Coal Miners’ Health Care: The First Ten Years of the Medical Care Program of the United Mine Workers of America Welfare and Retirement Fund

Janet E. Ploss
Albert Einstein College of Medicine
Bronx, New York 10461

Abstract

This paper analyzes the origins and development of the medical care program of the United Mine Workers of America Welfare and Retirement Fund. This program was unique in the history of health care organization in the United States in that its policies and practices represented a departure from the dominant mode of organizing and financing health care. From 1948 to 1978 it was viewed by many as a model for a national health service as opposed to a national health insurance program. The purpose of this article is to analyze the origins of the Fund medical care program and the early development of its policies. The history of the program contains important lessons concerning the politics of health care in the United States and the relationship between who controls the provision of health care services and the cost and the quality of those services.

Introduction

From 1948 to 1978, the medical care program of the United Mine Workers of America Welfare and Retirement Fund was the largest industry-wide, self-administered and comprehensive medical care program in the United States. It was viewed by many as a model for a national health service. Unlike negotiated health benefit plans utilizing private insurance carriers, the Fund medical program developed health resources where they were needed, arranged for its beneficiaries to receive the services they required, and introduced measures to control the quality and the cost of medical care. Some members of the Fund medical staff who had supported a national health care program since the 1940s believed that the successful approaches they were developing to some of the basic problems in health care organization and financing could be applied on a national basis. They felt they had devised workable solutions to the problems of (1) getting health care resources to underserved areas, (2) recruiting and retaining health personnel in these areas, and (3) controlling the quality and the cost of medical care.

In 1978, the coal operators were successful in getting the United Mine Workers of America (UMWA) to agree to a contract in which the Fund medical program was replaced by private insurance coverage on a company-by-company basis for active coal miners and their families, thereby eliminating what for thirty years had stood out as an alternative to the dominant mode of organizing and financing health care services in the United States. It is beyond the scope of this paper to consider the entire thirty year history of the Fund medical program.* However, the first ten years of the program contain important lessons for anyone interested in the relationship between who controls the provision of health care services and the cost and quality of those services. The purpose of this article is to consider (1) the medical care situation in the coal fields prior to the establishment of the Fund, and (2) the changing methods and policies developed by the medical staff of the Fund to meet the health care needs of coal miners and their families during the period from 1947 to 1957.

The Establishment of the UMWA Welfare Fund

The United Mine Workers of America Welfare and Retirement Fund was established in 1946 in an agreement reached between the UMWA and the federal government. On May 21, 1946, the federal government seized control of the mines in order to keep coal flowing into the industrial heartlands in the face of the failure of the coal operators and the UMWA to reach a collective bargaining agreement. The Union demand, which the coal operators had refused to meet and for which the miners had gone on strike, was for the establishment of a welfare and retirement fund financed by a royalty of five cents on each ton of coal produced. When the coal operators regained control of the mines, they could not easily undo what the federal government had sanctioned. But from 1947 to 1950 they did everything in their power to obstruct the operation of the Fund. Finally, in 1950, the coal operators stopped fighting the Fund and allowed the Union to control it, in return for a UMWA agreement not to oppose the mechanization of the mines. The Fund medical program was born out of the conflict between coal operators and coal miners, and its history can only be understood in terms of this conflict.

Medical Care in the Coal Fields Before the Fund: The Boone Report

On May 17, 1947, Admiral Joel T. Boone submitted a report entitled A Medical Survey of the Bituminous Coal Industry, to J. A. Krug, the Secretary of the Department of the Interior (U.S. Department of Interior, 1947). Section five of the 1946 Krug-Lewis Agreement, which had established the UMWA Welfare and Retirement Fund, stipulated that such a survey be conducted. A team of Navy medical and technical people under Boone’s direction examined housing, sanitation, water supply, industrial hy-

* This is the subject of "A History of the Medical Care Program of the United Mine Workers of America Welfare and Retirement Fund," an unpublished thesis submitted by the author to the Johns Hopkins School of Hygiene and Public Health in partial fulfillment of the requirements for the degree of Master of Science.
giene, medical and hospital care, and recreation at 260 mines, or 14 percent of the mines under government custody. The report of this survey, which became known as the Boone Report, defined the initial task facing the Fund medical program. It identified characteristics of the coal industry and medical care in the coal fields which continued to be important throughout the history of the Fund medical program.

**Medical Care Plans**

At 60 percent of the 260 mines surveyed, employing 70 percent of the miners, there was some form of pre-payment plan for general medical care. In most cases this was financed by a payroll deduction or "check-off" from the miner's wage which averaged from 75 cents to $3 per month for single miners, and from $1.20 to $3 per month for miners with families. The physician who received the check-off at a particular mine was usually selected by the coal operator. "Physicians were not selected primarily on the basis of professional qualifications and the character of the facilities and services that were offered, but on the basis of personal friendships, financial ties, social viewpoints or other non-medical considerations," (U.S. Department of the Interior, 1947, p. 123).

The Boone Report revealed that although check-off physicians were being paid out of miners' wages to provide general medical care to miners and their families, they also provided valuable industrial medical services for the coal company, apparently in return for "the privilege of obtaining the payroll check-off of the miners" (U.S. Department of the Interior, 1947, p. 109). These services included pre-employment physicals and treating miners injured in the mines. The Boone Report indicated that in treating industrial injuries "the company doctor submitted claims in only 21 percent of the cases treated, and that non-company physicians submitted claims in 89 percent of the cases treated," (U.S. Department of the Interior, 1947, p. 111). These findings suggest that the check-off system served an important non-medical function for the coal operators. It insured that the only physician available to coal miners was loyal to the company. The Boone Report also found that many company doctors were relatively ignorant of industrial medicine and conditions in the mines. Through this system of medical care, coal companies could effectively deny the existence of occupational disease, downplay the extent of occupational injury, and not be held responsible for either.

Miners' dissatisfaction with the check-off system was reflected in contract provisions in district agreements in eastern Kentucky (District 19) and in northern West Virginia (District 31). An August 1941 agreement in District 31 provided for a joint union-management committee "to locally work out the type of service to be furnished by the doctor for the amount paid" and a procedure for handling a doctor's failure to uphold the agreement. In April 1945, a provision of the District 19 contract established a joint committee to certify "candidates who aspire to become the camp physician" and stipulated that either the miners or the company had a right to call for the selection of a new company doctor if either party were dissatisfied with the existing doctor. (U.S. Department of Interior, 1947, p. 126)

**Hospitalization Plans**

In most cases, miners pre-paid for hospitalization through a separate payroll deduction. The most serious problems with the hospitalization plans were their ambiguity as to the services and benefits covered and the number of exclusions. Hospitalizations for contagious diseases (except for diagnosis of tuberculosis, venereal disease, mental illness, alcoholism, or "injuries related to intoxication or resulting from altercations and attempted suicide" were not covered. Since public health measures necessary for the control and prevention of contagious diseases were sorely lacking in these areas, the exclusion of hospitalization for contagious diseases was inappropriate from a health standpoint.

The most common complaints heard by members of the survey team were that there were insufficient numbers of physicians, hospitals, and nurses, and that "the costs to patients are not closely related to the actual cost of the medical care they receive."

In concluding its discussion of hospital plans, the survey team stated,

Medical security is a matter of paramount importance in the coal mining industry. Frequent periods of unemployment make it essential that provisions be made in all plans to extend credit to subscribers when they are not gainfully employed and to permit participants to receive benefits after employment is terminated . . .


The Boone Report concluded:

The present practices of medicine in the coal fields on a contract basis cannot be supported. They are synonymous with many abuses. They are undesirable and, in the numbers of instances, deplorable . . . The investigators of the Survey group believe that a pre-payment system, with plans financed by wage deductions and predicated on a freedom of choice of physicians and hospitals by the beneficiaries, would be best. Although payment of physicians is recommended on both a fee-for-service basis and a salary basis, where necessary, the former method is emphasized because, under present custom, it offers by far the greater assurance of a freedom of choice of doctors by the patients.


When the Boone Report was issued in March 1947, it was immediately sent to the press and to the AMA. The findings of the Boone Report made clear to the public and the medical profession that the demands of the miners
were justified and that something had to be done about the inadequacies and abuses associated with existing public health and medical care facilities and services in the coal fields.

The UMWA Medical Program

The Paraplegic Program

John L. Lewis, the President of the UMWA from 1919 to 1969 and the originator of the idea of a welfare fund financed by a royalty on coal produced, felt the first priority of the Fund medical program should be the men who had suffered disabling injuries in the mines. Most of these men had never received proper medical care, and had lost hope that their situations could ever be improved. Coal mining exacted a human cost which the UMWA felt should be borne by the coal operators. The UMWA Welfare and Retirement Fund was established on the basic premise that:

the provision for human equities in coal mining is as legitimate a cost of production as are the costs of maintenance and replacement of machinery, of power for haulage and tipples, of rails and equipment, of selling and overhead, and of the innumerable other cost items required to bring coal from its seams underground to the surface for marketing or use.

UMWA Welfare and Retirement Fund, 1951, p. 5.

In 1948 it was estimated that there was a backlog of 50,000 miners who had been disabled and were unable to work as a result of mine-related injuries or disease, and who had never received adequate medical care or rehabilitation services.

From late 1946 through 1948, the Fund medical program located and transported paraplegic and other severely disabled miners to treatment and rehabilitation centers in New York, New Jersey, and California.

Rehabilitation continued to be an important aspect of the comprehensive medical care program which began in 1949. However, the initial round-up of paraplegic miners was a dramatic, one-time event. As Dr. Lorin Kerr, then assistant to the executive medical officer of the Fund, stated:

This transition from helpless, bedridden, literally rotting creatures to working men in wheelchairs and on crutches and artificial limbs is one of the most dramatic stories in medical history, and a monument to the physicians and institutions that undertook this seemingly hopeless task.

Kerr, 1962.

The Structure and Administration of the Medical Care Program

By July 1949, the Fund had a central office in Washington D.C. and a regionalized system of ten area medical offices. Each area medical office was headed by a physician and a non-physician medical administrator. The staffs of the area medical offices also included public health nurses and rehabilitation specialists. The original tasks of each office were: (1) to make service and financial arrangements with physicians and hospitals who had agreed to participate in the program; (2) to assist beneficiaries in receiving the benefits from public health agencies and programs to which they were entitled; and (3) to review bills from health care providers, and when appropriate, send them on to Washington for payment, usually within 48 hours of when the bill was received.

In practice, there were regional differences in the Fund medical program due to differences in: (1) The relative importance of coal mining and coal miners in the community; (2) the nature and concentration of physicians and hospitals and other health resources in the area; (3) the area medical administrator’s perception of his role as a mediator between organized medicine and the miners, represented by district and local union officials; and (4) the health care concerns, the strength, and the militancy of the UMWA locals and districts within the jurisdiction of the area medical office. In other words, the actual administration of the Fund medical program and the implementation of its policies were determined by the interaction of objective conditions and the particular configuration of political forces in an area.

The Comprehensive Medical Care Program

The general medical care program was launched in early 1949, while some of the area medical offices were still being set up. Initially everything was covered: aspirin, dental care, office visits, eye glasses, hospitalization. The Fund medical program assumed at the outset that every physician was competent in the field in which he claimed to be. We believed that if we permitted our beneficiaries to choose any physician whom they wished, organized medicine at the national, state, and county levels would see to it that these physicians rendered services of high quality within their capabilities, and utilized specialist services at Fund expense when needed in the best interest of the patient.

Draper, 1958, p. 6.

The Fund sought to use existing hospitals and physicians as far as possible, but in some areas the availability and quality of hospital and physicians’ services were inadequate. The Fund encouraged local general practitioners to refer Fund beneficiaries to specialists, and it established a visiting consulting service which brought medical specialists from urban areas into the coal fields to consult with local general practitioners. However, many general practitioners were reluctant to make such referrals because of insecurity about their own medical knowledge and competence, and fear of losing patients.

From its beginning, the Fund medical program actively enlisted the cooperation of coal field doctors and organized medicine at all levels. Dr. Draper, the Executive Med-
The Einstein Quarterly Journal of Biology and Medicine

The initial, completely open and total comprehensive-coverage phase of the Fund medical program lasted from early 1949 to September 17, 1949, when everything came to a grinding halt. The UMWA and the coal operators were fighting for control of the production process and control of the Fund; eventually the operators refused to make royalty payments to the Fund. Without any income or reserves, the Fund was forced to halt benefits.

The Fund ran out of money soon after royalty payments were stopped for several reasons. First, there was widespread abuse of the program during its fully comprehensive, uncontrolled phase. These abuses included, among other things, (1) unnecessary dental extractions and dentures and multiple sets of dentures, (2) doctors in eastern Kentucky hiring nurses and billing for their services as doctors' visits, and (3) the cost of a tonsillectomy jumping from $35 to $150 in 90 days. Second, in one area there was a tremendous backlog of unmet medical need among Fund beneficiaries. Third, financing primary care on a fee-for-service basis was very expensive.

When the Fund medical program was terminated on September 17, 1949, the Fund borrowed money from the Union so that it could continue to subsidize Fund beneficiaries who were already hospitalized and keep its field staff in place. Josephine Roche, the director and one of the trustees of the Fund, vowed to try always to keep a one-year reserve on hand to avoid ever having to terminate the program again. Miners were out on strike over the Fund until March 1950, when George Love and John L. Lewis signed the historic 1950 agreement. This agreement increased the royalty to the Fund, placed the Fund on a sound financial basis, and marked the beginning of a twenty year period of acceptance of the Fund by the operators.

The Fund ran out of money soon after royalty payments were stopped for several reasons. First, there was widespread abuse of the program during its fully comprehensive, uncontrolled phase. These abuses included, among other things, (1) unnecessary dental extractions and dentures and multiple sets of dentures, (2) doctors in eastern Kentucky hiring nurses and billing for their services as doctors' visits, and (3) the cost of a tonsillectomy jumping from $35 to $150 in 90 days. Second, in one area there was a tremendous backlog of unmet medical need among Fund beneficiaries. Third, financing primary care on a fee-for-service basis was very expensive.

When the Fund medical program was terminated on September 17, 1949, the Fund borrowed money from the Union so that it could continue to subsidize Fund beneficiaries who were already hospitalized and keep its field staff in place. Josephine Roche, the director and one of the trustees of the Fund, vowed to try always to keep a one-year reserve on hand to avoid ever having to terminate the program again. Miners were out on strike over the Fund until March 1950, when George Love and John L. Lewis signed the historic 1950 agreement. This agreement increased the royalty to the Fund, placed the Fund on a sound financial basis, and marked the beginning of a twenty year period of acceptance of the Fund by the operators.

The Fund Medical Program with Limitations and Controls

In June 1950 the Fund medical program resumed, but with notable exclusions in coverage. No longer would the Fund cover home and office care and drugs other than those used in the hospital, or expensive drugs needed for chronic conditions. Hospitalization and physicians' services in the hospital were covered, but hospitalization for tonsillectomies and adenoidectomies, which in the experience of the Fund medical program had accounted for much of the unnecessary services and expenditures, now required prior authorization. The new program also excluded: (1) Hospitalization for the care of mental illness after the diagnosis had been established; (2) services which the patient was able to receive from other agencies, voluntary or governmental; and (3) services which the employer or any other third party was legally obligated to provide.

To forestall unnecessary hospitalization under this new system, out-patient services of a specialist were covered at Fund expense, provided that such service was authorized in advance. However, out-patient service which was the counterpart of care usually provided by general practitioners in the home and office was not included. Physicians and hospitals with whom the Fund had not made specific arrangements were required to obtain prior authorization from the Fund before hospitalizing or performing surgery on a Fund beneficiary. Thus the Fund could select providers with whom to make arrangements, and could terminate arrangements with providers who in its experience delivered poor-quality medical care. These providers were not completely excluded from receiving payment; they just had to obtain authorization ahead of time.

Alternatives to Fee-for-Service Medicine

At about the time the new program was launched, the medical staff began to experiment with other mechanisms for improving the availability and quality of medical care in the coal fields. The most important of these were the retainer method of payment and Fund support for the establishment of group practice clinics and a network of hospitals. These policies, and the administrative procedures which followed from them were based upon two key perceptions of the Fund medical staff. The first was that both adequate facilities and an adequate guaranteed income were required in order to attract well trained medical specialists to coal mining communities. The second was that the fee-for-service system was not the best way to organize and finance health care services. A member of the early Fund medical staff said,

The reason we wanted to offset fee-for-service was we didn't feel it was a good way to pay for anything, including medical care . . . What you get in medicine is a premium for surgery and for any other kind of care that you may give, and it makes it extremely difficult to control the cost of an overall delivery program.

Daniels, 1979.

The retainer method of payment (so called to avoid the anti-salary bias of the medical profession) was developed by the Fund medical program as an alternative to itemized, fee-for-service billing.

The retainer system, or fee-for-time arrangement, was first developed with solo providers. The idea behind it was to remove the financial incentive for unnecessary services inherent in the fee-for-service arrangement. The retainer concept was then modified for use with clinics. Instead
Coal Miners' Health Care

of fee-for-time, clinics were paid a percentage of their operating costs equal to the percentage of Fund beneficiaries in their patient load.

The Fund’s Support of Coal Field Clinics

In the early 1950’s, a number of consumer-sponsored, multi-specialty group practice clinics were established in the coal fields with the administrative and financial backing of the UMWA Welfare and Retirement Fund. The development of these group practice clinics financed on a retainer basis by the Fund provided a means for miners and the Fund to avoid the expensive but poor-quality medical care that had prevailed. Because the Fund did not pay for routine home and office care, general practitioners continued to receive a check-off to provide these services. These physicians often unnecessarily hospitalized Fund beneficiaries since, in the early 1950’s, the Fund allowed any physician, including a general practitioner, to hospitalize a Fund beneficiary at his or her own discretion, and then paid for the in-hospital physician services on a fee-for-service basis. Warren Draper described the resulting problems for the Fund in this way:

The number of patients hospitalized is larger, the length of stay is longer, and the costs are greater than is necessary. This is due in the main to the following factors:

a. It is to the advantage of the check-off physician to save time and money by getting as many patients into the hospital as possible.
b. It is to the advantage of the hospital to admit as many sure pay patients as possible and prolong their stay.
c. Inadequacy of facilities available to the check-off physician makes it difficult or impossible for him to care for cases which would not require hospitalization otherwise.
d. No encouragement is afforded to younger and better qualified physicians to enter into competition and improve conditions of practice because of company control and lack of means to break the present system.


On the one hand, the Fund medical program had found that the existing home and office care in the coal fields was of poor quality and too expensive to pay for on a fee-for-service basis. But on the other hand, when they stopped paying for home and office care, but continued to cover in-hospital physician services, they were faced with a high rate of unnecessary hospitalization. Part of the solution to this dilemma was the Fund’s support for the establishment of group practice clinics on a retainer basis.

Some members of the medical staff believed that this was a better way to practice medicine from the standpoint of both quality and economy. The Fund medical program had had problems with general practitioners not referring patients for specialists’ services when medically indicated, and hospitalizing and operating on beneficiaries without sufficient diagnostic work-up and without the involvement of specialists in their care. Group practice clinics which had different specialists working as a team, with laboratory and x-ray facilities all in one location, were viewed as a means of upgrading the quality of medical care in the coal fields. By helping to establish these clinics the Fund was able to attract well-trained physicians to coal mining communities. Such physicians would not have located in these areas if their income had depended on fees alone.

Coal mining communities needed health care services. But they were relatively small, and the mines did not provide year-round employment. This meant that a physician who set up a practice on a fee-for-service basis would have little financial security. That is one of the reasons why coal companies established the check-off system and why, before the establishment of the Fund medical program, virtually all coal field doctors received some form of check-off. Market forces have never resulted in an adequate supply of medical personnel in rural areas. This problem has been faced by miners, the UMWA, and coal operators since the late nineteenth century, and by the Fund since its inception in 1946. Fund support for consumer-sponsored group practice clinics was one approach to solving this problem.

It was understood that the clinics were to obtain as much support for their operation as possible from other sources. However, it was impossible to collect from fee-for-service patients the true cost of the services rendered to them for the following reason: If these clinics were to serve the entire community and thus have sources of income besides the Fund, they had to charge fee-paying patients the prevailing rates. But the prevailing rates for ambulatory care in the fee-for-service world were based on (1) more office visits per day, (2) a greater reliance on hospitalization and surgery as a source of physician income, and (3) fewer ancillary services. At the same time, in order to attract physicians to practice in coal field clinics, salaries had to be competitive with what they could earn elsewhere on a fee-for-service basis. Because these clinics offered more comprehensive medical care than fee-for-service medicine, their cost per visit was sometimes higher. Yet their charges to fee-paying patients could not reflect this higher cost, or they would lose these patients. Some members of the medical staff believed that salaried group practice was the best way of attracting well-qualified physicians to the coal fields and giving miners the best possible medical care. Therefore, they argued that the Fund should support the establishment of group practice clinics in isolated areas, regardless of a possibly higher cost per visit to the Fund. The alternative was that good quality medical services would continue to be inaccessible to Fund beneficiaries.

Placing individual physicians on salary, and the medical group as a whole on a retainer, meant that the medical group could practice medicine free from worries about whether or how they were going to get paid. This allowed them to focus all of their attention on providing the best
possible medical care. Physicians who wanted to be able to practice medicine in this way were attracted to Fund-supported clinics. Dr. Milton Levine, a graduate of the Johns Hopkins School of Medicine and one of the founders of the Bellaire Clinic in eastern Ohio, said:

"It's easy for any doctor to go into practice if he simply wants to make a living. But I want more from my medicine than that. I want to be able to practice in the way I was trained to practice it. I can do that in one of two settings—in a university or in a group where I have people of like mind, that is, people who want to practice university medicine.

"Dr. Sams: Why He Can't Deliver Babies in Bellaire," 1963.

And Dr. Birmingham, the Bellaire Medical Group's surgeon, said that surgeons in solo practice have "subtle financial pressures that are not present in this type of (group practice) set-up. I am completely free of any financial influence as to whether a patient should have an operation or not... I can go to sleep at night knowing I haven't done anything that wasn't medically indicated" (Ibid.). In a November 13, 1957 memorandum to Josephine Roche, Dr. Draper stated:

The Bellaire Clinic is very important to our program because: (1) It is staffed and equipped to render the best quality of medical care in the surrounding area. The clinic physicians are the best qualified specialists on the staff of the Bellaire Hospital and (2) Specialist consultation at the Clinic is required on all patients to determine whether or not hospitalization is essential.

Draper, November 13, 1957.

However, the medical staff's support for the retainer system did not mean that the clinics had a blank check from the Fund. The Washington office of the Fund was very conscious of the fact that under the retainer method of payment, physicians had no economic incentive to provide an adequate volume of services for the amount of retainer being paid. So the Fund monitored the number of visits to determine whether physicians on retainers were providing enough services, rather than just receiving an assured income and controlling their days and their case load.

In summary, consumer-sponsored group practice with physicians paid on a salary basis and with financial security provided by the Fund, not only attracted well-qualified physicians who were committed to providing high-quality medical care, but also made it possible for them to provide it. There was a spirit of cooperation between these "miners' clinics" and the Fund, based on a shared dedication to serving the miners and to practicing good-quality medicine. The greatest obstacle to the widespread development of consumer-sponsored clinics was the active opposition of local medical establishments.

**The Fund Medical Program and Organized Medicine**

The original assumption of the Fund medical program—that every physician was competent in the field in which he claimed to be—proved incorrect. Fund data indicated a poor quality of medical care (unnecessary hospitalization, unnecessary surgery, and excessive lengths of stay) when Fund beneficiaries in a particular area were compared to other groups in the same area. Warren Draper gave the following examples: (1) In one coal mining population of 64,655, the hospitalization rate for a 2.25 year period (January 1, 1955 to April 1, 1957) was 317 per 1000 for beneficiaries compared with 190 per 1000 for an adjoining population; (2) In one county the rate of appendectomies for Fund beneficiaries was 9 per 1000, while the rate for a smaller contiguous group was 5 per 1000. In the same area, Fund beneficiaries received cesarean sections at a rate of 11 per 100 deliveries, compared to a rate of 2 per 100 in the comparison population; (3) In a general hospital which had an average length of stay of 8 days, a study of a series of 239 Fund beneficiaries who had surgery revealed an average length of stay of 21.3 days (Draper, 1958, pp 7–8).

In 1952, when Draper and the area medical officers were becoming increasingly concerned over the quality of medical and hospital services available in some of the mine areas, Draper presented the problems the Fund medical program was facing to the AMA Council on Medical Service. In response, the Council conducted a survey to verify the nature and extent of the medical care problems the Fund's medical staff had identified, and to determine what, if anything, the AMA could do to help solve them. From 1952 to 1956, the AMA sponsored a series of conferences on coal field health care attended by representatives of county medical societies and the Fund medical staff. At these conferences the conflicts between some practicing physicians and the Fund medical program were aired, and the role of county medical societies in handling these disputes was discussed, but the problems were never resolved.

Area medical administrators found that county and state medical societies were unwilling to censure their own members. One area medical administrator said that the reasons state medical societies were reluctant to take decisive action to correct "gross deviations from professional and ethical standards" were that (1) Medical practices in the territory in question, although not of high quality, were probably no worse than in other sections of the state; (2) Such action would question officially the qualifications of general practitioners to do all types of surgery; (3) Other groups would tend to take the same action; (4) Private patients might learn of the action and demand consultation (American Medical Association. 1953).

Some representatives of the state and county medical societies acknowledged the problems and wanted to cooperate with the Fund medical program. They took the position that "if we don't control ourselves, we're inviting control by others." However, the unnecessary hospitalizations, unnecessary surgery, unduly long lengths of stay,
and surgery performed by insufficiently qualified physicians continued.

To control these abuses, the Fund medical program in 1955 instituted policies of requiring prior authorization of hospitalization by a qualified specialist, and of using "to the fullest possible extent the services of broadly competent and responsible surgeons according to criteria established by the American Board of Surgery and other agencies similarly qualified to pass judgment" (Draper, 1955, pp. 3-4). This action came after more than three years of evidence that Fund beneficiaries were being hospitalized and operated on unnecessarily, and after extensive but unsuccessful efforts by Dr. Draper, the area medical administrators, and some few members of state and county medical societies to get organized medicine to take responsibility for controlling the quality of medical care, instead of simply claiming sole right to do so. These policies were first implemented in the Denver area, where "the quality of medical care, hospital admission and length of stay were highly questionable" (Draper, 1958, p. 9). The resulting reductions in hospitalization and surgery are summarized in Table I.

These policies were adopted in other areas as of December 30, 1954. Dr. Draper said, "Similar results were beginning to show when the American Medical Association House of Delegates passed a resolution disapproving our requirement for consultation on all patients prior to hospital admission." These requirements resulted in "reductions of up to 75 percent in gynecological operations in some places, and in the reduction of the rate of hospital admissions from an average of 350 per 1000 beneficiaries to 180 per 1000 beneficiaries in one of our areas" (Draper, 1958, pp. 9-10). The Fund decided to avoid an open break with the AMA by dropping its requirement and looking for another way to accomplish the same objective. Draper noted that the AMA did not object to the Fund's "refusal to pay individual physicians for services of inferior quality as judged by qualified consultants, nor our unwillingness to pay physicians whose qualifications for surgery we are not in a position to judge, when Board or College surgeons are available."

I. The Effect of Requiring Prior Authorization for Hospitalization and Surgery by Board-Certified Surgeons in the Denver Area. (Rates are: Number per 1000 Beneficiaries per Year).

<table>
<thead>
<tr>
<th></th>
<th>Before</th>
<th>After</th>
<th>Percent reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Admission Rate</td>
<td>232.5</td>
<td>157.0</td>
<td>32.5</td>
</tr>
<tr>
<td>Hospital Days</td>
<td>198.5</td>
<td>125.4</td>
<td>36.8</td>
</tr>
<tr>
<td>Days per Case</td>
<td>8.6</td>
<td>8.0</td>
<td>7.0</td>
</tr>
<tr>
<td>Rate for All Surgical Procedures</td>
<td>76.4</td>
<td>63.8</td>
<td>16.5</td>
</tr>
<tr>
<td>Hemorrhoidectomies</td>
<td>2.9</td>
<td>1.9</td>
<td>34.5</td>
</tr>
<tr>
<td>Appendectomies</td>
<td>6.9</td>
<td>2.8</td>
<td>59.4</td>
</tr>
<tr>
<td>Gynecological</td>
<td>12.2</td>
<td>9.3</td>
<td>23.8</td>
</tr>
</tbody>
</table>


Immediately after the Fund medical program withdrew its requirement for prior authorization of hospitalization, representatives of the Fund began negotiating an agreement with the Committee on Medical Economics of the Pennsylvania State Medical Society. In November 1955 an agreement was reached and approved by the board of trustees of the Pennsylvania State Medical Society. The agreement included procedures for changes in Fund policies, Pennsylvania Medical Society endorsement of hospital Medical Audit Committees, and the statement that "it is the duty of all physicians, including those employed by the Fund, to expose incompetent, corrupt, dishonest or unethical conduct on the part of members of the profession." It was further agreed that "organized medicine does not concede to a third party the prerogative of passing judgment on the treatment rendered by physicians, including the necessity of hospitalization, length of stay, and the like. It is the responsibility of organized medicine to take the initiative in searching out abuses and instituting measures for their correction. The Medical Service of the Fund shall cooperate wholeheartedly in providing information to the proper committees of Hospital Staffs and Liaison Committees at local and higher levels to aid in the solution of such difficulties." The Fund retained its prerogative for consultation before or after hospital admission "for just cause such as recurrent admissions, repeated referrals, prolonged medical care, and excessive hospital stay," and supported the right of individual physicians to decide "the method of payment for his services without jeopardizing his relationship with the Fund" (American Medical Association Council on Medical Service, 1956).

This landmark agreement was reached after five months of negotiations. However, on October 23, 1956, after it had been in effect less than ten months, a small group of physicians from Allegheny County who strongly opposed the Fund's support of a new group practice in their area, pushed through a resolution at the meeting of the House of Delegates of the Medical Society which declared this agreement "null and void, terminated and ended." No reasons were given or arguments presented supporting this action. When this occurred, the already strained relations between the Fund medical program and organized medicine broke down completely.

Free Choice of Physician

The charge of physicians and medical societies throughout the coal fields was that in adopting these policies, the Fund was "discriminating unfairly, and interfering with the patient's free choice of physician." Dr. Draper's response to this charge deserves special attention, since it calls into question their concept of "freedom" and argues that the Fund medical program had in fact increased its beneficiaries' freedom of choice. Draper made clear that freedom requires economic power and resources, and the opportunity to use them, both of which the Fund provided to people who did not have them before. "The term
'free choice of physician' has not been adequately defined. It is subject, therefore, to almost any interpretation that an individual or group may wish to place upon it." Draper then argued that the Fund had actually contributed to the free choice of physician, "provided the interpretation of the term is according to the rule of reason." Before the Fund, miners and their families in many areas had no choice but to receive medical care from the camp physician, who was employed by the company. "There were seldom any other physicians whom they could afford to pay within a distance they could travel. Unemployed and disabled miners without an income had no choice other than that of a physician who would accept them free of charge for such limited treatment as he could afford to offer." The Fund changed this situation. "Instead of one physician, the beneficiary now has a wide free choice from the many physicians whom the Fund pays for services. More than 7,000 physicians were paid by the Fund during the past year" (Draper, 1960, p. 36).

Some physician members of state and county medical societies charged that "industrial and labor health plans including our Fund are 'threatening socialized medicine by the back door' " (American Medical Association, September 1953, p. 20). In an article entitled "Compromise of Free Practice of Medicine," Dr. David Katz of Pittsburgh said that the Fund's sole aim was "a miniature socialization of medicine." Katz went on to warn, It is possible, with many similar socialized units, that they could and may combine forces. Their subscribers or beneficiaries may be legion, covering a large percentage of people in the United States. This would then be tantamount to privately controlled socialized medicine. Our path is clear cut. Do we want such controls? If so, then we can drift with the current and accept the rules of such plans. If on the other hand, we wish to continue the free practice of medicine on a fee-for-service basis and free choice of physician, we must take exception to the rules of these plans and act accordingly.


On January 1, 1957, the Illinois State Medical Society told its members that it "does not look with favor upon any member physician who includes the UMWA Welfare and Retirement Fund in negotiations for medical, surgical, and obstetrical care for any beneficiary of the Fund" (Bulletin of the Illinois State Medical Society, quoted in Draper, 1957, p. 7). At the same time, it sent a telegram to UMWA officials in Illinois which stated the following:

The doctors in your area have and will continue to care for your medical needs. After January 1, 1957 the doctor you choose (not one chosen by the Welfare Fund) will send you a bill for service. Your members can then send their bills to your Welfare Fund for whatever payment the Fund wants to make to the members, not to the doctor. Your doctors feel that this will be less trouble for everybody this way.


Illinois was not the only state in which medical societies urged their members to break off relations with the Fund medical program. On January 9, 1957, Dr. Draper appealed to the AMA Committee on Medical Care for Industrial Workers. He pointed out that the Illinois State Medical Society had not used established procedures which might have allowed the problems to be resolved "through calm and judicial consideration by a body of organized medicine specifically designed for that purpose." This failure to use proper channels had caused "undesirable publicity, . . . rifts and antagonisms among various elements of the medical profession and its individual members . . . serious financial embarrassment to hospitals, and . . . inconvenience and hardship to hundreds of patients" (Draper, 1957, p. 8). Draper appealed to the Committee to "offer its good offices" to the resolution of the situation.

The outcome of this dispute marked the end of ten years of effort by the Fund medical program to work through the established channels of organized medicine. In the spring of 1957, representatives of the medical societies of Pennsylvania, Illinois, and Colorado met with the Committee on Medical Care for Industrial Workers of the AMA to draft guidelines for relationships between state and county medical societies and the Fund. On the objection of one medical society representative, Draper was not permitted to participate in the formulation of these guidelines. Even though Draper "informed the Reference Committee that the Guides were not acceptable in their present form and would not be followed if adopted," they were still submitted to and approved by the AMA House of Delegates the following day, June 6, 1957. These "Suggested Guides" asked the Fund to assume what it initially had assumed but then found to be incorrect: "Every physician duly licensed by the state to practice medicine and surgery should be assumed at the outset to be competent in the field in which he claims to be, unless considered otherwise by his peers." Dr. Draper said, "This would place us back where we were ten years ago with a repetition of all the evils we have suffered in between" (Draper, 1958, p. 10).

As a result of this stalemate with organized medicine, in October 1957 the Fund instituted a policy of "limiting its payments to physicians and hospitals whose services are necessary and essential in providing the hospital and medical care benefits which it (The Fund) has authorized" (Draper, 1958, p. 10). Each area medical office was directed to develop a list of participating physicians and hospitals. These lists were to include those physicians and hospitals which, in the experience of the Fund medical program, had (1) provided good-quality medical care, (2) charged reasonable fees, (3) seen a sufficient number of beneficiaries to be familiar with the services provided by the Fund medical program and its procedures, and (4) expressed a willingness to cooperate with Fund procedures.
Coal Miners' Health Care

Conclusions

Several conclusions can be drawn from this analysis of medical care in the coal fields before the Fund and during the first ten years of the Fund medical program. First, miners' experience with the company doctor system indicates the potential for abuse when employers control the provision of medical care to their employees. Second, the Fund medical program stands in sharp distinction to health insurance companies which historically have simply processed bills, neither intervening in the medical care market nor acting as health care advocate for their beneficiaries. Thus, the early history of the Fund medical program provides evidence that alternatives to the dominant mode of organizing and financing medical care in this country have existed and therefore can exist. This history has shown, however, that the provision of health services is an object of conflict and struggle between groups with different interests—between workers and employers, between recipients of services and providers of services, and between one group of providers and another group of providers. This implies that those who are interested in the provision of good quality health care to the majority of Americans who cannot by their own economic and political power secure it for themselves, will necessarily be involved in conflict and struggle to achieve that goal.

The history of the Fund medical program provides one example of the ongoing resistance of organized medicine to any outside control of physician practices. While this resistance serves the financial interests of some physicians, the experience of the Fund medical program leads one to question whether it is in the best interests of patients. It is important to recognize that the Fund medical program did not start out with strict policies to control physician practices. Instead, it began with the assumption that every physician was competent in the field in which he claimed to be; it implemented more restrictive policies only in the face of continual, bitter experience and its failed efforts at negotiating with organized medicine. This experience of the Fund medical program seems to suggest the desirability of external controls on physicians and of alternatives to the fee-for-service system when high quality medical care at a reasonable cost is the goal.

Acknowledgments

The original study from which this article was abstracted could not have been carried out without the help of current and former Fund employees, UMWA officials, coal miners, coal industry representatives, and many others who allowed me to interview them. I would like to acknowledge particularly the contributions of Thomas Berret, Stephen Caulfield, Leslie Falk, Richard Feise, and Lorin Kerr. I owe my greatest intellectual debt to Vicente Navarro, who has greatly influenced my understanding of the nature and politics of health and health care. Elizabeth Fee has reviewed and commented on this work at all stages, from the earliest thesis proposal to the present article, her lectures and papers on the history of medicine and public health have been an inspiration to me. Finally, I want to thank Herbert Lukashok and Victor Sidel for their encouragement and help in the preparation of this article. The author is a member of the class of 1984.

References


Daniels, H. (October 24, 1979) Personal Interview.

Draper, W.F. (May 25, 1953) "Increasing Effectiveness and Decreasing Cost of the Medical Program of the Fund." Memorandum to Josephine Roche, Washington, D.C.

Draper, W.F. (April 26, 1955) Memorandum to Dr. William A. Sawyer, Chairman, Committee on Medical Care for Industrial Workers, the American Medical Association, Washington, D.C.

Draper, W.F. (November 1, 1957) "The Quest of the UMWA Welfare and Retirement Fund for the Best Medical Care Obtainable for its Beneficiaries." Paper presented at the annual meeting of the American Association for the Surgery of Trauma, Hot Springs, Virginia.

Draper, W.F. (November 13, 1957) Memorandum to Josephine Roche.


