prepayment methods.³³ By 1949, some 24 group practice prepayment plans³⁴ were organized as consumer cooperatives with a wide distribution in the southwest and in the middle west. Some were small, but others reached a size so that they operated hospitals of substantial proportion. The growth of the group practice prepayment plans has, during the 1950's, been truly remarkable. The standards and levels of achievement have steadily risen so that the presence of their force on the health care scene has spurred greater interest in group practice and, at the same time, altered many pre-existing concepts. The practice of medicine could never again be the same the day HIP opened its doors.³⁵

Four of the leading group practice plans deserve special discussion. The Health Insurance Plan of Greater New York, the Ross-Loos Medical Group, the Community Hospital and Clinic, and the Group Health Association of Washington have all been "pattern setters" for the rest of the field.

The Health Insurance Plan of Greater New York had its beginning in 1943-44 through the efforts of many leading civic minded citizens, through the encouragement and wise counsel of Mayor Fiorello H. LaGuardia (and later Mayor William O'Dwyer) and with the considerable financial assistance of the New York Foundation. It was finally consummated in 1946 by special act of the New York State Legislature subject to the State Insurance Law as a non-profit corporation authorized to sell insurance and solicit contracts with employers and employees on a group basis. The corporate form was very broadly based in the community with prominent civic leaders associated with it as well as leaders of government, industry, banking, philan-