

Chapter One

The Birth of the Blues in North Carolina

To understand how health care has evolved in North Carolina over the past 75 years, it is important to first examine the medical, socioeconomic, and political realities of the early twentieth century. These realities were harsh, as evidenced by the rapid spread of infectious diseases, high infant mortality rates, poor access to hospitals, and few dollars available to pay for doctor visits. The need for access to affordable health care was a problem in dire need of a solution—one that Blue Cross and Blue Shield of North Carolina would ultimately help provide for decades to come. The company's legacy of care began in the era of the Great Depression and has continued through the most revolutionary period of medical advances in history (see *Medical Developments through the Years*).

The State of Our State: The 1920s

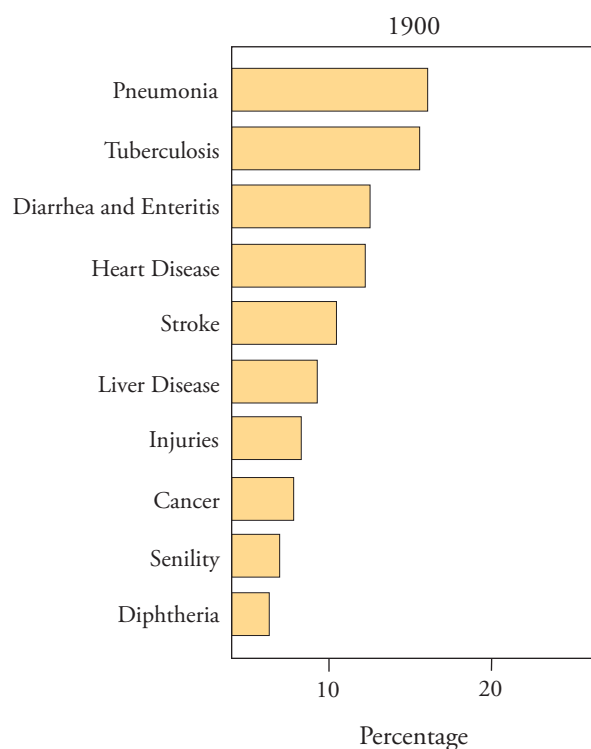
It was a decade of polarities—prohibition and speakeasies, women's voting rights and the “Red

Scare,” creationism versus evolution in the Scopes Monkey Trial. A great migration of African Americans left the South for major cities and factory jobs in the North as Ku Klux Klan activity escalated. The national economy was shifting from agricultural to industrial. In 1920, and for the first time in U.S. history, more Americans were living in cities than on farms. This shift posed particular problems for the South. As President Franklin D. Roosevelt declared in his famous Four Freedoms speech, “The South presents right now the Nation's No. 1 economic problem.”¹

In North Carolina, the economy was still primarily agricultural, as it had been since colonial times. Over 80 percent of the state's population was rural—mostly

A tobacco farmer pauses for water. In 1920, 80 percent of North Carolina's population was rural, mostly struggling farm families with little access to health care and few dollars to pay for it when needed. Photo by Bayard Wootten, courtesy of the North Carolina Collection, University of North Carolina at Chapel Hill.





At the beginning of the 20th century, many diseases spread unchecked because of ineffective medical treatments, poor nutrition, contaminated water, and unsanitary living conditions. Graph courtesy of the National Center for Health Statistics.

farm families struggling to live off their crops and livestock. Tobacco was the big money crop, fueling the fortunes of a few, such as the Duke family of Durham, whose focus was on cigarette manufacturing. The demand for cotton had spawned the textile industry, where factory mill jobs had provided a more secure alternative to the uncertainty of working the land.

But the temporary boom created by a high demand for agricultural goods and textiles during the First World War had ended by the mid-1920s. In fact, North Carolina agriculture entered a depression two years before the legendary stock market crash of 1929. Apart from a handful of tobacco barons and textile magnates, most North Carolinians lived on the economic edge. Two-thirds of families earned \$1,450 or less per year.

A severe public health crisis had also swept over the state during the war years, with thousands dying of typhoid fever and Spanish influenza. Half of North Carolina's 100 counties had no hospital. Likewise, there were few doctors, and poor country roads made reaching them even more difficult. The numbers in 1928 were dire: with only one doctor for every 1,244 people and one hospital bed for every 382 people, North

Carolina ranked 44th and 42nd, respectively, among the 48 states in the nation. To make matters worse, many people believed that they should go to the doctor or hospital only if they were near death. And with low family incomes, often near poverty level, it would prove nearly impossible for most to afford the ensuing medical bills brought on by an unexpected illness or accident. The severe financial hardship of hospitalization was compounded by the shame of being treated as a public "charity case." Some of those in need of treatment resorted to doing odd jobs such as painting at the hospital or offering chickens or meat in order to pay their bills.

Durham Visionaries Investigate the Idea of Hospital Prepayment

With mounting concern among community and government leaders about the lack of medical care, a visionary arrived in 1927 as the first dean of the newly formed Duke University School of Medicine. Dr. Wilburt C. Davison had heard about a hospital prepayment plan in use at the Roanoke Rapids Hospital for the employees of six area textile mills and their families. Mill families paid 25 cents per week under the Roanoke Rapids

Medical Developments Through the Years



Between 1900 and 1930, Americans suffered and died from diseases most of us can't even define today—pellagra and goiter, rickets and hookworm. During the 20th century, medical discoveries helped eliminate these and many other problems, and health insurance programs helped increasing numbers of average Americans pay for medical treatment.



Surgery in Avery County about 1920. In early 20th-century North Carolina, there were few hospitals and poor roads, so rural doctors were often forced to treat patients under primitive conditions. Photo by Bayard Wootten, courtesy of the North Carolina Collection, University of North Carolina at Chapel Hill.



Dr. W. C. Davison (above), first dean of the Duke University School of Medicine, and George Watts Hill (above, right), prominent Durham business leader. Together they founded the state's first hospital prepayment plan, the Hospital Care Association, in 1933. Photos courtesy of Duke University Medical Archives and the North Carolina Collection, University of North Carolina at Chapel Hill.



plan, which entitled them to ward beds in the community hospital. In addition, the mills employed several doctors and nurses, who provided free care to employees at home and in the hospital. Dr. Davison and Dr. Watson Rankin, director of the Duke Endowment, visited the city in 1927 to investigate how the plan worked and came away impressed: “We felt that if a prepaid medical and hospital program could work for mills in a single county, it might be successful for the state, and possibly for the nation.”²

Enthusiastic about the prepayment idea, Dr. Davison set about trying to interest local business leaders and doctors in creating such a plan in Durham. He fully realized that the inability to pay hospital bills would undermine both individual health and the new Duke University Hospital’s financial solvency. He found a receptive ear in George Watts Hill, board chairman of Durham’s Watts Hospital. Watts Hospital had a proud heritage of being the first hospital in North Carolina to offer free care to those unable to pay. This generosity had kept the hospital dependent upon assistance from its founder, George Washington Watts, as the number of charity cases had reached a high of 47 percent in its early years of operation. George Watts Hill was committed to finding a solution to the problem of providing medical and surgical

care to those who couldn't afford it. He began visiting local industrial leaders and eliciting their cooperation. With Hill's interest and influence, other Durham leaders shed their reservations and began offering support for the creation of a local hospital prepayment plan.

Dr. Davison also visited Oxford, England, where he had studied as a Rhodes scholar, to research what was known as the "Penny in the Pound" prepayment plan, created by the Radcliffe Infirmary and County Hospital. Integrating the best features of both the British and the Roanoke Rapids plans, as well as his own and Hill's ideas, Dr. Davison developed a new vision for a community-wide hospital prepayment plan. In August 1928, he wrote a paper entitled "The Hospital Association Plan as Applied to Durham." In it he announced the formation of a hospital association that would be affordable to the patient and could support the hospitals if even a minority of local citizens enrolled. A detailed description of Dr. Davison's plan was published in September 1928, including a schedule of benefits, proposed membership dues, and a method for collection.

A False Start on the Eve of the Depression

By the spring of the following year, both the vision and the support for a hospital prepayment plan were in place. On March 8, 1929, the Durham Hospital Association was organized at a meeting that members of the Chamber of Commerce, the Durham County Board of Health, the local Ministerial Association, and representatives from Watts, McPherson, and Lincoln Hospitals attended, pledging their cooperation and endorsement. The Association would not be operated for profit and would be open to any resident of Durham County, with a few exceptions based on health conditions. The group agreed that they would approach officials of the state's major industries, such as Erwin Mills and Liggett & Myers Tobacco Company, to gain support for promoting the plan to their employees.

Announcement of the Association's hospital prepayment plan appeared in the *Durham Morning Herald* on March 14, 1929, and described the basic dues and benefits. Over the next six months, membership applications and certificates were printed and equipment purchased in readiness for the Association's operational launch.

1920s

In the late 1920s, half of North Carolina's 100 counties have no hospital. Only one doctor is available for every 1,244 people.

People from all over the country seek the "rest cure" for tuberculosis in the sanatoria of Asheville, N.C.



1929

In 1929, mounting concern among Durham community and government leaders about the lack of medical care leads to the idea of a community-wide hospital prepayment plan.

Their vision is the beginning of a legacy of care and commitment to the people of North Carolina that would last into the next century.

But before the new Association had gotten off the ground, the economic bottom dropped out. On October 29, 1929—“Black Tuesday”—the stock market fell precipitously, signaling the start of the Great Depression. In the following years, 9,000 U.S. banks and 86,000 businesses failed. Wages plummeted by 60 percent and unemployment exceeded 25 percent, as the number of jobless rose to 15 million. Given this economic and social disaster, all activity toward establishing the Durham Hospital Association came to an abrupt halt. If the Depression had not disrupted Davison and Hill’s progress, it would have been the first voluntary health service prepayment plan in the nation. But their passionate commitment to the idea remained, although their ability to relaunch the plan would have to lie dormant for several years until sufficient economic recovery had taken place.

As it turned out, a similar hospital prepayment plan was simultaneously founded in December 1929 by a prominent Dallas businessman, Justin Ford Kimball. For 50 cents per month, the city’s schoolteachers paid in advance for hospital care through Baylor University. The Baylor Plan is

known as the prototype upon which later Blue Cross Plans were based. In truth, the impetus to create hospital prepayment plans was taking root based on local initiative in diverse locations all over the nation. Doctors had become more supportive of the idea, as the Great Depression had led them to recognize the need for their patients to budget for their medical expenses in advance. Also, occupancy rates at voluntary hospitals nationwide were at record low numbers, and many went out of business. The time was ripe for a new approach. By the early 1930s, six plans that were similar in their service goals, yet rooted in local conditions, were operating in cities such as Cleveland, Newark, and Washington, D.C. These early hospital prepayment plans were founded as nonprofit organizations so that they didn’t have to bear the overhead of taxes, which allowed a greater proportion of the membership fees to go directly toward payment of health care costs. Commercial health insurance carriers regarded the idea of prepayment as actuarially unsound, leaving the door open for voluntary public plans to gain ground with little competition.

1930



In 1930, the average life expectancy in the United States is 59.7 years. In North Carolina, it is even lower.

The federal government expands its role in public health protection and research by establishing the National Institutes of Health and the Food and Drug Administration in 1930.

Try, Try Again: The Hospital Care Association Is Born

Four years after the stock market crash, the idea for a local hospital prepayment association was revived in Raleigh by a group of businessmen led by Dwight Snyder. With encouragement from Rex and Mary Elizabeth Hospitals, they secured a charter on August 7, 1933, to organize a group hospitalization plan—the Hospital Care Association. A few days later, Snyder called upon George Watts Hill in Durham, who described his interest in prepayment efforts over the past five years and his continued interest in a statewide plan. Dr. Davison, too, became involved as one of the original board members. The new Hospital Care Association was the fourth Blue Cross Plan in the United States.

Although enthusiasm for the new organization was high among the six member hospitals in Raleigh and Durham, the benefits of a hospital prepayment plan had not been seeded in Raleigh as successfully as they had been in Durham during Davison and Hill's first attempt. It was a new concept that still seemed risky and untested to many. Snyder quickly approached Duke and Watts Hospitals for credit extensions of \$1,000 each. A cash operating fund of only \$250 was secured on a note signed by Hill, and a rent-free Durham office was set up in the downtown Trust Building. By November, E. M. Herndon, an original member of the Hospital Care

I Remember: "An idea was all he could offer . . ."

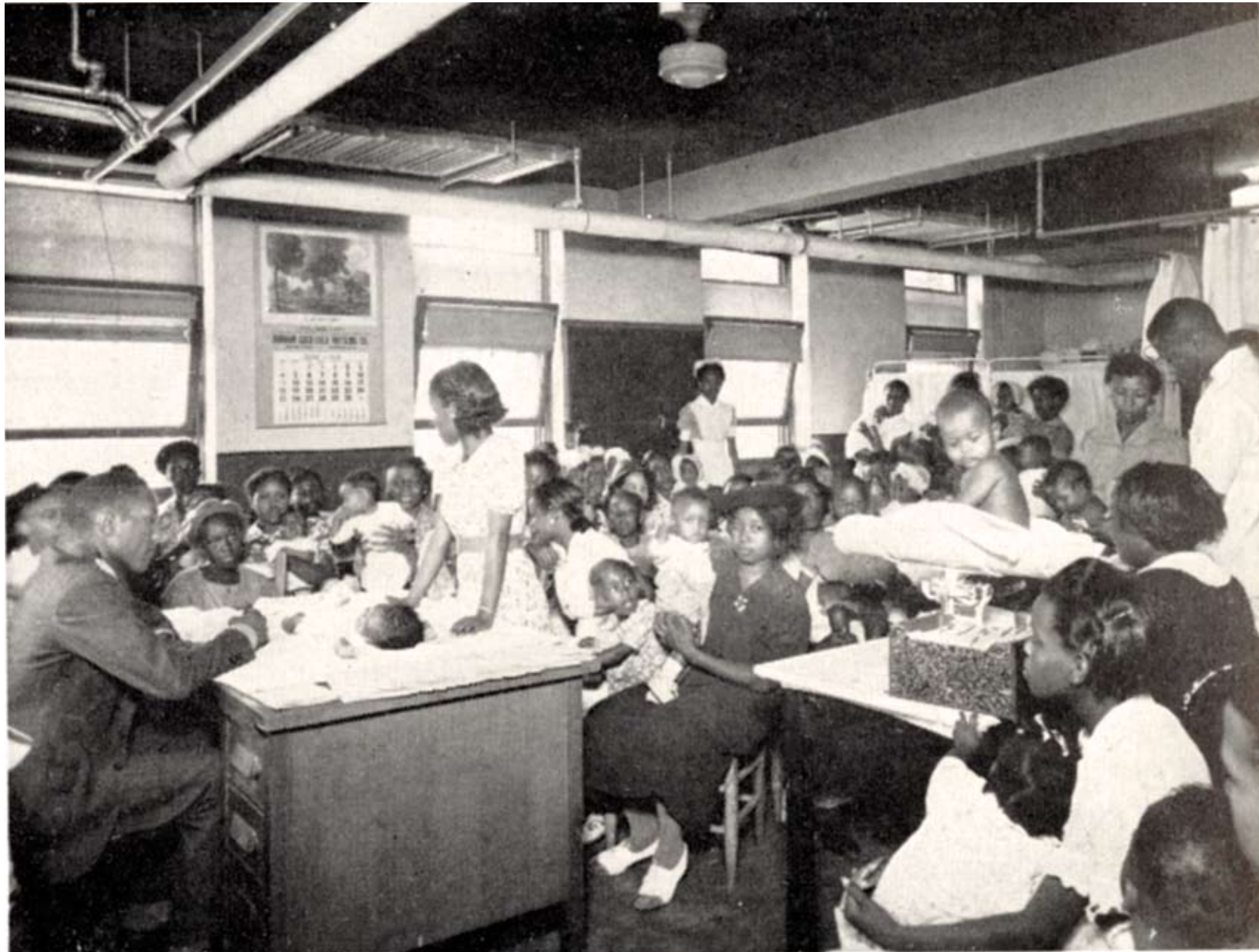
On September 22, 1933, Roy Medlin, formerly a printer in Raleigh, became the first subscriber ever enrolled by the Hospital Care Association. He remained continuously enrolled for more than 50 years. Medlin recalled: "A tall young man named Dwight Snyder entered my small print shop in downtown Raleigh with an idea. I soon discovered that an idea was all he could offer. We were all struggling to keep our businesses running without the use of cash, which in the year 1933 was very elusive.

"The idea seemed a very sound one to me and the trading began. Mr. Snyder wanted a used typewriter, application forms, and a few insurance policy forms to begin a new concept in the insurance field.

"After a few minutes of some deliberation, I knew he had me hooked, so I agreed to accept the first policy as payment for the items he needed to get him started."³

The first membership certificate issued by the Hospital Care Association in 1933 to Charles L. "Roy" Medlin. Photo courtesy of BCBSNC archives.





Well-baby clinic at Lincoln Hospital in Durham, 1938. In an effort to combat devastating maternal and infant mortality rates, hospitals began holding clinics to encourage hospital delivery and well-baby follow-up visits. Photo courtesy of Lincoln Hospital archives. Used with permission of Documenting the American South, the University of North Carolina at Chapel Hill Libraries.

Association founding group and later its first executive officer, was asked to move to the new Durham office in the role of sales manager.

With only one sales employee and a secretary, a desk and a phone, the Hospital Care Association began doing business. The first membership was bartered rather than sold. Roy Medlin, a Raleigh printer, and his wife agreed to become the first subscribers in exchange for printing the association's initial run of membership certificates (see *I Remember: "An idea was all he could offer . . ."*). At that time, coverage cost about two cents per day for an individual and seven cents per day for a family for 18 days of hospital care. Preexisting conditions such as pregnancy were covered, which set the stage for the birth of the nation's first "Blue Cross" baby, Ann Woodard, in December 1933. Her birth at Watts Hospital resulted in a \$60 bill for 10 days to the Hospital Care Association. Early Plan administrators had been fearful of including maternity benefits for fear of an "epidemic" of babies, but Hospital Care's experience proved to be a desirable benefit for many. To others, though, "maternity care didn't mean a thing because most babies were born at home," as E. M. Herndon acknowledged

and the state's high maternal and infant mortality rates revealed.⁴

With the help of the two Durham hospitals' trustees and their employer friends, Herndon began a group membership drive. The *Durham Herald-Sun* newspaper became the first employee group of subscribers for the fledgling Association. The Duke University faculty was the next group to enroll. But what seemed like a sales coup actually precipitated a big financial loss for the new organization in its first year, as claims exceeded income from the Duke University group.

During 1934, Hospital Care gained membership traction, enrolling more than 4,000 members. That fall, Herndon traveled to the annual meeting of the American Hospital Association in Philadelphia to discuss the potential of prepayment with hospital administrators. It would prove to be the initial formal meeting of organizations that would later become the first Blue Cross Plans. Yet the financial losses continued, and Snyder became concerned about the Association's financial position. From the start, utilization rates had been greater than expected. Some board members thought that abuse by enrollees was to blame, while others thought that

1930

In 1930, North Carolina's first four-year school of medicine and teaching hospital opens at Duke University.

1932

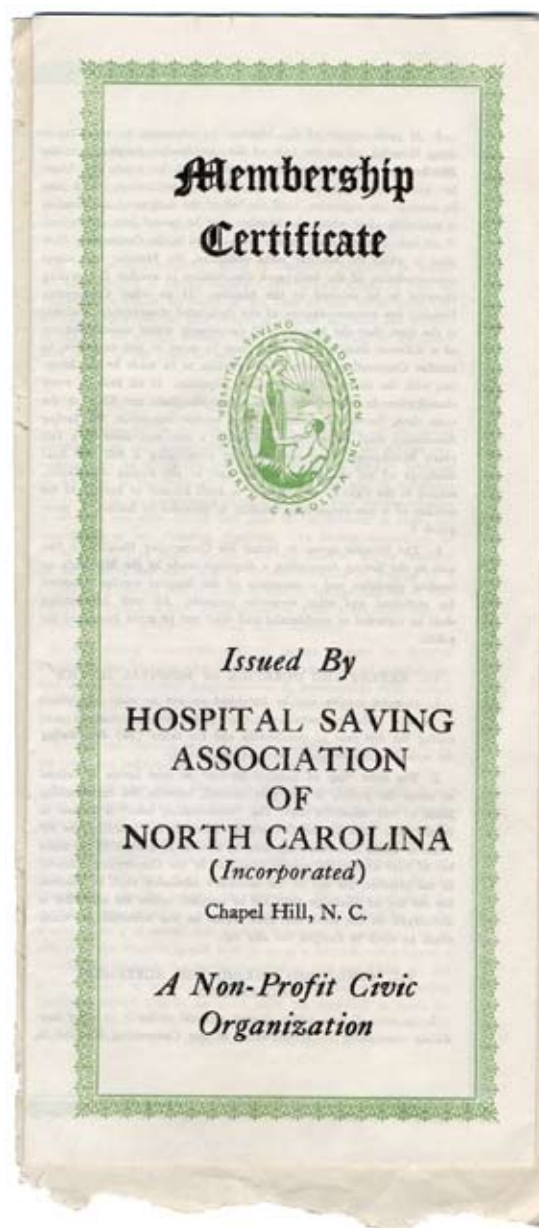


In 1932, The U.S. Public Health Service begins the 40-year Tuskegee Syphilis Study on 600 African-American men in Alabama. In an infamous breach of ethics, study participants never receive the proper treatment for their illness.

1933–34

In 1933–34, health insurance becomes available in North Carolina with the birth of the "Blue." The Hospital Care and Hospital Saving Associations are founded as rival "hospital prepayment plans," eventually merging to become Blue Cross and Blue Shield of North Carolina. For about \$7 per year, an individual could cover himself for 18 days of hospital care. Family coverage costs about \$25 per year.

An early membership certificate of the Hospital Saving Association, a rival hospital prepayment plan based in Chapel Hill, founded in 1934. Like Hospital Care, it was one of the nonprofit parent organizations that would later become Blue Cross and Blue Shield of North Carolina. Photo courtesy of BCBSNC archives.



the Plan needed to shift toward a more qualitative selection of risks.

Ultimately, Snyder resigned, and the Hospital Care Association was reorganized. Duke and Watts Hospitals, still committed to the potential of the prepayment idea, provided an infusion of \$6,000 each in capital to pay off the company's indebtedness. A new board was also elected to more closely direct the Plan's efforts to gain solid financial footing and credibility in the community. By the end of 1934, Hospital Care had opened its first district office in Asheville, and offices in Charlotte and Greensboro were added soon afterward.

Competition Close at Hand: The Hospital Saving Association

Many community leaders in the health care field had encouraged Hospital Care's formation. Among them was I. H. Manning, the former longtime dean of the University of North Carolina's School of Medicine and recent president of the North Carolina Medical Society. In a pattern remarkably similar to that of Hospital Care's founders, Manning, together with Graham Davis of the Duke Endowment, visited France and England in 1935 to study prepayment plans. They were convinced that the prepayment idea could meet the growing hospital care needs of North Carolina citizens and resolved to create a statewide, voluntary not-for-profit plan. With a \$25,000 grant from the Duke Endowment, they

filed a Charter of Incorporation for the Hospital Saving Association in March 1935.

The rival association opened its first office in Raleigh but quickly relocated to Chapel Hill's Public Health Building. The first certificates that Hospital Saving sold became effective on January 1, 1936. A group of schoolteachers in Charlotte was the first group enrolled by Hospital Saving. Fueled by its ambitious goal of enrolling 90 percent of the state's population, the new Plan grew quickly and by the end of 1936 had 14,395 members. Noting its rapid success, Hospital Care decided to extend its outreach beyond the confines of the Durham community. The business rivalry between the new Durham and Chapel Hill prepayment plans was under way. George Watts Hill admitted that "the folks in Durham" did not originally like the idea of competition but acknowledged that ultimately "competition keeps you smart. You don't get the chance to get lazy."⁵

Sales: The Old-Fashioned Way

Long before the advent of today's online applications and television advertising, the sales pitch was decidedly no-frills. As one of Hospital Saving's first salesmen, Bill Houck, recalled: "We spoke of enrolling people, we spoke of something you join, not something you bought. It was like a mutual aid society. Everybody would put their pennies in and help each other. It was a very simple concept. It was also simple in regard to the benefits and rates. Bed and board in a ward,



A snake-oil salesman approaches tobacco factory workers to pitch a questionable medical remedy. Fortunately, selling the new hospital prepayment idea in factories was met favorably—and provided a real health care value for workers and their families. Photo courtesy of the North Carolina Collection, Durham County Library.

I Remember: "Women put this thing on the map . . ."



Women sales representatives explain hospital prepayment options to Craven County turkey farmers. Photo courtesy of BCBSNC archives.

C. A. (Bill) Houck, Jr., began his 41-year career with Blue Cross and Blue Shield of North Carolina (BCBSNC) as a salesman for the Hospital Saving Association in 1938. Houck recalled: "When I went to work, as far as I know there was not a single man on the sales staff. They were all women. In the home office there were probably three or four men, and all the rest were women. Women really put this thing on the map. They believed in it, and they were terrific salespeople."

"Mrs. Stella Teague was the district manager for Hospital Savings in Winston-Salem. She was my boss, the one that hired me. She was operating her office under the staircase in her home in Old Salem. She was a terrific saleslady. She sold it like a religion. Within a year or two, she had 6,000 people enrolled. Subsequently, with the acquisition of Reynolds Tobacco Company and some other groups in about 1942, she had enrolled half the population of Winston-Salem! She gave me the best training I ever had."

"So I want to give a real accolade to the women because they were right up at the forefront of our early success."⁹

\$3 a day credit toward a private room, which cost the whole of \$5. We called it the '2 cents a day plan.'"⁶ Although the commercial insurance carriers were largely skeptical about the potential profitability of hospital prepayment in those days, the general public seemed ready to accept the risk. Houck indicated that the idea appealed to both employers and employees alike. Initially, Hospital Saving sold exclusively to groups, while Hospital Care also sold to individuals.

The first step in the group sales effort was to gain buy-in to the prepayment plan from the employer. A group could be formed only if half or more of the employees enrolled, with a minimum requirement of ten people. Sometimes talking over the loud factory machines until he was hoarse, Houck often explained the prepayment concept to employees one by one.

If he was lucky, the employer might agree to shut down the factory machines for a short while so that he could make a group presentation and sign people up. The sales kit consisted of one simple folder that explained the entire Plan at a glance, an application card, and a receipt book in case he collected the membership dues up front. More often, the employer would deduct the dues from the employee's paycheck on behalf of the Plan.

But Hospital Saving sold to more than just major industrial employers. Payroll deductions for teachers were not authorized by the state, but teachers' membership dues were collected and transmitted by a group treasurer. The Plan

also experimented with “pseudo groups”—a 75 percent employee enrollment rate could qualify several small businesses in one geographic area as a group. In rural areas, salespeople approached organizations such as the Grange, home demonstration clubs, and even rural churches.

Hospital Saving was, in fact, the only Plan in the nation with statewide operations, featuring members in 55 of North Carolina’s 100 counties in its first two years (see *I Remember: “Women put this thing on the map . . .”*). Yet there was concern early on that its wider geographic scope, however altruistic in its intent, was proving to be more of a business burden than an advantage, as Hospital Care had better enrollment in 1936.⁷ Both Plans’ success was instead rooted in the support of local member hospitals, and those hospitals helped the young Associations gain access within the community. Interestingly, North Carolina was one of only two states with two Plans competing for business in the same market territory.⁸

Growth Strategies

Both health Plans had originated with the goal of improving access to hospital care for the working and lower classes, yet their early sales strategies posed something of a paradox. They began by targeting the professional and white-collar workers in order to “sell” the safety and viability of the prepayment idea. The strategy both worked and backfired. At first, the people who used the hospital the most were highly educated or working

I Remember: “When I hear an ambulance . . .”

Elisha M. Herndon helped found the Hospital Care Association in 1933 and became its first chief executive officer, serving for 35 years the organization that would later become Blue Cross and Blue Shield of North Carolina. Herndon recalled: “I can remember in those days seeing an ambulance headed for the hospital and saying, ‘I hope the person in that ambulance isn’t our member. We

sure don’t have the money to pay the claim.’

“Now when I hear an ambulance, I hope it is one of our members with our very best coverage because not only are we an organization that wants to render good service, we’re now financially able to do so.”¹⁰

Photo courtesy of BCBSNC archives.



in health care, since they held less fear of doctors and hospitalization. Due to poor underwriting and higher-than-expected utilization rates, both Associations grew concerned about their financial losses. In fact, it took Hospital Care six years to realize its first slim operating profit (see *I Remember: "When I hear an ambulance . . ."*).

By late 1936, Hospital Care shifted its sales strategy toward those with lower incomes and began offering a less expensive certificate—two cents per day—identical to the rate schedule of Hospital Saving. Hospital Saving, too, had a primarily working- and lower-class membership base; 25 percent of its subscribers were textile workers, and 70 percent had incomes of less than \$700 per year.¹¹ Many of its rural subscribers were aided by the health care provisions of the Farm Security Administration (FSA) program, established in 1937 to help farmers recover from the Great Depression. As a result, FSA became the first government program administered by the Hospital Saving Association.

There were particular challenges to successfully enrolling North Carolina's black citizens in the new prepayment plans. For example, of Durham's population of 60,000, one-third

was African American, many of whom would qualify for low-cost hospitalization. But with the exception of tobacco factory employees, most of them worked in small industries, in retail stores, or for individuals and therefore could not be reached through group selling or collection by payroll deduction. As a result, sales representatives had to make individual calls and collect the dues personally. This proved to be an expensive practice: the membership cost for the same benefits of the original certificate was 50 percent greater for African Americans who were paid on a weekly basis. As E. M. Herndon acknowledged, "This increased cost to those least able to pay was a social and economic injustice."¹² In addition, in the racially segregated South of those days, concern about mixing white and black patients in the same hospital overwhelmed the need, and eventually the certificate was withdrawn.

The various sales strategies of the two Plans worked. By the late 1930s, Hospital Care's membership was doubling every year, and it had seven offices across the state. Although it had started operations two years later, Hospital Saving's growth quickly outstripped its competitor's membership numbers, exceeding 50,000 by 1937.

1933

Maternity benefits are included, influencing more women to give birth in the safety and sanitary conditions of the hospital instead of at home, attended only by a midwife, general practitioner, or experienced relative.



The nation's first "Blue Cross baby," Ann Woodard, is born in December 1933, at Durham's Watts Hospital to parents enrolled in the new Hospital Care Association.

Earning Blue Cross Approval

As the prepayment movement grew, the annual meeting of the American Hospital Association (AHA) provided Plan leaders with an opportunity to share their local experiences and explore their challenges. By 1937, the AHA offered associate institutional membership to any nonprofit organization meeting its 14 standards, which were developed as a protective measure for both the public and the affiliated hospitals.¹³ Approved Plans would qualify to display a symbol of affiliation—the Blue Cross. The AHA requested that both Hospital Care and Hospital Saving submit to an audit by an outside firm, with particular attention to their reserves. Both Associations subsequently agreed to institute the accounting plan suggested by the auditor. In addition, consideration was given to placing both Associations under the supervision of the North Carolina Department of Insurance, although they had originally been exempt from the state's insurance laws.¹⁴

On April 1, 1938, the Hospital Saving Association became one of the first 38 Plans approved to use the Blue Cross symbol. The Hospital Care Association gained approval later that year on September 1. The 40 organizations approved as “Blue Cross Plans” by the AHA in 1938 represented a total membership of almost 2 million people throughout the United States, clearly indicating that the nonprofit prepayment concept now had taken root on a national as well as a

local basis, even though many Plans were still struggling financially.

Although Hospital Saving had won the honor of being the first association in North Carolina to qualify as a Blue Cross Plan, by 1939 it was approaching bankruptcy and in serious danger of losing Blue Cross approval. The new Plan needed decisive leadership at this critical moment, and found it in Eugene B. Crawford. Most of the fledgling plans stayed away from hiring people with insurance experience for management positions, because they thought the health and social welfare aspects of their missions were more relevant to their hiring philosophy.¹⁵ Crawford had been a hospital administrator before coming to Hospital Saving, and his hospital knowledge and experience were pivotal in turning around the struggling Plan. He rapidly resolved the fiscal crisis by influencing its participating hospitals to accept 90 percent of the Plan's liability. Crawford was always committed to financial accountability, and under his leadership, Hospital Saving not only recovered but thrived, making remarkable gains in membership and introducing innovative programs.

Early Merger Discussions

In the wake of both Hospital Care and Hospital Saving gaining approval as Blue Cross Plans, the AHA began to exert some pressure for the two organizations to consolidate. In December 1938, the North Carolina Hospital Association



Hospital prepayment plans that met standards developed by the American Hospital Association to protect the public and hospitals were approved to display the Blue Cross symbol. Both N.C. Plans received Blue Cross approval in 1938. Photo courtesy of BCBSNC archives.



President Franklin D. Roosevelt signing the Social Security Act in 1935. While Social Security established important benefits for the elderly, it did not include health care. Voluntary rather than government-sponsored health insurance would provide access to affordable care for the rest of the century. Photo courtesy of the Library of Congress.

also came out in favor of the merger, listing the following advantages:

1. The merged membership would be as strong or stronger financially.
2. A strong and smooth-running organization would serve to ward off state government-sponsored medicine.
3. The unpleasant and antagonistic rivalry would be abolished.
4. Operating expenses could be decreased.
5. Group claims could be reduced.
6. Political pressure by individuals could be diminished.
7. More satisfaction of contracts could be achieved by utilization of the experiences of both organizations.¹⁶

Certainly these were undeniably sound business reasons, and a committee comprising representatives of both Hospital Care and Hospital Saving was established to study the feasibility of a merger. But negotiations floundered over issues of board structure and Plan identity, indicating a lack of willingness to genuinely overcome the Plans' differences. Whatever the root cause of the failure to reach agreement, this consolidation

effort would prove to be the first of many that would ultimately continue for another 30 years before coming to fruition.

Medicine and Government Take Notice

The Social Security Act had passed in 1935, providing a range of benefits for the elderly, but it did not include provisions for health care. With prepayment plans gaining acceptance throughout the country, the federal government began to explore the idea of compulsory national health insurance. As early as 1938, the Roosevelt administration organized a conference on the topic of national health programs and included “consideration of a general medical care program supported by taxes, insurance, or both.”¹⁷ In 1939, Senator Robert F. Wagner introduced the first “National Health Bill” (S. 1620), which incorporated the recommendations that had emerged from the National Health Conference held in Washington, D.C., a few months earlier to address problems in medical care. The bill proposed a national compulsory health insurance for almost all employees and their dependents, with benefits to include physicians’ services, hospitalization, drugs, and laboratory diagnostic

services. Costs would be covered through employer and employee contributions deposited in a health insurance fund. The plan was to be administered through the states.

Although the bill died in committee, the forces of organized medicine took serious note and began to back private hospitalization insurance in a more pronounced way. With the growing popularity of hospital prepayment, there had been increasing public demand for the development of similar service plans that would cover the provision of medical services, not just surgical care and hospitalization. The medical establishment recognized this demand as a realistic threat that could open the door to government-controlled medical care and diminish the quality of patient care as well as an opportunity to retain control of the provision of medical services by the doctors themselves. As a result, the American Medical Association (AMA) formally endorsed voluntary hospitalization insurance but with an important caveat—“providing all such plans do not incorporate medical service or medical care.”¹⁸ Instead, the AMA advocated for state and local medical societies to address their community’s needs by forming medical plans of their own.

1935

A crown jewel of FDR’s New Deal, the Social Security Act, passes. In failing to provide for health care coverage, it solidifies an American paradigm: that health coverage in the United States would be funded largely by individuals or employers, not the government.

1936



By 1936, Hospital Saving has members in 55 of 100 North Carolina counties.

In 1936, a Duke physician originates the use of ultraviolet radiation to control airborne infections in surgical operating rooms, a technique that has become widely accepted across the country.



An operating room prepared for surgery with ultraviolet light, X-ray screen, instrument table, and patient bed. The use of ultraviolet radiation to control airborne infections was an innovative surgical practice in 1936. Photo courtesy of Duke University Medical Center Archives.

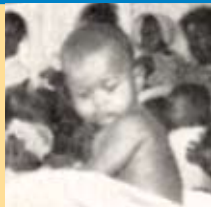
Hospital Care Association's 1933 charter had included provisions for the sale of surgical care, but as of the late 1930s, the Plan had not yet enacted such coverage and wanted the physicians themselves to provide the underwriting for any medical benefits. Hospital Saving Association also wanted to add surgical benefits to its coverage, but its original charter did not provide for them. The North Carolina Medical Society had been a committed sponsor of Hospital Saving since its inception, actively influencing the direction and management of its operations. Leaders within the Medical Society recognized the need to expand into the medical market but wanted to proceed cautiously.

In the meantime, the commercial carriers resumed their interest in providing health insurance. Although they had considered "sickness insurance" too risky during the formative years of the prepayment movement, by the late 1930s they recognized a growing market and

became an additional source of competition for both of North Carolina's nonprofit Plans. They began offering contracts with a limited schedule of surgical benefits, which became particularly popular with the state's key industries, especially textiles.

The 1930s had seen North Carolina's fledgling hospital prepayment plan, the Hospital Care Association, derailed by the depths of the Great Depression, then reborn out of the vision of a few pioneers who started with only a handful of dollars but with a determination to serve the profound health care needs in the state. The Hospital Care Association found a growing market in the state—and, with it, competition from the nearby Hospital Saving Association. In less than a decade, these two Plans had provided more than 100,000 North Carolinians with better access to health care. The roots of Blue Cross and Blue Shield of North Carolina were taking hold.

1937



In 1937, the infant death rate for babies under one year of age in Durham County, N.C., is 52.2 per 1,000 live births among whites and 94.2 per 1,000 among African Americans. Clinics are held weekly at Lincoln Hospital to encourage hospital delivery and well-baby follow-up visits.

1938

In 1938, the Hospital Saving Association becomes one of the first Plans approved by the American Hospital Association to use the Blue Cross symbol. Hospital prepayment plans are taking root across the country.

1939

In 1939, research demonstrates penicillin's ability to kill infectious bacteria.