UNITED STATES DEPARTMENT OF AGRICULTURE

FARM SECURITY ADMINISTRATION

OFFICE OF THE CHIEF MEDICAL OFFICER

ANNUAL REPORT

Fiscal Year July 1, 1940 - June 30, 1941

REPORT FOR FISCAL YEAR JULY 1, 1940 - JUNE 30, 1941

OFFICE OF THE CHIEF MEDICAL OFFICER
FARM SECURITY ADMINISTRATION

FOREWORD

By June, 1941, the medical care and sanitation program of the Farm Security Administration was five years old. Since this fiscal year report offers an appropriate opportunity to take inventory, an effort has been made to list in considerable detail the 900 medical and dental care groups operating in June composed of more than 110,000 families who are borrowers from the Farm Security Administration. The special medical aid program for agricultural migrants, the study of the physical status of FSA borrowers, and the expanding environmental sanitation program are also treated in some detail in sections of this report.

Four and a half million farm families, three-fourths of the entire agricultural population of the United States, had net cash incomes of less than one thousand dollars in 1940. It is particularly for this group that there is significance in the patterns being evolved to meet the health needs of rural rehabilitation and tenant purchase borrowers, resettlement project occupants, and migrant agricultural workers.

Medical Care Program for FSA Borrowers

The social and economic hazards of sickness and its costs are being challenged today by thousands of farm families. It is an organized challenge--not the ineffective effort of individuals acting alone, but an encouraging example of intelligent group action. By pooling their limited financial resources, these families have been able to reach an understanding with the various professional groups concerned with medical care in their communities. This gives them more ready access to facilities for various types of medical services.

The past fiscal year saw continued expansion of this medical care program. By June, 1941, 104,224 families were enrolled--over 545,000 persons. The 703 groups organized among these families extended into 881 counties in 35 states. They were made up of rural rehabilitation borrowers for the most part, but also included families in other FSA categories such as tenant purchase and resettlement project families.

There is evidence of increasing approval of the program on the part of organized medicine, an acknowledgment that the organization of payment for medical services need not interfere with the physician-patient relationship.

Dental Care Program for FSA Borrowers

Faced with the staggering problem of almost universal neglect of dental needs among its borrowers, the Farm Security Administration has been experimenting with a rather wide variety of approaches to the problem in collaboration with state and local dental societies. Because of limited funds, based on family contributions, and because of the nature of the problem, the program so far has been largely of an emergency character. The chief emphasis has been on eradicating sources of infection. That dental disease can be attacked effectively only by a program of prevention and control is recognized, however, and such an approach awaits only some practicable method of financing.

Dental care was first made available to FSA families on a prepayment basis as part of various medical care plans. Emergency dental service, confined largely to extractions, was included in a considerable number of plans because of the necessity for eliminating, in so far as possible, the systemic effects of dental disease. As of June, 1941, 15,493 families were enrolled in medical care groups which included emergency dental service within the scope of the various medical services offered.

There has been increasing recognition of the desirability of organizing separate and more complete dental care plans and during the past fiscal year there was an accelerated expansion of a separate dental care program developed in cooperation with state and local dental societies. As of June, 1941, there were 159 separate dental care groups in 167 counties in 14 states. The total enrollment of these separate groups was 23,450 families or 124,021 persons. The services in many of these plans included fillings, particularly for children, as well as extractions and soft tissue treatments to eradicate infection. A few plans included other types of restorative dentistry.

Health Program for Resettlement Projects

The resettlement projects offer an opportunity to develop a broader and yet more concentrated health program than is readily attainable when dealing with widely scattered farm families. In general there is decent housing and adequate sanitation in the projects, and a background of community organization offering a ready-made field for health education efforts.

Health centers have been placed in many projects, and more than fifty projects are served by full-time community nurses. The nursing program, carried out with the cooperation of health departments and practicing physicians, constitutes a broad form of generalized public health nursing including some bedside care and demonstration work in maternity and acute illness cases.

During the fiscal year the medical care program was extended to 19 additional resettlement projects, making a total of 75 projects with

medical care groups. There were 35 projects with separate medical care units, 37 with units combined with rehabilitation families, and 3 with both separate and combined units serving the project families. Families enrolled in separate units numbered 4,148, and there were 1,037 project families in combined units, or a total of 5,185 resettlement project families taking an active part in the medical care program.

Medical Care for Migratory Agricultural Workers

Since the spring of 1938 the Farm Security Administration has been providing medical aid for migrant agricultural workers in California and Arizona through the Agricultural Workers Health and Medical Association, a corporation financed by the Farm Security Administration. During the past fiscal year similar medical aid programs were established for migrants in Florida, the Rio Grande Valley in Texas, and the Pacific Northwest.

In these more recently organized programs the medical aid is furnished through clinics in the migratory labor camps and by referral from the clinics. The effect of this is to make medical care available chiefly to camp occupants and migrants in the vicinity of the camps, whereas, in California and Arizona , the medical benefits have been extended not only through camp clinics but through district referral offices to migrant families throughout wide areas in both states.

Physical Status of FSA Borrowers

The physical examination studies previously undertaken were continued during the past fiscal year. With completion of the seventeen-state study of 2,480 borrower families, detailed information concerning the physical status of low-income farm families is becoming available. Although the report of this study has not yet been completed, some of the significant findings are incorporated in a section of this report. As in the case of rejected draftees, the striking feature of the numerous physical defects found is that the great majority might have been prevented or might still be remedied.

Environmental Sanitation

It has been estimated that of the six million farms in the United States, approximately five and a half million are in need of some corrective measures to insure a safe farm water supply; that proper methods for the disposal of human wastes are lacking on four and a half million farms; and that four million farm dwellings are in need of either mosquito or fly proofing for controlling the transmission of certain diseases. Since these three fundamentals of sanitation are basic in a public health program, it is clearly indicated that the surface of the problem of rural sanitation has barely been scratched.

With the full realization of the problems ahead and with the knowledge that the lack of sanitary facilities is a major factor in the rehabilitation of farm families, the Farm Security Administration several years ago embarked on a program to do something about it. After experience in the operation of an environmental sanitation program, it is recognized that it is not a simple problem easily solved; that the remedy is tied in closely with that of land tenure, soil preservation and conservation, housing, food and clothing and medical care. Closely associated with all these factors is the economic stability of the farm family. It is clearly indicated that other governmental agencies must play a part in the environmental sanitation program, if the program is to succeed. The Farm Security Administration recognizing this has enlisted the aid of such agencies as the State and County Health Departments, Work Projects Administration, National Youth Administration, Extension Service, Soil Conservation Service, and Forest Service.

In the section of this report on environmental sanitation, the progress which has been made during the fiscal year 1940-41 is outlined. Much still remains to be done.

AGREEMENTS WITH STATE MEDICAL ASSOCIATIONS

THROUGH JUNE 1941

REGION I

Maine Medical Association	January, 1939 (limited to one county) June, 1940 (general agreement)
Medical and Chirurgical Faculty of Maryland	1939
New Hampshire Medical Society	November, 1938 (informal)
Medical Society of New Jersey	October, 1938 (Welfare and Medical Practice Committees) June, 1940 (Board of Trustees)
Medical Society of the State of New York	September, 1939 (Council) May, 1940 (House of Delegates)
Medical Society of the State of Pennsylvania	October, 1939
Vermont State Medical Society	October, 1938

REGION II

Michigan State Medical Society	October, 1940 (approved negotiations with Michigan Medical Service - which resulted in agreement in May, 1941)
Minnesota State Medical Association	February, 1941 (limited to three counties)
State Medical Society of Wisconsin	January, 1938 (FERA fee schedule)

REGION III

Illinois State Medical Society	May, 1937
Indiana State Medical Association	April, 1937 (common fund plans approved in November 1938)
Iowa State Medical Society	July, 1937 (agreement liberalized in November, 1938)
Missouri State Medical Association	May, 1937 (liberalized in 1939)
Ohio State Medical Association	July, 1937 (liberalized in 1939)

REGION IV

Kentucky State Medical Association	June, 1939
Medical Society of the State of North Carolina	December, 1937
Tennessee State Medical Association	December, 1937
Medical Society of Virginia	October, 1938
West Virginia State Medical Association	December, 1938

REGION V

Medical Association of the State of Alabama	January, 1938
Florida Medical Association	January, 1939
Medical Association of Georgia	March, 1938
South Carolina Medical Association	December, 1938

REGION VI

Arkansas Medical Society	1937
Louisiana State Medical Society	October, 1938
Mississippi State Medical Association	May, 1937 May, 1939 - resoluti disappro May, 1940 (clarifyin ruling which again f nished basis for agreement)

REGION VII

Kansas Medical Society	January, 1939 (inform
Nebraska State Medical Association	May, 1939
North Dakota State Medical Association	Spring, 1940 (plans subject to approval of State Association)
South Dakota State Medical Association	1939 (agreement is wi Inter-Allied Professi Council of South Dako

REGION VIII

Oklahoma State Medical Association	November, 1936 (specia fee schedule) September, 1937 (gener agreement)
State Medical Association of Texas	January, 1938

REGION IX

Arizona State Medical Association	April, 1939
California Medical Association	March, 1941 (agreement with California Physicians' Service)
Utah State Medical Association	May, 1937 April, 1939 (agreement with Medical Service Bureau)

REGION X

Colorado State Medical Society	September, 1938
Medical Association of Montana	December, 1939
Wyoming State Medical Society	April, 1939

REGION XI

Idaho State Medical Association	June, 1941
Oregon State Medical Society	September, 1939 (plans subject to approval of State Society)
Washington State Medical Association	April, 1939

REGION XII

Colorado State Medical Society	September, 1938 (listed under Region X)
Kansas Medical Society	January, 1939 (listed under Region VII)
New Mexico Medical Society	June, 1938
Oklahoma State Medical Association	September, 1937 (listed under Region VIII)
State Medical Association of Texas	January, 1938 (listed under Region VII)

RECAPITULATION

Definite working agreements or understandings in effect with 34 state medical associations.

Informal or limited agreements in effect with 9 other state medical associations.

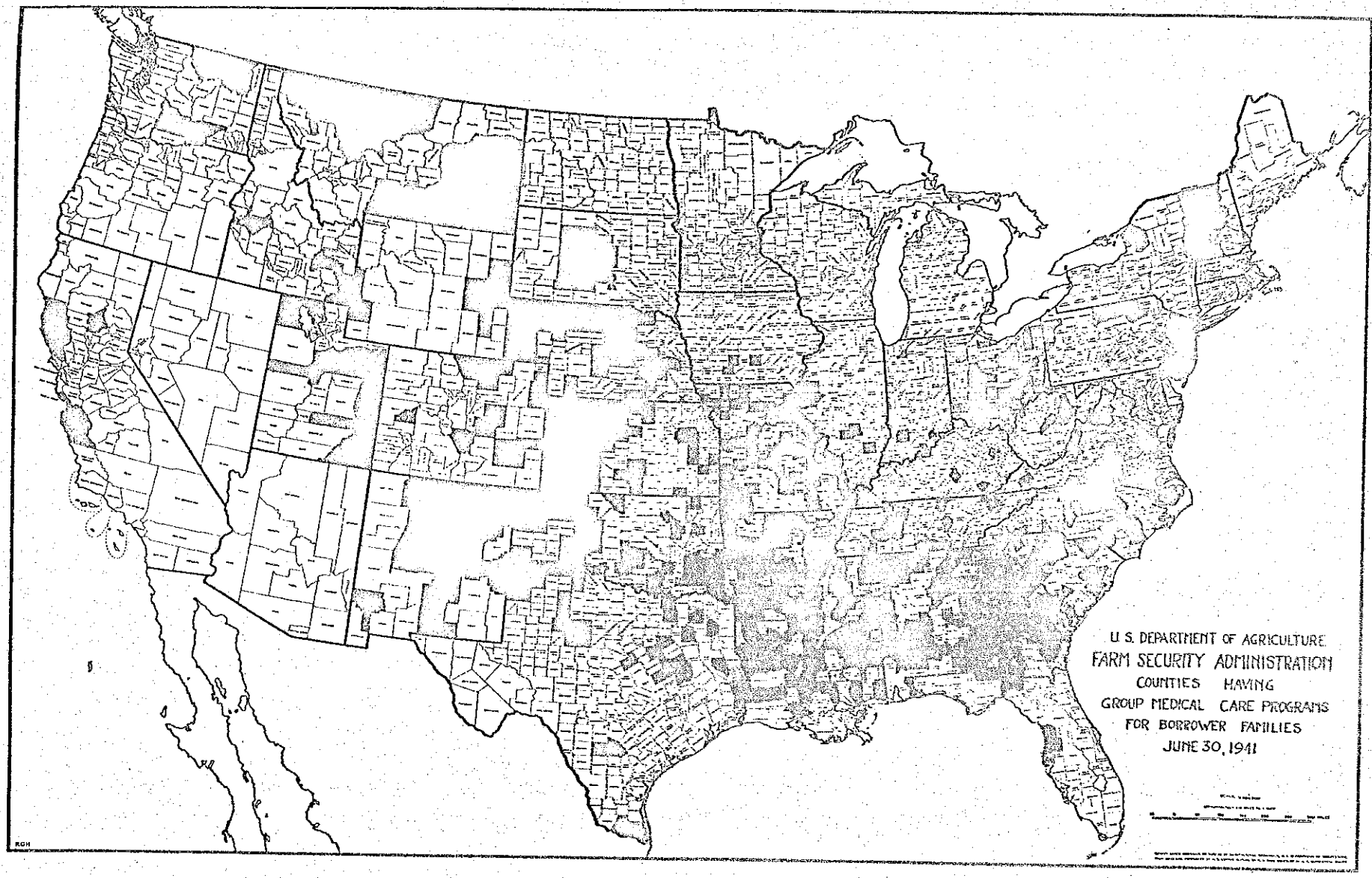
Total number of state medical associations with which working agreements, some informal or limited, have been reached through June, 1941 --- 43.

Table No. 1

States having group medical care units serving FSA borrowers (except units restricting membership to resettlement projects) showing the number of counties having such plans operating in June of each year from 1936 through 1941.

Region and State	NUMBER OF COUNTIES					
	June 1936	June 1937	June 1938	June 1939	June 1940	June 1941
All States	8	142	203	514	639	881
Region I				1	19	46
New Hampshire					2	2
New Jersey				1	1	19
New York						4
Pennsylvania					2	7
Vermont					14	14
Region III		1	5	31	55	116
Illinois					5	10
Indiana				5	4	6
Iowa		1	2	3	1	3
Missouri			2	12	28	56
Ohio			1	11	17	41
Region IV				25	84	102
Kentucky					4	3
North Carolina				10	35	38
Tennessee				7	10	20
Virginia				8	28	34
West Virginia					7	7
Region V	1	2	6	153	164	187
Alabama			3	23	33	40
Florida				5	5	6
Georgia	1	2	3	108	108	121
South Carolina				17	18	20
Region VI	7	17	60	112	131	148
Arkansas	5	14	56	67	68	59
Louisiana			1	7	21	30
Mississippi	2	3	3	38	42	59
Region VII		122	122	122	43	85
Kansas					20	28
Nebraska					23	43
North Dakota		53	53	53		
South Dakota		69	69	69		14

Region and State	NUMBER OF COUNTIES					
	June 1936	June 1937	June 1938	June 1939	June 1940	June 1941
Region VIII			4	19	52	49
Oklahoma			4	11	23	22
Texas				8	29	27
Region IX			1	1	4	16
California						7
Utah			1	1	4	9
Region X				4	9	43
Colorado				2	3	7
Montana				2	2	30
Wyoming					4	6
Region XI			4	2	1	11
Idaho			4	2	1	5
Washington						6
Region XII			1	44	72	78
Colorado					3	6
Kansas				25	25	24
New Mexico				7	22	20
Oklahoma				1	1	3
Texas			1	11	21	25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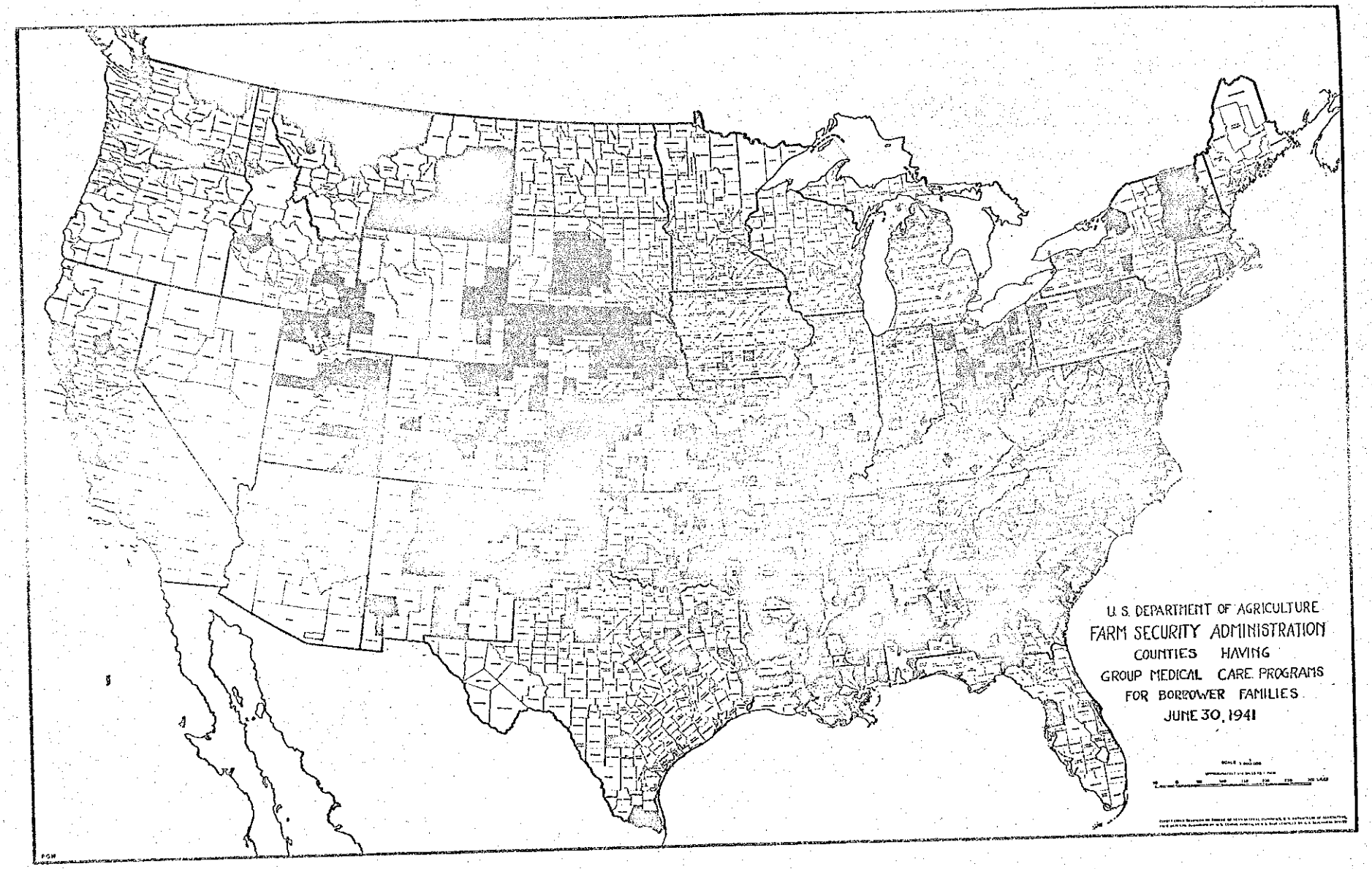
FARM SECURITY ADMINISTRATION
COUNTIES HAVING
GROUP MEDICAL CARE PROGRAMS
FOR BORROWER FAMILIES
JUNE 30, 1941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MEDICAL CARE PROGRAM FOR FSA BORROWERS

Basic to the general health work of the Farm Security Administration is the medical care program for borrower families which has been developed in close cooperation with the medical profession. Starting slowly in 1936 and 1937 this program now serves more than 100,000 farm families in thirty-five states.

Background. From the early days of the rehabilitation program it was evident that poor health and physical disability were among the primary factors keeping many families from becoming self-supporting. Lack of medical facilities and lack of ability to pay for such medical services as did exist were two of the underlying difficulties. These families lacked adequate medical care because they could not pay for it and they lacked adequate facilities for medical care because their incomes were too low to help maintain these facilities.

The various surveys and studies conducted in recent years by public and private agencies have thrown into the spotlight the serious medical care problems confronting rural families, particularly those with low incomes. In general, it has been shown that the volume of medical care which people receive decreases with the size of city in which they reside and that families in rural areas receive least of all. A similar reduction in the volume of medical care has been noted with decrease in size of income. The low income rural family is, therefore, subjected to forces from two directions cutting down the amount of medical care available to the family. This situation prevails in such varying fields as general practitioner care, surgery, hospital care, eye refractions, dental care, and smallpox vaccinations. Notwithstanding this reduced amount of medical care received by rural residents, available data indicate that the expenditures of these rural families for medical care are not markedly different from those of urban families with comparable incomes.

Surveys and studies, including the physical examination study referred to elsewhere in this report, only confirm what is common knowledge to the supervisors working with these low-income families. They have seen farmers dragging along for years with some partially disabling chronic condition. They know that many of these people hesitate to consult their physicians, knowing that they could not pay the bills. Minor ailments have often been uncared for until they became grave, and then a family's livestock or farm tools have had to be sold at a sacrifice to pay for a surgical operation or prolonged hospital care.

Because it is unpredictable, acute sickness often has thrown out of balance the carefully developed plan charting a family's course toward economic rehabilitation. The aim of the medical care program is to make necessary medical care readily available to all of the families receiving financial and supervisory assistance from the Farm Security Administration and to lessen the financial impact of sickness by

providing a mechanism whereby the families may budget a definite amount for services of the widest practicable scope.

Basic Principles. Over the five-year period during which the program has been developing there has been little deviation from the following broad principles laid down at the beginning:

1. Free choice of physician. The general policy is to develop no medical service plans in a state until a basic working agreement has been reached with the state medical association. Then county or district plans are organized in collaboration with local medical societies. The plans provide for medical society supervision over medical aspects of the program. Enrolled borrowers have free choice of physician from among those participating, usually from among all legally qualified physicians in the area. There is no interference with the personal relationship between physician and patient.

2. Group prepayment. Family participation dues are paid in advance on an annual basis. Borrowers are often assisted in making such payments, ordinarily through loans. The funds deposited by each family are placed in a pooled or common fund in the hands of a bonded treasurer or trustee, and from monthly or quarterly allotments of this fund payments are made to physicians, hospitals and druggists.

3. Family contributions based on average incomes. Participation rates are in general commensurate with average incomes of FSA borrowers in the area. The rates for a particular plan depend on the services covered and often upon the size of family as well as upon average income. When a given rate is beyond the ability of a family or a group of families to pay, an effort is made to base the family contribution on its ability to pay and some provision is made for supplementing this amount to the extent necessary.

4. Voluntary Participation. The borrowers are never compelled to participate. The local plan is presented to them; whether or not they become members is entirely for their decision. But in most cases economic necessity itself is a compulsion — they cannot afford not to participate.

Agreements with State Medical Associations. A working agreement or understanding with each state medical association has been considered a prerequisite to the development of local medical service plans. Additional progress was made during the past fiscal year in securing basic agreements or understandings with state medical associations. The number of these associations with which understandings of varying scope were in effect each fiscal year for the past five years is as follows:

June 1937	- 8	June 1939	- 34
June 1938	- 18	June 1940	- 39
	June 1941 - 43		

The four new working agreements obtained during the fiscal year were with the Michigan State Medical Society, the Minnesota State Medical Association, the California Medical Association and the Idaho State Medical Association. The Michigan State Medical Society and the California Medical Association designated the medical service organizations which they have sponsored — the Michigan Medical Service and the California Physicians' Service — as the agencies authorized to cooperate with the Farm Security Administration. The agreement with the Minnesota State Medical Association is limited in scope, being confined to approval by the Association of an experimental program which is to receive a thorough trial in three counties in the State before it is extended to other areas. The Idaho State Medical Association has gone on record as permitting its constituent county medical societies to work out plans for medical care groups with the Farm Security Administration if they desire to do so.

The negotiation of agreements has been postponed in the case of state medical associations in five states which have relatively low caseloads of FSA borrowers, namely, Massachusetts, Connecticut, Rhode Island, Delaware, and Nevada.

A list of the agreements with various state medical associations with the dates of the agreements follows the introduction of this report.

Expansion of Medical Care Program During the Fiscal Year. The progress made in preceding fiscal years in extending the medical care program into additional states and counties was continued during the fiscal year 1940-1941. Table No. 1, which precedes this section of the report, illustrates by regions and states the growth of the program from June, 1936 to June, 1941, except for medical care units restricting membership to occupants of resettlement projects. The total number of states and counties to which this program had been extended as of the last month of each fiscal year since June, 1936, is as follows:

Number of States and Counties with Medical Care Groups of FSA Borrowers

	June 1936	June 1937	June 1938	June 1939	June 1940	June 1941
States	3	6	14	25	31	35
Counties	8	142	202	514	639	881

Detailed data relative to the growth of this program during the past fiscal year by regions and states are included in Table No. 2. There was an over-all net increase of 26,171 families enrolled, representing an increase of 33.5 percent. As of June 30, 1941, 104,224 families were active participants, including 60.5 percent of all eligible FSA families in the areas covered. The following is an abstract from Table No. 2 showing the increase in the number of medical care units, the number of counties covered by the units, and the number of participating families and persons:

	States	Units	Counties	Families	Persons
June, 1941	35	703	881	104,224	545,673
June, 1940	31	546	639	78,053	418,382
Increase	4	157	242	26,171	127,291

In addition to the medical care units in the thirty-five states listed in Table No. 2, units were to go into effect in three additional states during the first few weeks of the following fiscal year.

Membership Growth in Individual Units. Most of the expansion which took place during the fiscal year was naturally due to the addition of new medical care units. However, it was felt that it was important to measure the growth of units already established as a test of the vitality of the program. For this reason, the data assembled in Table No. 3 were obtained for those medical care groups which were operating both in June, 1940 and in June, 1941.

The experience of the 487 units for which records are available reveals a net increase of 10.6 percent in the number of enrolled families, with 36.5 percent of the eligible FSA families in the areas concerned not yet enrolled.

Although there was an over-all net increase of 10.6 percent in family enrollment, there was a decrease in the number of participating families in these established units in 13 of the 31 states represented.

The best over-all record was made by the groups in Regions III, IV, and VI. In Region III there was a net gain of 33.4 percent in the number of families enrolled, with no state in the Region showing a decreased enrollment. However, even with this gain, the total enrollment of these units at the end of this period was only 36 percent of the families eligible for a membership in the 47 counties covered. In Region VI there was a 30.3 percent gain, with no state showing a loss. In Region IV there was a 26.7 percent over-all gain in the number of members, despite the decrease in one state, Virginia.

The most unsatisfactory record with respect to these continuing units was made by Regions I, V, VII, and XII. In Region VII there was a 15.7 percent decrease in enrollment, with both states represented showing a loss. In Region XII there was a 6.1 percent decrease, with two out of five states showing losses. In Region I there were net losses in enrollment in three out of four states, although there was an over-all increase of 10.7 percent in the four states as a whole. Region V had a drop in enrollment in three out of four states, with an over-all net increase of 4.7 percent, but this must be considered in the light of the fact that the enrollment in these Region V units stood at 81 percent of all families eligible as of June, 1941.

Units Terminated During Fiscal Year. Excluding a number of medical care units suspended temporarily during the fiscal year and operating again by June, 1941, there were 44 units terminated during the year which had been in operation in June, 1940. These 44 units represented 8.1 percent of the 546 units in active operation at the outset of the fiscal year. The following table shows the experience of the seven regions in which the termination of units occurred.

No. of Units Operating in June, 1940 and No. and Percent of these Units Terminated During Fiscal Year 1940-1941

	Units June, 1940	Units Terminated	Percent Units Terminated
Region III	53	7	13.1
Region IV	61	8	13.1
Region V	162	6	3.7
Region VI	130	13	10.0
Region VIII	50	7	14.0
Region X	8	1	12.5
Region XII	31	2	6.5

Several reports concerning terminated units have indicated that renewal of the program could be expected after necessary readjustments had been effected. The future experience in the counties in which the 44 units were terminated or suspended will be observed closely.

Factors Underlying Membership Losses and Termination of Units. The factors underlying the decreases in membership in 13 states and in many units in the other 18 states cannot be evaluated authoritatively without further study and analysis. However, it is possible to discuss some of the more obvious factors as revealed by field experience of personnel engaged in medical care activities. In most instances these have been the same factors, somewhat intensified, that have been responsible for the suspension or termination of units. These factors may be related to the three interested groups: the FSA personnel, the families, and the physicians. It would be an error to consider these factors universal, as there are gratifying exceptions in many districts, but in varying degree they apply rather generally.

The shortcomings of FSA personnel sometimes encountered may be summed up as: (a) lack of thorough understanding of the medical care program; (b) failure to consider program an integral part of their rehabilitation efforts; (c) allowing pressure of other work to prevent giving adequate time to program; (d) apathy and indifference in some instances; (e) failure to provide for renewed participation in farm and home plans; (f) lack of effort to establish a close working relationship with physicians; and (g) viewpoint that the program is the sole responsibility of specialized personnel. These factors, which are inter-related, add up to a failure to assume proper responsibility for developing and maintaining the program. They have a direct bearing on the attitude of

borrowers toward the program. They are factors which operate in the regional and state offices as well as in the district and county offices.

Some of the factors underlying membership losses which pertain to the enrolled families include: (a) the understandable feeling, which may be subconscious, that they are not part of the plan, that the plan is superimposed and is not their plan — a feeling which stems from lack of direct representation during the planning stage and often during the operating stage — and the related factor of lack of sufficient knowledge of details of the plan and its purpose; (b) tendency to withdraw following a year when no medical service is needed; (c) disinclination to add further to their debt structure by borrowing funds for participation; and (d) family physician not taking part in plan.

There may be a direct relationship between a dwindling membership or a terminated unit and the local situation in the medical society or among individual physicians. Some of the more specific reasons underlying the termination of certain units are listed in the review of activities in Regions IV, VI, and VIII. Many difficulties have been due to a lack of understanding on the part of the physicians of the objectives not only of the medical care program but of the general rehabilitation program, a shortcoming which can hardly be blamed on the physicians. Some physicians find it difficult to adjust their thinking to the group prepayment principle. At times there has been trouble because physicians have treated the borrowers as though they were objects of relief or charity. In a number of instances units have been terminated or suspended as a direct result of disagreements between individual physicians or between factions in a county medical society. Many of these difficulties could be obviated if there were always a strong medical advisory or review committee with the courage of its convictions, and if the medical society and its members were willing to give the local plan a fair trial. It is generally true that smoothly running, successful plans are found to have strong medical advisory committees.

Another difficulty encountered recently is that of physicians leaving the rural areas to go into military service. Units have been terminated because of the sheer lack of available physicians in given areas. The defense activities have simply accentuated an existing problem relative to the shortage of rural physicians and the long distances which the few practicing physicians in many areas have to travel to make home calls.

Families in Program by FSA Classification. In assembling data relative to active medical care units, an effort has been made to secure accurate statements from the field regarding the enrollment of FSA families in various categories. Information regarding the number of eligible families and the number of enrolled families has been summarized in Table No. 4 for rural rehabilitation borrowers, resettlement project

occupants, other FSA (including tenant purchase) families, and non-FSA families. The figures given for eligible and enrolled "other FSA families" doubtless include certain categories of rehabilitation families other than active standard cases, as well as tenant purchase borrowers. The following is an abstract from Table No. 4 showing the breakdown of the enrolled group for the country as a whole and the percent of eligible families enrolled:

	Eligible Families in Counties with Units	No. of Families Enrolled	Percent Enrollment
Rehabilitation borrowers	157,071	98,263	62.6
Resettlement project occupants	1,663	1,037	62.4
Other FSA (including TP) families	11,583	3,813	32.9
Non-FSA families		1,111	
	170,317	104,224	60.5*

*Non-FSA membership omitted in computing this percentage.

All data in this part of the report are exclusive of data pertaining to medical care groups which restrict membership to resettlement project occupants. The data given above relative to resettlement project families are for those medical care units which combine resettlement families in their membership with rehabilitation and other FSA families. As of June, 1941, resettlement families from 40 resettlement projects were combined in units of this type with other families on the FSA rolls.

In addition to 1,037 resettlement project families enrolled in 40 combined units, 4,148 other project families were enrolled in 38 separate units as of June, 1941, making a total of 107,261 FSA families in 741 medical care groups, and a total of 108,372 member-families including non-FSA families.

The Farm Security Administration has not taken the initiative in connection with the enrollment of 1,111 non-FSA families in various units. This matter is duscussed in the review of activities in Montana, Nebraska and Utah. The addition of low income non-FSA families not only meets with the approval of the physicians in the few areas concerned, but it has been done at their request. Some of the 1,111 families are former FSA borrowers who have paid their loans in full but who are still entitled to medical services until their current memberships expire.

Percent of Eligible FSA Families Enrolled. That participation is voluntary in these 703 medical service plans requires no proof other than the fact that 60.5 percent of eligible FSA families in the 381 counties constituted the total FSA enrollment in the plans as of June 30, 1941.

The percentage of enrollment was over 60 percent in only two regions, and it was under 50 percent in five of the eleven regions with active units.

Percentage of Enrollment of FSA Families in Counties with Units

All Regions	60.5		
Region I	50.8	Region VIII	49.6
Region III	38.6	Region IX	56.5
Region IV	46.9	Region X	43.2
Region V	84.3	Region XI	45.3
Region VI	66.9	Region XII	56.3
Region VII	55.6		

The factors responsible for low participation in a given unit or in a region as a whole are much the same as those underlying membership losses or the termination of units. The battle for adequate participation is half-won when there are administrative determinations in a region which result in the realization that the health program is an integral part of rehabilitation. The battle finally will be won when FSA personnel not only come to this realization but when in translating it into action they draw upon the latent resources of the borrowers — the farmers and their wives. These families have within themselves largely untapped sources of interest, energy, and perseverance in this cause which affects them so directly.

Forms of Organization. In general, there are two fairly distinct forms of organization in the medical care units, trusteeships and health associations.

In a simple trusteeship there is no definite organization which the families join as members, although there may be an elected or selected "advisory committee" or "governing body" of borrowers representing their interests. The borrowers sign participation agreements designating someone as trustee to represent their interests and to administer the medical care fund. The trustee is usually a "neutral" person who is neither a borrower, a physician, nor an FSA representative.

Where health associations of borrowers have been organized, they are ordinarily informal, unincorporated associations. The boards of directors are elected by the members at county-wide or neighborhood meetings. In certain states there are FSA representatives on these boards. The medical care funds are administered either by the tresurer of the association who may as a rule be a non-member, or by a trustee approved by the board, the medical society and FSA representatives.

In some district plans, such as those in Montana, there is a health association unit in each county or in each area served by an FSA county office, with an over-all district association to deal with the physicians on a district basis. This type of organization provides a mechanism whereby local initiative and local responsibility are fostered.

As of June, 1941, trusteeships constituted the form of organization in 455 of the 703 medical care units exclusive of separate resettlement project units, and associations of borrowers had been organized in the 248 other units. All of the units in Regions I, III, IV, and V were trusteeships. All in Regions VII, VIII, IX, X, and XI were associations, many of them very informal in character. In Regions VI and XII there were both trusteeships and associations, there being a preponderance of associations in Region VI and a greater proportion of trusteeships in Region XII.

County, District and Statewide Units. Of 703 medical care units in operation in June, 1941, 623 or 88 percent were limited geographically to one county each. Of the remaining 80 units, 52 were two-county units, 14 were three-county units, nine extended to from four to six counties, and five comprised ten or more counties each. Two of the large district plans were statewide -- the Vermont program (14 counties) and the New Jersey program (members from 19 of the 21 counties). The other three large district units were in southwest Kansas, Montana, and South Dakota.

District plans covering more than one county are almost essential when there is a small, scattered caseload. Even when the caseload is substantial, there are obvious advantages inherent in district plans, related first to "spreading the risk," i.e., broadening the "insurance" base, and second, to simplifying the task of negotiating with professional groups which are frequently organized on a district basis. A small unit with but 50 or 60 member-families often operates with surprising stability in so far as the provision of general practitioner care is concerned, but it is necessary to have a broader base if hospitalization and surgical care bills are to be handled satisfactorily. Moreover, a district plan makes possible more efficient business administration, for it offers a substantial financial inducement to the trustee who administers the medical care fund.

The serious weakness of a poorly organized district plan is found in the lack of acceptance of responsibility by FSA personnel, borrowers, and physicians. The temptation to take shortcuts, to neglect the all-important educational work among these three groups locally, may ultimately prove disastrous. Local responsibility is fundamental. There must be local borrower representation, through a county association or committee constituting a unit of the larger organization, and there must be local advisory committees of physicians as well as an over-all district committee except in districts of moderate size with relatively

few physicians. If these conditions are to be met, local FSA personnel must play an active part -- the third factor essential to the successful operation of a district plan.

Scope of Services Offered in Medical Care Groups. Because of the limited ability of borrower families to pay for medical care, the emphasis during the early years of the program has necessarily been on providing primarily the care essential to the treatment of acute illness, but, in so far as possible, provision has also been made for the correction of chronic defects which constitute a retarding factor in rehabilitation.

The scope of services offered in each region is shown on the graph which follows Table No. 4. Moreover, Table No. 5 includes data relative to the various combinations of services which are offered in the various states and regions, and Table No. 6 indicates the scope of the service offered in each medical care unit. Although, in general, there is emphasis on developing plans covering services of the widest practicable scope and on expanding the services offered in existing plans, nevertheless there are certain regional and state differences in the scope of services offered which are due to a considerable extent to the availability outside of the FSA program of certain services for the medically indigent. For example, free or low cost hospitalization and surgical care are available to medically indigent families, including most FSA borrowers, in certain states such as Pennsylvania, North Carolina, Mississippi, and Louisiana.

It will be noted in Tables No. 5 and 6 that the services offered are broken down into five categories, i.e., physicnas' care, surgeons' care, hospitalization, drugs, and dental care.

"Physicians'" services may be taken to include those services ordinarily rendered by a general practitioner, that is, office, home, and obstetrical care.

"Surgeons'" services relate in many units strictly to major surgical services rendered hospitalized patients, as a rule, cases of an acute or emergency character. In some units this category of service includes not only surgical care but the care of other specialists or even of general practitioners rendered in the case of hospitalized patients.

"Hospital" service refers as a rule to ward care, and the benefits ordinarily include such services as the use of operating room and the performance of routine laboratory examinations. There is often a limitation in the number of days of care provided in a given case or provided for an individual or a family on an annual basis.

When "drugs" are listed as included in the services offered in a given unit, the implication is that some definite provision has been made for the furnishing of ordinary medicines, usually including prescribed drugs.

In a large number of other units, such drugs as the physicians themselves ordinarily dispense are included in the benefits even though "drugs" may not be listed among the services.

"Dental" care, when listed with the services provided in these medical care units, refers to very limited emergency dental care, usually extractions indicated to relieve pain or eradicate infection, except in a few units such as certain units in Region VII where $4 of each family's membership fee is set aside in a separate fund to pay for fillings for children as well as for emergency extractions. There is a definite trend toward developing separate dental care plans rather than including dental services in the medical care plans.

The following table shows for the 104,224 families enrolled in June, 1941, the number of families entitled to services in the five different categories and the percentage of all participating families entitled to each type of service:

Type of Service	No. of Families	Percent of Enrolled Families
Physicians' care	103,770	99.6
Surgeons' care	71,055	68.3
Hospitalization	64,492	61.8
Drugs	54,066	51.9
Dental care	15,493	14.9

In most medical care units there are limitations in the services provided in the case of chronic illness and pre-existing conditions. These limitations relate primarily to hospitalized cases, although some of the plans for general practitioner care include a limitation of but one office or home call per week in the case of chronic illness. An encouraging beginning, however, has been made in including those services essential to the treatment of chronic or pre-existing conditions which may constitute a hazard to the health of the individual or a retarding factor in rehabilitation. For example, the Montana program includes "all reasonable medical and surgical services", and the California program includes the care of any chronic conditions found in children under 18 years of age. Moreover, in certain other plans, such as those in effect in some counties in Region III and Region VII, and in the revised program in southwest Kansas in Region XII, provision is made for the necessary care of conditions threatening health or rehabilitation. It is noteworthy that in certain areas the physicians themselves are insisting that the local plans cover a scope of service broader than that now in effect.

Annual Membership Rates. In Table No. 5 the average annual membership rates are listed for different combinations of services in each state and region and in the United States as a whole. In Table No. 6 the average annual membership rate is given for each medical care unit.

Virtually all membership rates were determined locally by regional, state, and local FSA personnel in conference with the physicians concerned. But out of this wide variety of rates established for various combinations of services in widely scattered localities, there has come about a certain degree of uniformity in so far as the relationship is concerned between rates and services on the one hand, and, on the other, average family incomes in given states. The average family income for a given county or district could not be determined with accuracy, but the average family net incomes for the 1940 crop season for FSA borrowers in given states were used as a basis for the calculations, the results of which are set forth in Table No. 5. "Net income" means that income available to a family after farm operating expenses have been paid. It represents substantially more than the net cash income for it includes the value of products such as food and fuel produced on the farm for home consumption. If borrower participation rates for various medical services had been compared to net cash incomes, the percentages of incomes represented would have been substantially higher.

A review of Table No. 5 reveals that it would be reasonable to raise certain membership rates as the benefits of given plans are broadened. On the other hand, it is clear that family contributions will have to be supplemented as more-inclusive plans extend into certain needy areas. In this connection it must be borne in mind that since families have various legitimate medical expenditures over and above those represented by their membership fees, except in some unattained "ideal" program, it would be unfair for annual membership rates to represent the highest percentage of income which could be exacted. Moreover, program planners calculating family contribution rates in needy areas must never overlook the danger of forcing families to sacrifice other vital living standards, or neglect the possibility of intelligent subsidization when clearly indicated.

There is a tendency in certain regions to adopt flat membership rates. Even in those plans in which the rates vary with the size of family, the basis for setting the rates is in no sense an actuarial one but is rather a concession to the understandable feeling on the part of many families and physicians that the rate should be higher the more members there are in a given family. In a large number of plans there is a basic rate of $14 or $20, for example, for the farmer and his wife, with either $1 or $2 being charged for each dependent up to a certain maximum such as the rate for a family of eight or more. The membership rates listed in Table No. 5 and 6 do not take into account extra charges imposed in a few medical care units, such as an extran charge of $10 in Region I for each obstetrical case, and a small charge for the first home call in any illness in the California program.

Methods of Paying Professional Groups for Services. There is such variation in the matter of distributing funds to those rendering services that it is difficult to cite any common pattern evident

through the program as a whole. However, there are certain underlying features characteristic of the entire program. In the first place, the Farm Security Administration does not set the fees or rates to be charged by professional groups. Secondly, the review and auditing of bills is placed in the hands of committees representing the groups rendering the services.

Although not universal, there is a characteristic method of paying for the services of physicians. Ordinarily annual funds deposited by members for physicians' services are divided into equal monthly allotments. Approved bills for services in a given month are paid in full by the trustee if the allotment is sufficient. If bills cannot be paid in full, the allotment is distributed to the physicians on a pro rata basis, each physician receiving the same percentage of payment on his bills. As a rule, any monthly surpluses are held to the end of the fiscal year and applied against unpaid balances of physicians' bills, and then by agreement, bills are written off as paid in full. Some variations in this pattern may be cited: (a) there may be one pooled or common fund for office, home, and obstetrical care and another for surgical or other specialist care; (b) there may be one fund for all physicians' services, including surgical care; (c) allotments and payments may be on a quarterly rather than a monthly basis; (d) larger allotments may be provided for four or five winter months; (e) surpluses may be distributed to increase allotments for remainder of year or to increase allotments for winter months; (f) payments made throughout the year may be limited to 50 percent payment on approved bills, with the surplus distributed at the end of the year as a means of securing a more equitable distribution of the funds.

In 54 medical care groups in 55 counties, physicians are being paid on a capitation basis, i.e., in accordance with the number of families selecting them as family physicians rather than on the basis of the amount or type of service rendered each month. These units served 9332 families as of June, 1941, in Regions V, VI, IX, X, and XII. Each unit on a capitation basis is so listed in Table No. 6. In each instance, the local medical society has itself adopted this method of payment in preference to the usual type of pooled fund plan. It is still too early to judge whether this kind of plan will operate to the satisfaction of both patients and physicians and whether it will meet the family needs more adequately than plans of the other type.

Hospital bills are paid in various ways, including (a) having a separate pooled fund, with the hospitals agreeing to accept partial payment if necessary; (b) having a fund combined with the surgical care allotment, with bills being paid from the same fund for both hospitalization and surgical care; (c) having all funds for a month pooled in a single allotment, with hospital bills within certain limits being handled as preferred charges paid in full prior to further distribution of the allotment; (d) having all funds in one general allotment, but with hospi-

tals accepting the same pro rata reduction in bills as the other professional groups; (e) having the whole matter of payments to hospitals handled by an existing group hospitalization plan.

The provision of prescribed drugs has proved to be a rather perplexing matter. There is a tendency to limit drugs to U. S. Pharmacopoeia and National Formulary preparations, and to exclude unusual or expensive products such as biologicals and vitamin concentrates. Some of the ways in which payment for drugs is being handled are as follows: (a) having a pooled fund combined with the general practitioner care fund, with druggists taking the same pro rata reduction, if necessary, as the physicians, or with druggists guaranteed a certain minimum "cost plus" payment; (b) having physicians include charges for prescriptions in their bills, making their own arrangements with local druggists; (c) making drug bills preferred charges, paid in full before physicians are paid; (d) having separate pooled fund from which full or partial payment of drug bills is made.

Impact of the Program on Medical Profession. Through development of the medical care program the medical purchasing power of substantial groups of rural families has been increased, thus helping to maintain medical facilities in areas threatened by a continued diminution in such facilities. Studies of the medical care expenditures of FSA borrowers indicate that their past expenditures were uniformly lower than their current expenditures through the program.

There have been instances where physicians have moved into medically needy areas because of the organization of medical care groups of FSA borrowers. There have been other instances where physicians have been induced to hold regular office hours in localities previously without such service.

It is not known whether the development of the program has resulted in the actual organization of local medical societies, but there have been repeated instances of renewed activity in medical societies which were previously morbid if not moribund. It must be acknowledged that the somewhat controversial aspect which physicians commonly see at first in the program may have had something to do with this rejuvenation of medical societies, but whatever the primary cause, there has resulted an awakened interest in medical society action. It is not unusual for an FSA representative to encounter "the largest society meeting in years" when the FSA program is on the agenda. Not unusual was the report of a society secretary that for the first time in many years every doctor in the county had joined the society, a result which he ascribed largely to the FSA program.

It is clear that the program is playing an active part in awakening physicians to the needs of medically indigent rural families. They are learning that they have the opportunity to meet these needs and at the

same time to receive extra income from a relatively new source. They are learning, by doing, to assume their rightful responsibility toward the medical aspects of organized medical services. They have seen that they can work with a governmental agency without its trying to dominate them.

At the meeting of the American Medical Association held in Cleveland, Ohio, June 2 to 6, 1941, two reports were submitted to the House of Delegates that mentioned the medical care program of the Farm Security Administration. The report of the Committee on Legislative Activities included the following statement: "Any plan to promote improvement in the collective family health among Farm Security Administration clients should redound to the general benefit. The aid given farm families which improves their economic condition and enables them to liquidate their obligations later has a sound economic basis. If the aforementioned rehabilitation plan is developed, it should receive the approval of the component county medical society and should be accomplished through that society." The report of the Reference Committee on Legislation and Public Relations expressed "highest approval" of the "policy of arriving at understandings with constituent state medical societies," noted with pleasure the report of the rehabilitation medical work, and stated: "Any attempt to restore health and self respect to American families and to preserve individuality, independence and security is to be commended."

Review of Medical Care Activities in the Twelve Regions. In the following pages is given a review of medical care developments in each Region. Reference to separate resettlement project programs, dental care plans and the health program for migratory agricultural workers will be found elsewhere in this report. The following review relates primarily to medical care activities on behalf of FSA borrowers.

Region I

Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire New Jersey, New York, Pennsylvania, Rhode Island, Vermont

During the fiscal year ending June 30, 1941, there were no significant developments relative to working agreements or understandings with the various state medical associations in Region I. Satisfactory agreements were already in effect with the associations in the seven states in which activities were concentrated during the year. Because of the relatively small number of borrowers and the rather highly industrialized character of most of the areas involved, efforts directed toward obtaining working agreements with state medical associations were postponed in Massachusetts, Connecticut Rhode Island, and Delaware.

At the end of the previous fiscal year, there were only 4 medical care groups in operation in Region I, there being one each in New Hampshire, New Jersey, Pennsylvania, and Vermont. These 4 plans extended to 19 counties but covered only 540 families or 2746 persons.

By the end of June, 1941, 11 medical care units were in effect in Region I covering 46 counties in 5 states, the state added during the year being New York, with 3 units in 4 counties. Aside from the new plans in New York, the expansion of the program in Region I was found for the most part in New Jersey and Pennsylvania. The 11 groups included 1597 families or 7841 persons, representing an increase of 196 percent over the number of families participating the previous fiscal year.

The growth of the medical care program in Region I from the time when the first county unit was established in New Jersey is shown in the following table:

No. of Counties with Medical Care Groups of FSA Borrowers

	June 1939	June 1940	June 1941
New Hampshire		2	2
New Jersey	1	1	19
New York			4
Pennsylvania		2	7
Vermont		14	14
	1	19	46

Although it is gratifying to note the increase in participating families and in the number of counties to which the program was extended during the past fiscal year, the responsibility for more concentrated efforts in connection with the plans already organized is seen in the fact that in 46 counties covered, only 50.8 percent of the borrowers eligible for participation in the plans are actually enrolled. Moreover, in 3 of the 4 units which were operating in Region I as of June, 1940, there was a decrease in the number of families participating, representing a decrease of 12 percent in New Hampshire, 18 percent in New Jersey (Atlantic County), and 10 percent in Pennsylvania. This situation is hardly mitigated by the fact that an increase of 23 percent in the number of families participating in Vermont counterbalanced other losses, making a net increase of 10.7 percent in the number of families participating in units which were in effect both in June, 1940 and in June, 1941.

Aside from two medical care plans in New York which include hospitalization and surgical and specialist care, the various plans in effect in Region I provide general practitioner care at annual rates which ordinarily range from $16 for a couple to $20 for a family of six or more. On the basis of studies directed toward ascertaining the actual experience of the families involved, efforts are being made to extend certain plans in the region to include hospitalization and the services of surgeons and other specialists.

The form of organization in Region I is a simple trusteeship, the trustee ordinarily being a "neutral" person rather than a representative of the borrowers, the physicians or the Farm Security Administration. Committees of borrowers are being organized to serve in an advisory capacity and thoughts are being directed toward the organization of health associations to provide an opportunity for the borrowers to take a more active part in the program.

Maine. Although a working agreement was reached with the Maine Medical Association at the end of the previous fiscal year, it was possible to devote only a limited amount of time to promoting the development of a medical care program in Maine during the year. By June, 1941, certain preliminary steps had been taken toward developing a district plan providing rather comprehensive services in a six-county area centering around the city of Bangor.

Maryland. The first medical care plan to be developed in Maryland was approved toward the end of the fiscal year by county medical societies in Queen Annes, Caroline and Kent Counties. This plan, which was to include general practitioner care and prescribed drugs, was expected to begin operations on July 1, 1941.

New Hampshire. The district plan which had been in effect in Grafton and Cheshire Counties since January, 1940, ended the fiscal year with a 12 percent loss of membership. The number of families participating was

only 41 percent of the total number of borrowers eligible in the two counties. Steps necessary to improve this situation were being studied at the end of the fiscal year.

The Coos County Medical Society, in April, 1941, approved the development of a plan which would be an independent unit. It was not yet in operation at the end of the fiscal year.

New Jersey. The Medical Service Administration of New Jersey is administering a statewide plan for Farm Security Administration borrowers which represents an expansion of the general practitioner care plan in effect previously in Atlantic County. This plan, which is based on annual participation rates of from $16 for a couple to $20 for a family of 6 or more, went into operation on May 1, 1941. At the end of the fiscal year, 397 families were enrolled in the plan, representing 19 of the 21 counties in the State. Only 43 percent of all families eligible were enrolled.

New York. The first units organized in New York State commenced operations during the past fiscal year, 2 units covering 3 counties having started in July, 1940, and the third in April, 1941. Two of these units (Washington and Chenango Counties) in addition to general practitioner care include hospitalization and surgical and specialist care limited to acute conditions. The hospitalization plan in effect in Washington County is based on an annual rate of $10 per family for 14 days' ward care per person, with a limit of 28 days per family. In this plan, approved hospital bills were paid in full at charges which averaged about $4 per patient-day and a small surplus was available at the end of the year to serve as a reserve fund for the following year.

Another type of hospitalization plan is in effect in Chenango County. The borrowers have joined the hospitalization plan in the area which has an annual family rate for ward care of $10.92, covering 18 days per person. In this plan, administered by Hospital Plan, Inc., dependents other than young children must pay an additional $1 per day when hospitalized.

At the end of the fiscal year a program was being developed in the western part of New York which might be administered by Western New York Medical Plan, Inc.. Approval of this plan had already been secured from 4 of the 6 county medical societies concerned. Another plan in New York, that in St. Lawrence County, had also been approved and it was expected to start operations on July 1.

Pennsylvania. Fairly satisfactory progress was made in Pennsylvania during the fiscal year, there being an increase from one plan in 2 counties to 5 plans covering 7 counties. Although these plans differ somewhat in detail, they all provide general practitioner care at rates ranging from $16 to $20 per family. As of June 30, 1941, 390 families

were enrolled in these plans, representing 55 percent of the borrower families eligible.

At the end of the year the medical societies in two other counties had approved plans to begin operation by September 1, 1941, and negotiations were in progress with two other medical societies. The aim was to extend the program to approximately 30 additional counties during the coming fiscal year.

Vermont. The 14-county statewide program in Vermont completed its second year of operation on June 30, 1941. Although there had been an increase of 23 percent in the number of participating families during the fiscal year, the number enrolled at the end of the year represented only 51 percent of the total number of families eligible.

It was expected that during the coming fiscal year steps would be taken to add hospitalization and surgical and other specialist care to the services available through the plan, thus increasing its effectiveness as a source of protection to the families enrolled.

Region II

Michigan, Minnesota, Wisconsin

Although several dental care plans were in effect in Michigan and Wisconsin by June, 1941, there were no medical care plans in actual operation in either of these states or in Minnesota. Nevertheless, definite progress had been made during the fiscal year and the approval of the medical profession had been secured for the establishment of plans for borrower families in Michigan and Minnesota.

Michigan. Negotiations with the Michigan State Medical Society had been undertaken first in 1938, but no definite working agreement was secured until the past fiscal year. This long delay was due to activities of the Society directed toward setting up a statewide pre-payment plan for low income groups. Pending the organization of such a plan, the State Medical Society had been unwilling to cooperate in organizing plans to meet the special needs of FSA borrowers. After enabling legislation was secured, the Michigan Medical Service, Inc., was organized in 1939, and shortly thereafter it offered a prepayment plan providing physicians' services to families with gross incomes of $2,500 or less, at an annual rate of $54 for a family of average size. Since this plan was based on participation rates well beyond the ability of FSA borrowers to pay, negotiations during the past fiscal year were directed toward securing the cooperation of the Michigan Medical Service in administering a special program for FSA borrowers at a rate commensurate with their average incomes.

In October, 1940, the Michigan State Medical Society approved the negotiations between the FSA and the Michigan Medical Service which finally resulted in a specific agreement in May, 1941. At that time, the Board of Directors of the Michigan Medical Service approved a plan to be put into effect on a trial basis in one county, the thought being that it might be extended to other counties as soon as the original plan had proved reasonably sound. The plan offered was similar to the regular $54 plan but was to be made available to FSA borrowers at an annual rate of $26.50 per family. The plan is to cover medical and surgical care in the office, home and hospital, including services rendered by such specialists as radiologists and pathologists. Obstetrical benefits are excluded during the first year of participation of any family. In general, the services are limited to care in acute conditions but upon the recommendation of any physician a case with some chronic or pre-existing condition may be reviewed by the Medical Advisory Board when it is felt that the health of the patient is seriously affected or the rehabilitation of the family retarded. It is understood that the Medical Advisory Board will be liberal in approving corrective treatment for such cases.

At the end of the fiscal year, an effort was being made to organize this plan on a trial basis in one county in the state. Once the plan proved successful the objective was to extend it to at least one county in each FSA district before the end of the next fiscal year. Another aim for the coming year was to find some solution to the problem of providing hospitalization at a cost within the ability of the families to pay. It was expected that there would be further negotiations with the Michigan Society for Group Hospitalization although the Society had taken the position in the past that it could not consider sponsoring a plan which would cost less than its regular $18 rate.

Minnesota. Following a period of intermittent negotiations with the Minnesota State Medical Association, extending back to 1938, the Association in February, 1941, approved the establishment of medical care plans for borrower families to be on a trial basis in three counties. By the end of the fiscal year, the Morrison and Otter Tail County Medical Societies had approved a plan providing physicians' services and surgical care for acute conditions at an annual rate of $23 per family. Approximately 250 families had signed participation agreements for these two plans which were expected to start operations on August 1. If these plans proved successful, the State Medical Association agreed that permission would be extended to FSA representatives to approach other county medical societies throughout the state.

Wisconsin. The only understanding with the State Medical Society of Wisconsin is that extending back to January, 1938, which provided that the various county medical societies would cooperate in setting fees for the borrowers at the level of the FERA fee schedule. The State Society has been unwilling in the past to agree to plans based on the insurance principle and during the past fiscal year there were no particular negotiations with the State Society for the purpose of effecting a more

satisfactory agreement. It was recognized in Region II that it would be helpful in connection with the negotiations in Wisconsin, as well as in other states, if a full-time regional medical officer might be employed. At the end of the fiscal year there was provision in the regional budget for such assistance, and it was expected that a regional medical officer would be on duty during the coming fiscal year.

Pending the securing of an agreement with the State Medical Society, the FSA borrowers in Oconto County were approached toward the end of the fiscal year with reference to their possible interest in taking part in a medical care plan. The interest among the families was such that the enrollment of 118 families was secured without delay. Representatives of these families approached the County Medical Society just before the end of the fiscal year, and the society agreed to take up the matter at a meeting to be held in July.

Region III

Illinois, Indiana, Iowa, Missouri, Ohio

The thorough organizational work which has been emphasized in Region III resulted in healthy growth of the medical care program during the fiscal year 1940-41, particularly in Missouri and Ohio. There is evidence that Farm Security Administration personnel from the regional and state levels to the district and county levels have become better informed concerning the program and that they are not only interested in it but are cooperating actively in its promotion. Doubtless the expansion of the program has been aided by the adoption of uniform policies and the formulation of a uniform plan of operation which is used throughout the region.

During the fiscal year there was general improvement in relationships with the various state medical associations. The original agreements between the Farm Security Administration and these associations were strengthened during the year, particularly in Missouri.

The number of medical care groups in Region III, the number of counties covered, and the number of families participating were all more than doubled during the past year. In June, 1940, 53 units were in operation in 55 counties in the 5 states, and these plans covered 2766 families or 13,064 persons. As of June, 1941, there had been an increase to 111 different units in 116 counties, covering 7519 families or 36,499 persons. There was an increase of 172 percent in the number of participating families. These figures represent net increases, taking into account the fact that 7 county units were terminated during the year. Although the membership of the medical care units which were in operation both in June, 1940 and in June, 1941 increased by 33 percent, the total

number of families participating in all of the units in the region in June, 1941 represented only 38.6 percent of the families eligible to participate in the areas involed.

The following table shows not only those states in which the greatest expansion took place during the past year, but gives a general picture of the growth of the program in Region III from its beginning in 1937:

No. of Counties with Medical Care Groups of FSA Borrowers

	June 1937	June 1938	June 1939	June 1940	June 1941
Illinois				5	10
Indiana			5	4	6
Iowa	1	2	3	1	3
Missouri		2	12	28	56
Ohio		1	11	17	41
	1	5	31	55	116

With very few exceptions, a uniform plan is being put into effect in Region III which provides physicians' services including the services of surgeons and other specialists. Although surgical work is confined largely to the treatment of acute conditions, corrective surgery falls within the benefits of many of the plans when a given condition threatens the health or rehabilitation of the individual concerned. In general, there is a flat annual charge of $23 per family for these services, with $16 being allocated for physicians' care, $6 for surgeons' services and $1 for administrative expenses. In a few counties, $23 is the maximum rate, with slightly lower rates for small families.

The trusteeship form of organization is followed, with a committee of three physicians to supervise medical aspects of the plan, and with a governing body of from five to seven borrowers elected by the membership to represent different areas in the county. A trustee is appointed by the governing body of borrowers, subject to the approval of the physicians' committee and the local representatives of the Farm Security Administration.

In the Annual Report for the fiscal year 1939-40 it was noted that there were only 8 county units still on the basis of individual participation which was once characteristic of Region III plans. This number had dwindled by June, 1941 to only 5 such plans, 3 in Missouri and 2 in Ohio. The process of converting plans of the individual type to plans based on the insurance principle has thus been almost completed.

Illinois. Despite the termination of one county program in Illinois during the fiscal year, there was a net increase from 5 county units to 9 units in 10 counties. There was an increase of 76 percent in the number of participating families, 643 being enrolled as of June, 1941. The active organization of medical care units was in process at the end of the year in 26 additional counties.

Indiana. Relatively little progress was made in Indiana during the fiscal year, there being an increase from 3 units in 4 counties to 5 units in 6 counties, with 207 families enrolled as of June, 1941, representing 29 percent of the families eligible in the 6 counties. It is encouraging to record the fact, however, that 46 additional county units were in the process of being organized at the end of the year.

Iowa. At the end of the previous fiscal year there was only one plan in operation in Iowa, and as of June, 1941, there were 3 plans in effect covering 335 families. These 3 plans taken together have the highest percentage of eligible families enrolled of any state in the region, namely, 59 percent. However, the one plan which operated throughout the year showed only a 3 percent gain in membership.

Missouri. A very good working relationship has been established between representatives of the Farm Security Administration and the Missouri State Medical Association. As an example, representatives of the State Medical Association have agreed to attend meetings of medical societies at the request of the Farm Security Administration in cases where there is apparent misunderstanding of the program on the part of physicians in local societies. This spirit of active cooperation is one of the factors accounting for expansion of the program in Missouri from 27 medical care units in 28 counties to 54 units in 56 counties. As of June, 1941, 3492 families were enrolled in the various units, representing a net increase of 171 percent over the previous year. This takes into account the loss of 6 county units terminated during the year.

Even though there has been satisfactory growth in the number of medical care units in Missouri, there is a serious problem to be faced relative to the number of families actually enrolled in the areas to which the program extends. Only 32 percent of the total number of eligible families were enrolled as of June, 1941.

A promising development for the coming fiscal year is the prospective development of a 7-county program in Southeast Missouri which would include rather comprehensive health services. The general plan is to charge families at an annual rate of $42 for the ordinary services being developed or under consideration for early development in the region. These services would include physicians' care at $16, surgeons' care at $6, hospitalization at $8, limited dental care at $6, prescribed drugs at $5, and the remaining $1 for administrative expenses. In addition, it is contemplated that the program would provide for the correction of certain chronic conditions over a period of time at an annual cost of $7 per family for certain types of corrective work, and $2 per family for eye glasses. A dental trailer would operate in the area and a public health nurse would be employed by the proposed association to serve in each county. There would also

be direct financial support of a laboratory to be administered by the State Health Department. These various services would cost an average of $16.65 per family in addition to the $42 referred to, or a total of $58.65 per family. This program, which is designed to meet the needs of over 4000 FSA families of various categories in the area, would have to be rather heavily subsidized at first. All families able to do so would be requested to pay $42 toward the total cost, or as large a portion of the $42 as possible.

Ohio. Substantial progress was made in Ohio during the fiscal year, there being an increase from 17 county units to a total of 40 units in 41 counties. The number of families increased by 205 percent to a total of 2842 families enrolled as of June, 1941. That further expansion of the program is imminent is seen in the fact that 30 additional county units were in the process of organization at the end of the year. If the objective of organizing plans in these counties is attained in the coming fiscal year, it will mean that the program has been extended to 71 out of a total of 88 counties in the state.

Region IV

Kentucky, North Carolina, Tennessee, Virginia, West Virginia

Recently the understanding with the Kentucky State Medical Association was broadened to cover plans providing surgical care and hospitalization as well as general practitioner care. At the end of the fiscal year there was a foundation of satisfactory working agreements with all five state medical associations in Region IV. Moreover, local professional groups were, with few exceptions, proving to be very cooperative.

During the year there was an increase in Region IV from 61 medical care units in 84 counties to 77 units in 102 counties. There was a 55 percent increase in the number of participating families, bringing the total number of member families up to 7912--over 45,000 persons. These gains were made despite the termination of 8 units covering 17 counties, a lapse in activity which was felt to be only temporary in most instances. Gains during the year can be measured only partially by the figures given, for as of the end of June various county medical societies in all five states had approved units to go into operation in 32 counties early in the following fiscal year.

The chief causes underlying the termination of 8 units in Region IV illustrate rather graphically some of the problems faced. They may be summarized as follows: Plan A--misunderstanding over provision of drugs; physicians paid for drugs they prescribed, and not enough money left to satisfy physicians. Plan B--physicians wanted 100 percent

payment. Plan C--physicians collected fees on the side and the plan was suspended by FSA action. Plan D--review committee of physicians "approved any and all bills presented"; also some abuse by families. Plan E--physicians skeptical from the start and did not give plan fair trial. Plan F--unit dwindled and finally was suspended due to apathy on part of local FSA personnel using the excuse that the families were unable to pay the cost. Plan G--a district plan too loosely organized, without local responsibility; defense activities keeping physicians busy in other than rural areas. Plan H--the only physician in the rural area called to military service.

The following table shows how the Region IV program has developed since the fiscal year 1938-1939:

No. of Counties with Medical Care Groups of FSA Borrowers

	June 1939	June 1940	June 1941
Kentucky		4	3
North Carolina	10	35	38
Tennessee	7	10	20
Virginia	8	28	34
West Virginia		7	7
	25	84	102

Counting the number of counties to which the program has been extended does not give the measure of the extent to which needs are being met. The number of participating families in Region IV could be more than doubled within the 102 counties in which plans are already operating.

In Region IV there are trusteeships rather than associations of borrowers. In general, there is a separate allotment of funds for each type of service; for example, an allotment for general practitioner care and other allotments for surgical care and for hospitalization when these services are included in the plan. Advisory committees of borrowers have been elected at group meetings in certain counties, but these committees are not yet as active as would be desirable.

Kentucky. The chief activity in Kentucky during the year was that of working with both the Farm Security Administration personnel and the medical profession on the preliminary ground work essential to the expansion of the program. Although only 3 county units covering 277 families were operating in June, medical society approval had been secured for 14 additional units to be started early the following fiscal year.

North Carolina. Because of the suspension of units in 6 counties, believed to be temporary, there was a net gain of only 3 counties during the year. However, there was a net increase of over 10,000 persons,

bringing the enrollment up to 59 percent of the families eligible in the counties organized.

Almost all of the North Carolina plans are confined to general practitioner care. Hospitalization is handled for the most part on an individual case basis through the cooperation of county welfare departments. The local welfare agency certifies that a given case is entitled to welfare rates, ordinarily about $2 per day, and in such instances there is no charge for medical or surgical services provided in the hospitals.

Tennessee. The greatest expansion of the program in the region was recorded in Tennessee, with a net increase from 8 units in 10 counties to 17 units in 20 counties. There was an increase of 166 percent in the number of participating families. At the end of the year 7 additional county units were ready to commence operations. Activities in Tennessee have taken a new lease on life with the new state FSA policy that provision be made for medical care participation in all new farm and home plans and that additional efforts be directed toward enrolling old borrowers through group meetings.

Virginia. Despite the suspension of the 9-county district plan in Southwest Virginia, there was a net gain during the year from 13 medical care units in 28 counties to 17 units in 34 counties, with 1359 families enrolled as of June, 1941. The chief reasons underlying the suspension of the district plan were cited above in the reference to "Plan C".

The chief problem faced in Virginia is that of inadequate enrollment of families in the areas to which the program has been extended. The number of enrolled families represents only 33 percent of those eligible. Moreover, there was a decrease of 12.5 percent in the number of families participating in the 11 units which were operating both in June, 1940 and in June, 1941.

West Virginia. As of June, 1941, the only units operating in West Virginia were the 7 county units which had been started in the spring of 1940, but 7 additional plans had been approved by medical societies to go into operation early in the next fiscal year.

The same difficulty encountered in Virginia, that of enrolling a substantial proportion of the borrowers, is found in West Virginia. Even though there was in increase of 78 percent in the number of participating families during the past year, there was still only 32 percent participation at the end of the year based on the total number of eligible families.

Region V

Alabama, Florida, Georgia, South Carolina

The past fiscal year has seen the continuation in Region V of the previous year's period of consolidation, with slower expansion of the program than in 1938-39 when there were such rapid developments. There was an increase during the year from 162 medical care groups in 164 counties to 181 groups in 187 counties. There was a 13 percent net increase in the total number of families enrolled, with 33,285 families - over 180,000 persons - taking part as of June, 1941. Most of the expansion took place in Alabama and Georgia, there being an increase of almost 3,000 families in Alabama and more than 1,000 families in Georgia. Only 6 county units were terminated during the fiscal year, a "morality" of less than 4 percent. A number of the units which had been terminated during previous periods were reinstituted.

Growth of the program in Region V from the organization of the unit in Harris County, Georgia, in March, 1936, is illustrated in the following table:

No. of Counties with Medical Care Groups of FSA Borrowers

	June '36	June '37	June '38	June '39	June '40	June '41
Alabama			3	23	23	40
Florida				5	5	6
Georgia	1	2	3	108	108	121
S. Carolina				17	18	20
	1	2	6	153	164	187

The record which Region V has made in enrolling a large proportion of eligible families is outstanding. As of June, 1941, the enrollment stood at 84 percent of the total number of families eligible in the counties to which the program extended. This favorable situation is the direct result of the regional policy relative to including an appropriate amount for medical care participation in farm and home plans. Participation in the medical care program is not compulsory but when funds for participation are set up in a family's plan, there is more than ordinary inducement to the family to become enrolled.

In those medical care groups which were operating both in June, 1940 and in June, 1941, for which complete reports are available, there was an average increase of 4.7 percent in the number of families enrolled. An increase of 16 percent in Alabama saved the region as a whole from a rather poor record with respect to these plans which operated throughout the year for there was a decrease of 1 percent in the number of families in Georgia units, a decrease of 10 percent in the South Carolina units, and a decrease of 13 percent in the number of enrolled families in the Florida units.

Almost 90 percent of the families enrolled in Region V are in medical care groups which have limited hospitalization and surgical care benefits as well as general practitioner care. Provision for ordinary drugs is made in about 80 percent of the units in the region. The average annual participation rates are about $17 per family in Alabama and about $15 per family in Florida, Georgia and South Carolina. The usual method of allocating funds is to set aside 20 percent of the total annual funds deposited by the families in an account from which payment is made for emergency hospitalization cases. From this account, payments are made both to hospitals and to surgeons insofar as funds are available. As a rule, 80 percent of the total funds deposited is allocated for general practitioner care and the provision of ordinary drugs.

There has been an interesting increase in the number of medical care units in which physicians are paid on a capitation basis. In plans of this type, the physicians are paid in accordance with the number of families utilizing their services as family physicians, rather than in accordance with the number of items of service rendered. The number of units on a capitation basis in Region V increased from 6 the previous year to a total of 26 in Alabama, Georgia and South Carolina as of June, 1941. As a rule, the capitation fee paid to the physicians covers both general practitioner care and ordinary drugs. The two most prevalent methods of handling the provision of drugs under the capitation plan are for the physicians to dispense drugs themselves and for the physicians to make arrangements with local druggists whereby the druggists are reimbursed by the physicians for the drugs prescribed. Several county units discontinued in previous periods have been reinstituted by having them change over to the capitation plan.

The form of organization of medical care units in Region V is that of simple trusteeships. The need for more active family participation in the activities of the units is acknowledged.

Alabama. There was an increase from 33 county units to 40 during the fiscal year, with a 25 percent increase in the number of families enrolled. Only 2 county units were terminated during the period, and the experience relative to reinstituting suspended plans has always been good in this State. Alabama is the only state in the region in which there was an increase in the number of enrolled families in those units which were operating both in 1940 and in 1941, there being an increase of 16 percent, bringing the proportion of those enrolled up to 90 percent of the families eligible in the counties covered.

Every medical care group in Alabama provides limited hospitalization and emergency surgical care as well as general practitioner care and drugs. The rates are somewhat higher than they are in other states in the region, averaging anout $17 per family. At the end of the year there were 8 units on a capitation basis, a natural spread of this type of plan from its focus in Wilcox County.

Florida. Difficulties are still being encountered in expanding the program in Florida. At the end of the previous fiscal year 5 county units were in operation, and with 2 county units being terminated during the year and other counties added, there were 4 units in 6 counties operating in June, 1941. Only 320 families were enrolled in these groups, representing a decrease of 44 percent from the number of families enrolled the previous year. In the 3 groups which operated both in June, 1940 and in June, 1941, for which records are available, there was a 13 percent decrease in the number of participating families.

Georgia. There was further growth of the program in Georgia during the year, with an increase from 106 units in 108 counties to 117 units in 121 counties. There was a net increase of 7.6 percent in the number of families enrolled, bringing the total number up to over 15,000. Only one group was suspended during the year, and this took place in a county in which only one physician is located.

There are 13 medical care groups in Georgia on a capitation basis, some of them representing units which had previously operated in a very unsatisfactory manner on a fee-for-service basis.

South Carolina. Although the number of county units in South Carolina increased from 18 to 20 during the past year, there was a slight decrease in the total number of families enrolled. In those units which operated throughout the year there was a 10.1 percent loss in the number of participating families. As of June, 1941, 5 additional county medical societies had approved plans which were to go into operation early the following year.

In two counties in South Carolina in which there has been a delay in arranging for physicians' services on a prepayment basis, an interesting plan has been developed to cover emergency hospitalization and surgery. In one of these counties the families pool $5 each, and in the other $3 each, creating a special fund from which payments are made when catastrophic illnesses occur. It is felt in the region that this type of plan may reduce the necessity for direct financial assistance to families pending the development of more complete plans and that it may be easier to institute plans of the ordinary type once these limited arrangements have proved their worth.

Region VI

Arkansas, Louisiana, Mississippi

As in 1939-40 there was definite expansion of the medical care program in Louisiana, with Mississippi sharing the honors during the past year. There was evidence of more general acceptance of the program on the part of the medical profession in these two states and in Arkansas.

In Region VI as a whole, there was a net increase during the fiscal year from 130 units in 131 counties to 146 units in 148 counties. The program was thus extended to two-thirds of the 221 counties in the region. Moreover, there was a net increase of 48% in the number of families covered, with a total of 29,372 families or about 150,000 persons enrolled in the program as of June, 1941. These families represented 67 percent of all families eligible in the counties in which units have been organized.

These gains were made in Region VI despite the fact that 13 county units, or 10 percent of all units operating in June, 1940, were suspended during the past fiscal year. The factors underlying the suspension of these units include the following: (a) disagreeing factions in medical society; (b) indifference of physicians toward program; (c) physicians concentrated in the towns, or too few physicians in the county, with borrowers widely scattered in the rural areas; (d) disagreement between physicians and druggists; (e) failure of FSA personnel to set up participation funds in family budgets; (f) refusal of physicians to accept Tenant Purchase families on the program.

Region VI includes some of the oldest plans organized for FSA borrowers in the United States. With Region V, it has certain plans which commenced operations in 1936. The following table shows the expansion of the program in the region from its beginning:

No. of Counties with Medical Care Groups of FSA Borrowers

	June '36	June '37	June '38	June '39	June '40	June '41
Arkansas	5	14	56	67	68	59
Louisiana	-	-	1	7	21	30
Mississippi	2	3	3	38	42	59
	7	17	60	112	131	148

It is usually a healthy sign when medical care groups gain in membership. Region VI has an excellent record in this respect. In those groups which were operating both in June, 1940 and in June, 1941, there was a 30 percent increase in the number of enrolled families, bringing the total in these units up to 66.7 percent of the families eligible in the areas concerned.

Various combinations of services are offered in the plans in Region VI. In general, the services in Arkansas include limited hospitalization and emergency surgical care as well as general practitioner care. As a rule, 80 percent of total funds is set aside to pay family physicians for their services and the remaining 20 percent constitutes a separate fund from which payments are made insofar as it is possible for hospitalized cases.

The provision of drugs has been eliminated for the most part from the Arkansas program. In many instances additional small loans are made to the families to enable them to pay for drugs on an individual basis. In most of the units in Louisiana and Mississippi provision for hospitalization is omitted because of the availability of Charity Hospitals in Louisiana and because of state appropriations for hospitalization of the medically indigent in Mississippi. The latter arrangement is rather unsatisfactory and it is expected that eventually provision will be made for hospitalized cases in the Mississippi plans.

Almost all of the units in Arkansas are organized as unincorporated health associations. In Louisiana there are trusteeships and in Mississippi there tend to be associations in most of the older plans and trusteeships in those units organized recently. Whatever the form of organization, an effort is being made to see that the borrowers have representation either on boards of directors of the associations or on advisory committees in the case of the trusteeships. These boards or committees usually include from 3 to 7 borrowers chosen by the families either in county-wide or in neighborhood meetings. One of the chief functions of these committees is that of appointing trustees. It is recognized that neither the boards of directors nor the advisory committees are as active as would be desirable, and more stress is being laid on group action.

Arkansas. Although there was a decrease from 68 county units to 60 separate units in 59 counties, the groups in 9 counties having been suspended, nevertheless there was a net increase in the number of enrolled families in Arkansas with 11,624 families or 57,214 persons being enrolled at the end of June. This represented an increase of 6.5 percent in the total number of participating families, and the June total represented 65.6 percent of all families eligible in the counties concerned. Moreover, there was an increase of 14.3 percent in the number of families in units which were operating both in June, 1940 and in June, 1941.

At the end of the fiscal year efforts were being directed toward solving the problem of providing hospitalization. The State Hospital Association had agreed to appoint a committee to work with the Farm Security Administration in developing a mutually satisfactory program. The group hospitalization organization in Arkansas had shown considerable interest in developing a special plan based on annual payments of $12 per family. It was possible that during the coming year a somewhat more adequate arrangement for hospitalization than that existing in the past would be tried on an experimental basis in the county units, with families paying from $5 to $7 annually for certain limited benefits.

As of June, 1941, two county units in Arkansas were paying physicians on a capitation basis. Representatives of the State Medical Society, while not approving plans on this basis, had given permission for such plans to be developed upon the request of the county medical societies.

Louisiana. There was an increase of 111.5% in the number of participating families in Louisiana, with growth of the program from 21 to 30 parish units. The 6,046 families enrolled at the end of the year constituted 55.9 percent of all eligible families in the parishes concerned. A healthy sign of growth was an increase of 60.9 percent in the number of enrolled families in the 21 units which operated throughout the year.

Mississippi. With the renewed basis for a working understanding with the medical profession in Mississippi, there was again substantial spread of the program in the State with an increase during the fiscal year from 41 medical care groups in 42 counties to 56 groups in 59 counties. Even though units in 4 counties were suspended during the year, there was a 92 percent increase in the total number of families enrolled, with 11,702 families and over 60,000 persons actively participating as of June, 1941. In the 36 counties for which records are available in which units were operating throughout the fiscal year, there was a 42.5 percent increase in the number of families enrolled, bringing the total enrollment up to 74.6 percent of those eligible in the counties covered.

It is of considerable interest that a majority of physicians in the Mississippi counties in which medical care units have been organized are said to prefer payment on a capitation basis. Almost all of the new plans being organized are being set up on a capitation basis and a number of the older plans are changing over from common fund or "pool" plans to capitation plans.

Region VII

Kansas (80 counties), Nebraska, North Dakota, South Dakota

Perhaps the most significant development in the medical care program in Region VII during the past fiscal year was the initiation of a large district unit in South Dakota, signalizing the renewal of a close working relationship with the medical profession in South Dakota after a lapse of almost two years. There was also evidence of progress in Kansas and Nebraska and some groundwork was accomplished in North Dakota preparatory to renewing medical care activities there on a district or county basis.

In June, 1940, there had been 42 medical care units operating in 48 counties in Nebraska and in the Region VII part of Kansas (which covers 80 counties). As of June, 1941, there were 53 units in operation in 85 counties in Kansas, Nebraska and South Dakota. The net loss in the number of participating families both in Kansas and in Nebraska was just counterbalanced by the addition of the 14-county district unit in South Dakota, making a net increase for the region of only 0.9 percent

in the number of families enrolled. The 7479 families in the various units at the end of the year represented 55.6 percent of the families eligible in the areas concerned.

For those units which operated both in June, 1940 and in June, 1941, there was a loss of 1151 families, representing a decrease of 15.7 percent. This loss of families and the relatively low percentage of participation was acknowledged to constitute a serious threat to the continuation of the program in some counties in the region. The following table illustrates the status of the medical care program in Region VII from the time when the statewide plans were operating in North and South Dakota.

No. of Counties with Medical Care Groups of FSA Borrowers

	June 1937	June 1938	June 1939	June 1940	June 1941
Kansas				20	28
Nebraska				28	43
North Dakota	53	53	53		
South Dakota	69	69	69		14
	122	122	122	48	85

The best record of any region has been made by Region VII with respect to providing broad coverage for families enrolling in the medical care program. Although it must be recognized that certain of the services offered are limited in scope, the fact is that every enrolled family in the region is entitled to benefits which include general practitioner care, emergency surgical care, limited hospitalization, and at least emergency extractions in the field of dental care. Moreover, 95.7 percent of all families enrolled are entitled to the provision of ordinary prescribed drugs. These various services are ordinarily provided at an annual charge of $30 per family. Negotiations with hospitals and druggists are left up to the local medical societies and the bills for hospitalization and prescribed drugs are paid in full as preferred charges at the negotiated rates arranged by the physicians.

An interesting innovation has been an increase in membership dues to $33 per family in some units with the increase being based on adding certain services. The additional benefits are either certain preventive procedures, such as desirable immunizations or, as in some units, $4 of the $33 family deposit is set aside for a limited plan of dental care. According to the latter plan, $4 from each family constitutes a separate pooled fund from which payments are made for extractions, and for fillings and prophylaxis for children under seventeen. In this plan, a committee of dentists supervises the dental aspect of the general program and members go directly to their dentists rather than being referred for dental services by their family physicians.

In several units the physicians are setting aside a certain proportion of each monthly allotment to be used as a special fund to reimburse individual physicians when there is an especially heavy load of illness in any one community during the month. It is still too early to evaluate this development, although it has proved of direct benefit where it has been tried. It is recognized in the region that the proper administration of a special fund of this type requires an impartial and effective auditing committee of physicians.

The form of organization in Region VII is that of the informal unincorporated "medical aid association", with a treasurer or trustee. Each association has a board of directors composed of three borrowers and two representatives of the Farm Security Administration. As a rule, there is at least one ex officio member, ordinarily a physician. In most units there is a grievance committee composed of two borrowers, two physicians and the local FSA RR Supervisor.

In many of the medical care units in the region a few non-client low income farmers have been permitted to participate, not at the request of the Farm Security Administration, but upon the request of the medical societies. As of June, 1941, there were 300 non-borrower families enrolled in various units in the region.

Kansas. Although there was an increase from 20 county units to 24 units in 28 counties of the 80 counties in the Region VII part of Kansas, there was a decrease of 11.2 percent in the number of enrolled families. The 2970 families participating in June, 1941, represented 57 percent of those eligible in the counties concerned. There was a decrease of 17 percent in the number of families enrolled in those units which operated throughout the year, reducing the percentage enrollment of those eligible to 59.2 percent. At the end of the year, medical societies in 6 additional counties had approved units which would go into operation early the next fiscal year.

Nebraska. There was an increase from 22 units in 28 counties to 28 units in 43 counties during the fiscal year, but there was a net loss of 1.4 percent in the number of families enrolled. The 4008 families participating in June, 1941, represented 55 percent of those eligible in the counties covered. In those units which operated throughout the year, there was a decrease of 14.6 percent in the number of enrolled families, lowering the percentage enrollment to 58.5 percent of those eligible. As of the end of the fiscal year medical societies in four additional counties had approved units which were expected to go into operation soon.

North Dakota. After there had been a lapse of approximately a year in the medical program for borrowers in North Dakota, the State Medical Association in the spring of 1940 gave permission to FSA representatives to approach local medical societies throughout the State. The understanding at that time was that any new plans would be set up on a

district or county basis and that any plan agreed upon by a local medical society would be submitted to the Executive Committee of the State Medical Association for review and approval. During the past fiscal year, an approach was made to certain local medical societies in the State and as of June, 1941, the physicians in Grant and Wells Counties had agreed to the establishment of medical care units, provided they secured the approval of the State Medical Association.

South Dakota. Through an agreement with the Inter-Allied Professional Council of South Dakota, regional FSA representatives secured the approval of the Pierre District Medical Society for the organization of the Pierre District Medical Aid Association which commenced activities on April 1, 1941. By the end of June, the number of families enrolled in the Association had increased from 300 to 501 families or 2304 persons, representing 53 percent of the families eligible in the district. The plan adopted is similar to the more recent plans in Kansas and Nebraska, with the families paying $33 annually for the broad coverage characteristic of plans in the region.

Prior to the end of the fiscal year the Mitchell District Medical Society approved organization of the South Central District Medical Aid Association which is to include borrowers from 13 counties and will be set up at the same $33 rate as that in effect in the Pierre District Association.

Region VIII

Oklahoma (74 counties), Texas (207 counties)

Little progress was made in organizing new plans to go into effect during the past fiscal year in Region VIII, but approval was secured for 21 county units to go into operation early the following year. Many factors account for the slow progress in the region, but they might be summarized by stating that district and county FSA personnel have not yet assumed their proper responsibility for plans already placed in operation and for the development of new plans.

There has been more difficulty in securing accurate reports from the field in Region VIII than in the other regions, and the figures given in this report may be subject to slight modification. According to the records available, there was a decrease during the fiscal year from 50 units in 52 counties to 48 units in 49 counties. There was a net increase of 3.5 percent in the number of enrolled families, with the 5865 families enrolled as of June, 1941, representing 49.6 percent of those eligible in the counties concerned.

Seven county units had been terminated during the year in Oklahoma and Texas and the organization of new units did not counterbalance these

losses. The factors underlying the suspension of these 7 units include the following: (a) Lack of interest on the part of FSA personnel, (b) small caseload, (c) friction among physicians, (d) opinion of physicians that more money available through individual grants, (e) proprietary hospital "wanted the FSA to make up deficits."

According to available data, the status of the program in Region VIII for the past four years is illustrated by the following table:

No. of Counties with Medical Care Groups of FSA Borrowers

	June 1938	June 1939	June 1940	June 1941
Oklahoma	4	11	23	22
Texas		8	29	27
	4	19	52	49

There is a wide variety in the combinations of services offered in Region VIII plans. In general, there is rather broad coverage with an attempt being made to furnish limited hospitalization and emergency surgical care as well as general practitioner care and ordinary drugs. In a few plans, certain limited dental services are included.

Health Associations constitute the usual form of organization in Region VIII. These associations have boards of directors composed of three borrowers elected as representatives of the families and two FSA representatives. The borrower members of these boards have proved very effective in handling abuses by enrolled families. The active participation of families in the operation of the various units is being stressed throughout the region. In a few counties the borrowers on the boards of directors have met with the committees of physicians, a development which it is hoped may spread both in the region and to other regions.

Oklahoma. The organization of two new medical care units was not enough to balance the suspension of three units and consequently there was a decrease from 23 county units in 1940 to 22 county units in June, 1941, in the 74 counties in Oklahoma included in Region VIII. In those units which operated throughout the fiscal year there was a 21 percent increase in the number of families enrolled, accounting largely for a net increase of 19 percent in the total number of families enrolled throughout the region. The 3283 families belonging to the health associations in June, 1941, represented 47 percent of those eligible in the 22 counties covered.

At the end of the year, plans had been completed for starting new units in 5 additional counties in Oklahoma. Once these county units were in operation it would leave 47 more counties to which the program could be extended in the future.

Texas. Although there has been a working agreement with the State Medical Association of Texas since January, 1938, steps were being taken at the end of the fiscal year to clarify this agreement, bringing it up to date with current developments.

In the Region VIII part of Texas (covering 207 counties), according to available reports, there was some decrease in the extent of the program during the fiscal year, with the 27 units in 29 counties in 1940 dropping to 26 units in 27 counties in June, 1941. There was an 11.1 percent decrease in the number of families enrolled, with the 2582 families taking part in June, 1941 representing 46.4 percent of families eligible in the areas concerned. In those units for which records are available, which operated throughout the fiscal year, there was a 12.4 percent decrease in the number of enrolled families, reducing the percentage of enrollment to 53.5 percent of the families eligible. During the twelve-month period, 4 county units were suspended but it was almost certain that 3 of them would be reinstituted once certain readjustments had been made.

Substantial expansion of the program in Texas was expected early in the following fiscal year for plans had been completed for the program to extend to 16 additional counties. This would still leave 164 counties not covered in the Region VIII part of Texas.

Region IX

Arizona, California, Nevada, Utah

The medical care program for FSA borrowers was extended to California for the first time during the past fiscal year and preparations were almost completed for initiating the first medical care unit to be developed in Arizona. Moreover, there was substantial progress in extending the program into new counties in Utah.

As of June, 1940, the only medical care units for borrower families in Region IX were 4 county units in Utah, with a total enrollment of 790 families. By June, 1941, 10 units in 16 counties in Utah and California were in operation, with a 111.6 percent increase in the number of borrower families participating. The 1672 families taking part in these units at the end of the year included 1213 FSA borrowers or 55 percent of the eligible borrower families in the areas involved. Three of the medical care groups in Utah included a total of 453 non-borrower families, a situation discussed later in this report.

The following table shows the expansion of the program in Region IX from the time when the first county unit started in Utah:

No. of Counties with Medical Care Groups of FSA Borrowers

	June 1938	June 1939	June 1940	June 1941
California				7
Utah	1	1	4	9
	1	1	4	16

The usual form of organization in these medical care units in Region IX is the unincorporated health association. A positive effort is being made in the region to shift more responsibility to the borrowers through assigning them definite duties related to the operation of the health association. It is worthy of note that the more recently organized associations in the region, those set up in 1941, are potentially the media for the purchasing or marketing of any services or goods needed by the members. The board of directors of one of these associations is formed by having the borrowers in each neighborhood elect a representative to serve on the board. The various board members are responsible for holding meetings of the members in their particular neighborhoods, usually four such meetings each year, for the purpose of acquainting the members with current developments and getting ideas from the membership which may be passed on to the board. The treasurers of these associations, who are borrowers, may act as trustees of the medical care funds.

Arizona. Since April, 1939, there has been a working agreement with the Arizona State Medical Association. In May, 1941, the Association approved the development of a medical care plan for FSA borrowers in Maricopa County which was also approved by the Maricopa County Medical Society prior to the end of the fiscal year. This plan, which is designed to meet the needs of approximately 400 borrower families in the County, is to be administered by the Agricultural Workers Health and Medical Association, the organization handling the medical care program for migratory agricultural workers in Arizona and California. The plan calls for annual payments of $35 per family for home, office, clinic and hospital care rendered by physicians and for 10 days' hospital care in any one illness. In general, the services are confined to care in acute conditions, although a desirable exception to this is that any chronic conditions among children are to be handled under the plan. It is expected that families living near a clinic operated by the AWH&MA will receive such care as may be appropriate through the clinic and that they will be referred to local physicians of their choice for services not readily available through the clinic. Each of these clinics is staffed by local physicians serving in rotation.

Physicians are to be paid in accordance with the regular fee schedule of the AWH&MA, without proration, and any excess of costs over total family contributions is to be met by AWH&MA funds. This program, which differs rather markedly from the usual pattern, must be considered experimental in character.

California. The California Physicians' Service, an organization set up by the California Medical Association to operate prepayment plans of medical care, was designated by the California Medical Association as the agency to cooperate with the Farm Security Administration in developing a medical care program for FSA borrowers. Consequently, the California Physicians' Service and the FSA initiated an experimental program on June 1, 1941, which is confined to approximately 300 borrower families and is to be considered a one-year experiment. The thought is that this trial program may provide the basis for a revised and mutually satisfactory program for all borrower families in California.

The California Physicians' Service is composed of over 6300 licensed physicians. In its regular program which covers about 37,000 persons, it offers physicians' and surgeons' care and hospitalization to groups of employed individuals at an annual cost of $30 per person. In the experimental program for FSA borrowers, the families pay annual rates which vary with the size of family and which in actual experience average approximately $48.75. Typical rates are $30 for one person, $42.50 for two, $51.50 for five, and $60 for nine or more.

The services provided borrowers through the CPS plan include medical and surgical care in the office, home or hospital. A fee of $1.50 must be paid for the first home call in any illness. Care of chronic or preexisting conditions is excluded except in the case of children under 18 who may receive such care including corrective surgical care. Hospital care is limited to 10 days for any one illness and is provided for obstetrical cases only in special instances. Drugs including biologicals are included but the family must pay the first $1.50 toward the cost of prescribed drugs in each illness. Necessary X-ray and laboratory services are provided.

On June 1, 1941, three medical care units operating under the CPS plan were initiated in 7 counties in California. As of June 30, there was a total of 264 families or 1108 persons enrolled. These families constituted 70.4 percent of those eligible in the 7 counties. The average membership fee in the Monterey Farmers' Health Association was $48.43 as of June 30; that in the North Coast Farmers' Association was $50.27, and that in the Farmers' Health Association (Butte County) was $48.04.

Nevada. There were no particular developments during the fiscal year in Nevada which has a scattered caseload of less than 500 families.

Utah. During the past year there was an increase from 4 county medical care units to 7 units in 9 counties. There was an increase of 78 percent in the number of families enrolled, bringing the total up to 1408 families. The 955 FSA families constituted 52 percent of those eligible in the 9 counties concerned. In the 4 county units which operated throughout the fiscal year there was a 10.8 percent

increase in the number of enrolled families, and the FSA families taking part in the 4 units constituted 72 percent of those eligible as of June, 1941.

Three of the health associations in Utah include a large proportion of non-FSA borrowers, those located in San Juan, Grand and Wayne Counties. The combined membership of these three associations includes 453 non-FSA borrower families as against 158 families on the FSA rolls. These associations operate in isolated areas and serve primarily as mechanisms for assuring a guaranteed minimum income to physicians who settle there. In San Juan and Wayne Counties the existence of the associations is responsible for bringing professional care to areas where either none had been available or where physicians had come and gone because of their inability to attain security. In each instance the physicians concerned are anxious to build up the membership of the associations and they have no desire to restrict membership to particular groups. While FSA personnel were largely responsible for the initiation of these plans, the plans are not, except for Wayne County, looked upon as FSA programs.

The plans in the other four medical care units in Utah are more typical. Annual family membership rates are set at $30 and the services ordinarily include physicians' and surgeons' care, limited hospitalization and prescribed drugs. An interesting innovation, an adaptation of the method of payment used in the Utah dental care program, is an arrangement in connection with the unit recently organized in Uintah and Duchesne Counties whereby 50 percent of funds allocated for physicians' care is set aside until the end of the fiscal year to be available at that time to supplement incomplete payments made to physicians during the year. The thought is that this may provide a more equitable distribution of the funds. A somewhat similar plan is being tried in certain counties in Region III.

Region X

Colorado (49 Counties), Montana, Wyoming

As a direct result of the notable advance made in extending the program in Montana, there was a general expansion of the program in Region X from 8 medical care units in 9 counties in June, 1940, to 22 units in 43 counties in June, 1941. There was an increase of over 300 percent in the number of families enrolled throughout the region, with 3260 families or 16,364 persons participating at the end of the fiscal year. For those units in the three states which were operating both in June, 1940 and in June, 1941, there was an increase of 14.3 percent in the number of enrolled families. As of the end of the year, plans had been approved by county medical societies for extension of the program into 7 additional counties in the three states.

The following table illustrates the growth of the medical care program in Region X since it began approximately three years ago:

No. of Counties with Medical Care Groups of FSA Borrowers

	June 1939	June 1940	June 1941
Colorado	2	3	7
Montana	2	2	30
Wyoming		4	6
	4	9	43

As in a number of other regions, considerable difficulty is being encountered in enrolling a sufficiently high proportion of FSA borrowers in the various plans organized. The families enrolled in all of the units as of June, 1941, represented 43.2 percent of the families eligible in the 43 counties concerned. The families in those units operating since previous fiscal years represented 52 percent of the number of families eligible.

The form of organization followed in Region X is that of unincorporated health associations, with boards of directors elected by the borrowers. These boards have proved their worth not only as advisory bodies, but as a medium for informing the member families thoroughly as to their privileges under the plans. In the Wyoming plans, the trustees of the medical care funds are "neutral" persons; in the Montana program they are physicians known as "medical directors"; and in Colorado, certain of the trustees are physicians and others are neither physicians, borrowers nor FSA employees.

Although the scope of services offered in the various medical care units in Colorado and Wyoming varies considerably, there is a common pattern in all but one of the 11 units in Montana. In the Montana program, which has a flat annual rate of $30 per family, all reasonable physicians' and surgeons' services are provided including the services of such specialists as radiologists. Treatment is not limited to acute conditions but on the other hand is available in cases where corrective surgery, for example, is required. It is evident from reports received from Montana that a considerable proportion of the funds expended represent payments to physicians for such preventive services as health examinations, for surgical corrective work including a considerable number of tonsillectomies and hernia repairs, and for X-rays and laboratory work.

Colorado. In the 49 counties in Colorado included in Region X, despite the somewhat unreceptive attitude of many representatives of the medical profession there was an increase from 3 county units to 6 units in 7 counties during the fiscal year. The 606 families enrolled at the end of the year represented 53.8 percent of those eligible in the 7 counties.

In the county units which were operating both in June 1940 and in June 1941, there was an increase of 61 percent in the number of enrolled families, with the membership at the end of the year representing 55 percent of those eligible. It is of interest that non-borrowers are eligible to become members of the health associations in 2 county units in Colorado provided that they are acceptable both to the boards of directors and to the county medical societies.

Montana. The Medical Association of Montana has been unusually cooperative in backing up the efforts of FSA representatives in their approach to local medical societies throughout the State. With this backing, and with the active support of the FSA State Office in Montana, the program organized along the lines previously referred to was extended during the past fiscal year into 28 of the 56 counties in the State. Taking the two-county unit previously in operation into account, there was an increase from 1 unit in 2 counties to 11 units in 30 counties, with an enrollment of 2209 families as of June, 1941. Despite the wide extension of the program from the geographical standpoint, there was still the problem of inadequate enrollment to be faced, for at the end of the year only 39 percent of the families eligible were enrolled.

A number of non-FSA borrower families are members of health associations in Montana, the total number in units of the usual type being 303 families at the end of the year. These families were, of course, enrolled with the approval of the medical societies concerned.

Toward the end of the fiscal year the Medical Association of Montana reviewed the operation of the program to date and recommended very little in the way of change except to declare thatmedical services should in every case include laboratory and X-ray work without extra charge.

Wyoming. In June, 1940 there were 4 county units operating in Wyoming and by June, 1941 this number had increased to 5 units in 6 counties. The 445 families enrolled at the end of the year represented 53.5 percent of those eligible. In the four units which operated throughout the year there was an increase of only 1 percent in the number of enrolled families.

The unit operating in Weston County was to be suspended temporarily at the end of the fiscal year. The physicians in the County were not satisfied with the agreement which they had entered into to provide surgical as well as medical services inasmuch as surgical cases had to be sent outside the County. It is probable that this unit will be reinstituted. More than counterbalancing this loss was the approval by medical societies in three aditional counties of units to be placed in operation early the following year. Moreover, there was a better working relationship with the medical profession throughout the State and it was felt that future expansion of the program could be anticipated.

Region XI

Idaho, Oregon, Washington

The past fiscal year has seen the extension of the medical care program into the State of Washington for the first time. The other outstanding development in the region with respect to the health program for families on the rehabilitation rolls was the action taken by the Idaho State Medical Association in June, 1941, when the Association went on record as permitting the constituent county medical societies to cooperate in developing medical care plans for FSA borrowers if they desired to do so.

There was a general increase in the number of medical care units operating in Region XI from one unit in Idaho, in Bear Lake County, to 8 units in 11 counties in Idaho and Washington. As of June, 1941, 868 families were enrolled in these various units, representing 45.3 percent of the families eligible. The number of counties covered at the end of the fiscal year does not represent fairly all the progress made during the year, for the approval of several additional medical societies had been secured for extension of the program early in the following fiscal year.

The following table shows the extent of the program in Region XI during the past four years:

No. of Counties with Medical Care Groups of FSA Borrowers

	June 1938	June 1939	June 1940	June 1941
Idaho	4	2	1	5
Washington				6
	4	2	1	11

The usual form of organization in Region XI is the unincorporated health association, although it appears that any groups organized in Oregon must be incorporated to avoid coming under the State Hospital Association law which requires the posting of a $10,000 bond.

The plans being developed in the region are broad in the scope of services provided. All of the plans in operation include physicians' services, emergency surgical and hospital care, and ordinary drugs. Some of them include emergency dental extractions as well.

Idaho. Although there has been a general understanding that FSA representatives migh approach county medical societies in Idaho, it was not until June, 1941, that the House of Delegates of the Idaho State Medical Association took favorable action concerning the program. The Association left details of any plan to be decided upon by the local medical societies desiring to cooperate with the Farm Security Administration.

There was an increase in Idaho from one county unit to 4 units in 5 counties. The 537 families enrolled at the end of the fiscal year repsented 51.4 percent of those eligible in the five counties concerned. By the end of the year the approval of county medical societies had been secured for extension of the program into ten additional counties in the State. It is of interest that FSA borrower families in Caribou County, Idaho, are taking part in the medical care unit in Lincoln County, Wyoming, an arrangement which not only crosses state but regional lines.

Oregon. In September, 1939, the Oregon State Medical Society indicated that FSA representatives might negotiate with county medical societies throughout the State with a stipulation that special permission must be secured before approaching any medical society and that any plan agreed upon locally must be submitted to the State Society for approval. The helpful cooperation extended by so many other state medical associations has never been forthcoming in Oregon, and as a consequence there are still no medical care plans in actual operation. Nevertheless, several physicians in Crook and Deschutes Counties in eastern Oregon have expressed their willingness to enter into an agreement with FSA borrowers in the areas and tentative plans have been made for initiating a program at $30 per family which would provide general medical care, emergency surgical care and hospitalization, and ordinary drugs.

Washington. The first medical care plans to go into effect in Washington were placed in operation during the fiscal year, there being 4 medical care units in 6 counties active as of June, 1941. A problem faced in other states was already evident in that the 331 families enrolled at the end of the year represented only 38.3 percent of those eligible in the six counties. The annual rates in the 4 units average approximately $30 for rather broad services confined largely to acute conditions. In one county, emergency dental extractions were included in the plan as well as the services offered in the other units, namely, physicians' and surgeons' care, limited hospitalization and ordinary drugs. At the end of the year the approval of the county medical society had been secured for a unit in one additional county and negotiations were in progress in several other counties.

Region XII

Colorado (14 counties), Kansas (25 counties), New Mexico, Oklahoma (3 counties), Texas (47 counties)

In general there is evidence of a good working relationship with the medical profession in New Mexico and in the portions of the other four states which comprise Region XII. It is of interest that reports from the region indicate that many physicians are insistent that the medical program, broad as it is in the region, be made more inclusive.

During the past fiscal year there was an increase from 31 units in 72 counties to 36 units in 78 counties in all five states in the region, but there was a decrease of 2 percent in the number of families enrolled. The 5395 families participating in the various units as of June, 1941, represented 56.3 percent of those eligible in the 78 counties concerned. In those units which operated throughout the fiscal year, there was an average decrease of 6.1 percent in the number of enrolled families although there were slight increases in the units in Colorado and Texas. During the year three counties were dropped from the program, one of them being a county in Kansas which had been incorporated in the Southwest Kansas district plan and the other two being county units in New Mexico, one of which started on February 1, 1941, and was suspended shortly thereafter.

The following table shows the status of the program in Region XII from the point of view of the number of counties covered from its beginning in June, 1938:

No. of Counties with Medical Care Groups of FSA Borrowers

	June 1938	June 1939	June 1940	June 1941
Colorado			3	6
Kansas		25	25	24
New Mexico		7	22	20
Oklahoma		2	1	3
Texas	1	11	21	25
	1	45	72	78

In general, the services provided in the Region XII plans are quite comprehensive in scope although in most of the units the emphasis is on the care of acute conditions. Annual family rates range in general from about $25 to $35. During the past year three county plans have operated on a capitation basis, but at least one of these plans is going to be reconverted to the fee-for-service basis under which it operated during its first two years.

A few health associations have been organized in Region XII, but in general the form of organization is that of simple trusteeships. The policy in the region is to work toward the organization of more associations, to the end that the borrowers may assume an increasing share of responsibility for dealing with the physicians and for securing an active satisfied membership.

Colorado. There was an increase from 3 county units to 5 units in 6 counties in the 14 county area of Colorado included in Region XII. The 410 families enrolled at the end of the year represented only 35 percent of the families eligible in the 6 counties. For the two units which operated throughout the year for which records are available there was an increase of 5.3 percent in the number of families enrolled.

Kansas. In June, 1940, there were 4 medical care units covering all of the 25 counties in the Region XII part of Kansas. As of June, 1941, there were 6 units in 24 counties and the 16-county district plan in southwest Kansas also included the three counties in the Oklahoma panhandle. There was a rather marked decrease in the number of families enrolled in the Kansas units, there being a decrease of 33.7 percent. The 754 families taking part at the end of the year represented 42 percent of those eligible. In the four units which operated throughout the year, there was a decrease of 35.6 percent in the number of families enrolled.

Several changes have taken place in the Southwest Kansas Mutual Aid Association during the past two years. During the first year of its operation the membership dues were $30 per family and the services provided included general practitioner care, emergency surgical care and hospitalization, prescribed drugs and emergency dental care. In its second year of operation, the provision of drugs was excluded and the physicians received a higher percentage of payment on their bills. For its third fiscal year, that for the year starting May 1, 1941, the annual family rates have been increased to $35 and the treatment of certain chronic conditions interfering with the health or rehabilitation of the individuals enrolled has been included in the plan. Hospital bills still constitute preferred charges which are paid in full before payments are made to physicians and dentists.

New Mexico. Whereas there were 12 medical care units in 22 counties operating in New Mexico in June, 1940, there were 12 units in 20 counties operating in June, 1941. There was a decrease of 13.4 percent in the number of families enrolled. The 2441 families belonging to the 12 groups in June 1941 represented 67.6 percent of those eligible in the 20 counties. In the 11 units which operated throughout the year, there was a decrease of 12 percent in the number of enrolled families.

Oklahoma. Borrower families in one of the three counties in the Oklahoma panhandle for a time maintained a medical care unit of their own. But the more feasible arrangement seems to be for the families living in this part of Oklahoma, which lies within Region XII, to secure their medical care through units in adjacent Kansas and Texas counties. Since many of these families were enrolled in the Southwest Kansas Mutual Aid Association as of June, 1941, the names of these three counties have been listed under that district unit in Table No. 6.

Texas. In the 47 counties in Texas included in Region XII, there was an increase during the fiscal year from 12 medical care groups in 21 counties to 13 groups in 25 counties, with an increase of 37 percent in the number of families enrolled. The 1790 families who were members of the groups in June, 1941, represented 56 percent of those

eligible in the 25 counties concerned. In the 12 units which operated thoughout the fiscal year, there was an increase of 30 percent in the number of enrolled families, with the total number of families at the end of the year representing 70 percent of those eligible.

An experimental hospitalization plan was put into effect on September 1, 1940, in connection with medical care units in five Texas counties. This plan, administered by Group Hospital Service, Inc., of Texas, cost the families $7 per year for certain emergency hospitalization benefits. In general, the benefits were originally confined to accidents and other emergency surgical cases, covering a maximum of 14 days' ward care per case, but after the plan had operated six months, a flat $25 benefit to cover 4 days' care was added to cover all obstetrical cases. As of the end of the fiscal year, it was evident that Group Hospital Service was able to pay the hospital bills in the five counties at the minimum rates negotiated and to accumulate a moderate surplus.

MEDICAL CARE FOR MIGRATORY AGRICULTURAL WORKERS

Tens of thousands of migrant farm families, seeking work in the various harvests in Pacific and Atlantic Coast states, and in states such as Idaho, Colorado, Texas, and Michigan, can neither pay for medical attention nor secure it through relief agencies. On the one hand they have perhaps the lowest living standards of any group in the United States, with incomes usually ranging between $200 and $450 a year for a family, and, on the other, they do not meet local residence requirements for relief assistance. Poverty, malnutrition, exposure, and the insanitary conditions under which migrants are forced to live, make them an easy prey to disease. The threat of the spread of communicable disease, as migrants move from one farming area to another in search of work, is a problem which cuts across state lines.

Since 1936 the Farm Security Administration has been helping the states meet some of the most urgent health and housing problems created by this wave of migration. To provide sanitary facilities and temporary shelter, 50 camps, 19 of which are mobile, had been placed in operation by June, 1941 in California, Arizona, Oregon, Washington, Idaho, Texas, and Florida. These camps have a combined capacity of 10,915 families. Each permanent or standard camp has a health center with a public health nurse in charge, and isolation units for cases of contagious disease. A mobile clinic with a nurse in charge is assigned to each of the larger mobile camps. The state health departments assist in providing immunizations and conducting various preventive activities.

Since the spring of 1938, medical care has been provided migrants in California and Arizona through the Agricultural Workers Health and Medical Association, a corporation which the migrants join as members. This non-profit organization, which is subsidized by grants from the Farm Security Administration, is administered by a Board of Directors on which are represented the California State Health Department, the State Medical Association, the State Dental Association, and the Arizona State Medical Association, as well as the Farm Security Administration. Through agreements between the AWH&MA and organized professional groups in California and Arizona, migrant families are receiving necessary medical care, hospitalization, prescribed drugs, and limited dental care.

During the past fiscal year similar medical aid programs were established for migrants in Florida, the Rio Grande Valley in Texas, and in the Pacific Northwest -- Oregon, Washington, and Idaho. The chief difference between these new programs and the original program in California and Arizona is that in the more recently organized programs the medical aid is furnished through the camp clinics. The general effect of this is that medical care is secured most readily by camp occupants and migrants in the general vicinity of Farm

Security Administration camps, whereas, in California and Arizona, membership in the AWH&MA has been extended on the basis of need to migrant families throughout wide areas in both states.

Because of differences in these programs, and the early stage of development of three of them, no effort is made in this report to present a comparative analysis of their operations. With the current adoption of more uniform systems of accounting and reporting, such analyses will become practicable.

Agricultural Workers Health and Medical Association (California and Arizona -- Region IX.) As of June, 1941, the AWH&MA was well into its fourth year of successful operation. Although certain changes in organization and procedure were instituted during the year, the program had become relatively stabilized in its operation.

Medically indigent agricultural workers classed as non-residents of California or Arizona may apply for medical treatment at one of the Association's permanent clinics, emergency clinic centers, or district referral offices. In June 1941, there were 9 clinics in California and 7 in Arizona, and 15 other emergency clinic centers or referral offices had been established in the two states at points of concentration of migratory workers. It should be added that as of the end of the fiscal year, 13 standard camps had been established in California and 3 in Arizona, with a total capacity of over 4,000 families, and also 6 mobile camps in California and 2 in Arizona, with a combined capacity of over 1,600 families.

When a migrant is approved for membership in the AWH&MA, a membership card good for one year is issued entitling him and his family to care furnished by local physicians who serve in rotation in the clinics or to care on a referral basis, when he may select his physician or dentist from a list of those participating. The Association pays clinic physicians on an hourly or clinic basis, and it makes payment for all authorized referral work, at fees and charges agreed upon, including surgical and other specialist care, x-rays and other diagnostic services, prescribed drugs, hospitalization, emergency dental care -- and even special diets in cases of malnutrition. Elective as well as emergency surgical care, and urgently needed restorative dentistry, may be authorized by the Medical Director or one of the two Medical Advisers of the Association.

As of June, 1941, 13,486 families were active members of the Association, including 54,961 persons. There is a constant turnover, many memberships expiring and others being initiated or renewed. More than 4,000 applications for medical care were accepted in June.

Reports submitted by the AWH&MA indicate that during the fiscal year there were 118,309 clinic visits, 41,951 referral cases and 11,394

hospital cases. Clinic costs totaled $163,787.23, making an average cost per clinic visit of $2.11. Cases referred to outside physicians and dentists cost the Association $468,131.47 during the fiscal year or $11.13 per case, and the cost of hospitalization was $426,115.73 or $37.39 per hospitalized case.

Expenditures of the AFH&MA for all purposes during the fiscal year ending June 30, 1941 were as follows:

Clinic expense	$ 163,787.23
Referral activities	
Physicians	443,452.07
Hospitals	426,115.73
Dentists	25,679.30
Drugs	50,573.11
Nursing	7,185.91
Miscellaneous	14,976.18
Administrative	299,472.47
Total	$1,431,242.00

The true "administrative" expense is much lower than that indicated. The figure given includes salaries, travel and general expense for nurses as well as clerks in the emergency clinic centers and district offices, an activity directly related to the furnishing of medical aid. Such expenditures should probably be considered as operating costs. True administrative and overhead costs would probably include only the salaries and travel expenses of the Medical Director, Medical Advisers, business, statistical and clerical employees at the main offices, and also general expenses in conjunction with these offices.

Because of the lack of suitable hospital facilities in the area and the difficulty of handling maternity and other cases in camp dwelling units and shelters, the AFH&MA operates a 55 bed convalescent center at Eleven Mile Corner, Arizona. This center, the "Burton Cairns Convalescent Center", was placed in active operation on January 18, 1941. Reports for the period from that date through June 30, 1941, indicate that 455 persons were hospitalized, including 35 obstetrical cases and 85 minor surgical cases (arrangements had not yet been made for handling major surgical cases at the Center). A total of 2,678 days of hospital care was provided during the period.

The operation of the Agricultural Workers Health and Medical Association involves an interesting combination of medical care principles and techniques. In general free choice of physician is preserved, through the panel type of service, but in consultation with the medical societies the panel system has been modified by the introduction of clinics which make it possible to reach more people at a reduced cost. The program utilizes both the fee schedule, for office and hospital

practice, and salaried physicians working in the clinics. It is hoped that the Burton Cairns Convalescent Center, and another one planned, will provide more extensive medical service than has been possible in the past and will further reduce operating costs.

Migratory Labor Health Association (Florida -- Region V). During the fiscal year three standard camps were in active operation, the Osceola Camp for 159 white families (with 151 more units under construction), the Okeechobee Camp for 346 colored families (230 additional units almost completed), and the Pompano Camp for 316 colored families. Two additional camps nearing completion, with a combined capacity of 503 families, were to begin operation early the following fiscal year.

Pending the organization of an association similar to the AWH&MA, the serious health problems of the camp occupants were handled by employing public health nurses to serve each camp and by having local physicians serve regular hours in the clinics under government appointment. Direct financial assistance was extended when hospitalization was required. With the organization of the Migratory Labor Health Association, the program since January 1, 1941, has been analogous to that in California and Arizona. The Florida Medical Association and the State Health Department have representatives on the Board of Directors of the Association. The aims of the Association, which is financed by the Farm Security Administration, are to provide physical examinations of all persons registered, to record and attempt to correct physical disabilities, to provide necessary medical, hospital and dental care, to stress proper prenatal, delivery and postnatal care, and to locate and provide immediate treatment for cases of venereal disease.

Local physicians hold daily clinic sessions, and they are on call for emergencies. Definite provision is to be made for dental care, through local dentists holding regular hours at the clinics, and through a mobile dental unit for the colored families.

From January 1 to June 30, 1941, with the program just getting underway, there were 7,309 clinic visits and 22 hospital cases handled by the Migratory Labor Health Association. The Association's expenditures for the period were distributed as follows:

Nursing	$1,618.00
Other clinic expense	2,306.74
Referral activities	
Physicians	508.00
Hospitals	770.79
Dentists	21.00
Drugs	5.00
Miscellaneous	196.79
Administrative	3,711.40
Total	$9,137.72

The fact that administrative costs are relatively high at first, in any new program of this sort, is reflected in the above statement of the early expenditures of the Association.

At the end of the year plans were made to provide for the construction of a convalescent center similar to that at Eleven Mile Corner, Arizona, designed to meet the needs of migrants in the Lake Okeechobee area. This center was expected to be in operation early in 1942.

Texas Farm Laborers Health Association (Texas -- Region VIII). To meet the urgent needs of migrants in the Rio Grande Valley, four standard camps had been placed in operation prior to the past fiscal year (Raymondville, Robstown, Sinton and Weslaco), and two more were established toward the end of the fiscal year (Crystal City and Princeton). These six camps have a combined capacity of 1,397 families. A seventh camp (Harlingen) was to open in August, 1941.

The health program for migrants in the Rio Grande Valley is similar to that in Florida, being confined for the most part to camp occupants and migrants in the general vicinity of the camp clinics. Since December 16, 1940, the program has been administered by the Texas Farm Laborers Health Association, a corporation financed by the Farm Security Administration. The Association employs nurses to serve in each camp clinic under the direction of a supervising nurse and the part-time Medical Consultant. Local physicians hold regular clinic sessions at the various camps. Cases needing specialist treatment are referred to other physicians, surgeons, and to nearby hospitals.

During the period December 16, 1940 to May 31, 1941, the distribution of expenditures of the Association was as follows:

Clinic expense (including nursing)	$ 11,910.97
Referral activities	
Physicians	5,387.50
Hospitals	2,043.35
Drugs	288.90
Miscellaneous	51.22
Administrative	5,254.34
Total	$ 24,936.28

During this period there were 8,877 clinic visits, 1,431 referred cases, and 56 hospital cases. Considerable expansion in the program was anticipated in the next fiscal year. It was expected that administrative costs, which it is natural to find relatively high at first, would become reasonable as the program expanded.

Agricultural Workers Health Association (Idaho, Oregon, Washington -- Region XI). As of the end of June, 1941, six standard camps with a

capacity of 1,423 families, and eleven mobile camps for 1,830 families, had been established in the Pacific Northwest.

Throughout the fiscal year medical services were made available to camp occupants by placing local physicians under government appointment to serve in the clinics and by extending direct financial assistance to migrant families in the payment of hospital and specialist care bills. The camps were served by public health nurses on government salaries. Although the organization of the Agricultural Workers Health Association was completed in March, 1941, it was not to take over the actual administration of the medical aid program until July 1. The Agricultural Workers Health Association is a corporation financed by the Farm Security Administration.

During the fiscal year FSA expenditures for the camp health program in Region XI, exclusive of administrative costs, were as follows:

Nursing	$12,321.00
Other clinic expense	9,566.00
Referral activities	
Physicians	6,884.00
Hospitals	16,416.60
Total	$45,187.60

Reports indicate that 9,083 cases were treated during the year. It was expected that the program would be expanded the next fiscal year to cover migrant families in areas adjacent to the camps. Moreover, a nursery and school hot lunch program was to be added, and also at least one mobile dental unit.