NATIONAL CONFERENCE ON RURAL HEALTH

FIRST ANNUAL MEETING, HELD IN CHICAGO,
MARCH 30, 1946

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Purpose of Conference

DR. F. S. CROCKETT, Chicago: The purpose of this conference is to seek improvement in rural medical service. Rural medical service is more than having a doctor in the community. Good housing, warm clothing, a suitable diet, together with adequate health education are important factors in maintenance of rural health. The problem is economic and social as well as professional. Given all of these, yet the well trained physician cannot operate in a professional vacuum. The good physician never ceases to improve his educational and professional skills. He must have available diagnostic resources, such as the laboratory, x-ray and an opportunity for consultation with his fellows and with those who have acquired special training, if he is to give the sort of service satisfying to his professional soul. Attracting and retaining well equipped doctors, such as returning veterans and recent graduates, to areas some distance from medical centers will be helped by what we doctors and interested farm groups do here and carry back to our home states.

The problem cannot be solved on a national level. It must be worked out in the community where the need resides. Every one in the community must join if any effort is to succeed. One of the first things to be done is to find out where medical service is lacking. Some states have made surveys of rural and urban medical facilities. In some states councils have been created joining all elements within the state in this health effort. Committees of state medical societies should join actively with their comparable farm group committees in identifying themselves with existing state councils or inspiring the creation of such organizations where not now existing. Since legislation to create more hospitals and other facilities may be passed by Congress, rural areas will benefit. This feature should be of especial interest to us.

Sound judgment should direct the location of hospitals and other facilities in relation to population served—distances that the sick can be transported, the physical features of roads and terrain and the professional personnel available for good results.

Providing plans for the payment of good medical and hospital care is another part of our problem. It is hoped that in all our states the medical profession will sponsor plans to aid those who find it difficult to pay for catastrophic illness. In some states such plans already exist but serve principally industrial groups. Our state committees should seek to extend these benefits to country people. One of the difficulties will be in application of such plans to farmers of the marginal type unable to pay the usual total premium for medical care and hospitalization insurance. Whether the general plan of the Farm Security Administration could be adapted to this segment of our country population, where the family pays something which in turn is supplemented by general taxation, remains to be seen. I believe it has possibilities as well as difficulties. At least it is something for our state committees to consider.

It is our duty, the duty of those we represent, to exercise the greatest vigilance wherever we believe our common interests are threatened through federal domination. There can be too high a price paid for help. Medical care of our farm people is a nationwide problem which can best be solved on a state and county basis. This is your opportunity to do a constructive job in your own home states.

Address of Welcome

DR. OLIN WEST, Chicago: I extend to you in behalf of the Committee on Rural Medical Care of the American Medical Association and the American Medical Association and its constituent units a most cordial and sincere welcome. We are delighted to have in this audience representatives of national farm organizations, individual farmers, representatives of state medical societies and some physicians not representing any of those organizations. The American Medical Association and its constituent units are sincerely interested in the efforts being made for the solution of the problems involved in the farm care. Some states have already organized committees representing organized agriculture. These problems are not going to be easy of solution. Some of the problems involved are factors that are actually involved in biologic law, the very law of nature, and in economic law. These laws are well nigh immutable. Many of those factors or changes effected in those laws are going to be effected through process of evolution and not through revolutionary procedures.

The Farmers' Medical Care Problem

MR. RANSOM E. ALDRICH, Jackson, Miss.: The chief problem of medical care in rural America is cost. It is economic. It is social. I live in a county that doesn't have an active practicing physician. The nearest physician is 22 miles away. The flat charge is a dollar a mile. The low income group in American agriculture simply doesn't get medical service from

that kind of charge. They go without it. I don't know that the doctor can render service any cheaper than that. I know we must work out some type of prepayment plan. We must work out a program of health centers, diagnostic clinics, ample service and large hospitals in the areas where they can be supported. Some of our people are too anxious to build hospitals in areas that can't support them. Before a hospital is established there must be a survey made and adequate profession for maintenance in that community. It would be a tragedy to have ghost hospitals all over America. We can provide hospital services and adequate beds, and then I am urging your group to see that rural America has just as good a supply of doctors as any other group in America and that they are just as well trained. Frankly, people think you have the standards too high for doctors. Your costs are exorbitant. I don't entirely subscribe to that. I do say we have a shortage and I think it is up to you and the agriculture group to stimulate interest in producing enough doctors to serve rural America. From our committee of the American Farm Bureau Federation I pledge you our support in trying to work out a constructive long range adequate program.

DISCUSSION

DR. L. W. LARSON, Bismarck, N. D.: Rural health has always been a problem. Education of the farmer through the public schools and universities, press and radio, and improvements in the means of transportation from the farm to the town and from the town to the city have certainly decreased the seriousness of the problem. However, two phases of the problem remain unsolved; they are (1) availability and (2) cost of rural medical care. Availability of rural medical care resolves itself into the problem of either bringing the doctor to the people or making it possible for the people to get to the doctor. The fees for the actual services rendered by the rural practitioner are not exorbitant; they are usually much lower than the fees charged for comparable services in urban areas. Improvements in transportation, particularly in the development of good highways which are passable throughout the year, will accelerate the growing tendency of rural people to bring the patient to the doctor. This will reduce the cost of medical care; it will conserve the time of the physician, who too often spends the majority of his working hours in traveling to and from his patient. The only solution of the problem of cost of rural medical care is to raise the level of the farmer's income or reduce the cost of the physician's services or spread the cost of medical care throughout a prepayment medical insurance plan.

A Public Health Program for Rural Areas

DR. FRED D. MOTT, Washington, D. C.: The disadvantage in rural health is chiefly with respect to those conditions which can be influenced directly by modern health educational and preventive services. Thus the death rates of rural infants, pre-

school children and youths 15 years of age and over were higher in 1940 than those of residents of large cities. While cities of 100,000 or more had an infant mortality rate of 34.3 in 1942, the rate was 43.3 in rural places and 44.6 in semirural towns. The rural maternity mortality rate in 1941 was almost one third higher than the big city rate. As of 1940 we find that the infectious and more or less preventable diseases take larger rural tolls. If we consider the most rural state and the most urban state in each of the nine census regions we find that, as a group, the most rural states had higher case rates in 1942 for chickenpox, whooping cough, mumps, scarlet fever, diphtheria, septic sore throat, malaria, bacillary dysentery, typhoid and paratyphoid, tularemia and smallpox. Trends show that tuberculosis and syphilis may soon become primarily rural. Despite gratifying progress since passage of the Social Security Act in 1935 there were still 1,242 counties in 1942, 40 per cent of all the counties in the nation, without full time county or district health departments. Excluding the people covered by municipal health agencies in these counties, there still remained 33 million people, one fourth of our national population, lacking the protection of a full time health department. Moreover, this consideration of the counties lacking any official health coverage gives only part of the picture. Few of the rural health departments that we do have are housed, staffed or financed in a manner adequate to do their job.

Competent authorities agree that $2 per capita is required to provide satisfactory public health services. Yet in rural counties the per capita expenditure for public health work is hardly 50 cents annually. Total expenditures by local health agencies in our most rural states in 1942 were at only about half the rate of those in the most urban states. A study of Farm Security borrower families in 1940 showed that only 37 per cent of children up to 8 years of age had been vaccinated against smallpox either at public health clinics or by private practitioners. In contrast, 89 per cent of children in this age group had been vaccinated in twenty-eight large cities studied in the National Health Survey. The same story holds true for tuberculosis control, venereal disease control, health education or almost any other accepted function of a local health department.

The American Public Health Association has proposed a sound plan that would group counties with small populations into districts of at least 50,000 people. On this basis the 3,070 counties in the nation could be grouped into fewer than 1,200 districts, a far more sensible organization of public health than today's 18,000 independent, uncoordinated health jurisdictions. If rural communities would put up about one dollar per person per year themselves, to match about another dollar coming from outside sources, far more could be done to improve rural health than anything we have accomplished up to this time.

Most states now have permissive legislation regarding the establishment of local health departments. Under these laws a county or a community may appropriate funds for public health. Surely we have reached the stage where we should insist on mandatory state legislation under which appropriate public health units would be established throughout the state and their financial support would be required. We already have laws of this kind governing the establishment of public schools. Similar legislation would be the surest way—and an entirely practical and intelligent way—to make public health services available to every rural citizen within a reasonable period of time.

The major public health problems today are the degenerative diseases of advancing years—the various diseases of the heart, the blood vessels and the kidneys, diabetes, cancer and arthritis.

I want to touch on the fundamental question of rural purchasing power and the medical purchasing power of farm families. In 1941 half of all farm operators had annual net cash incomes of less than $760 per family, including income from all non-agricultural sources. So far as rural medical purchasing power is concerned, as contrasted to general purchasing power, it is revealed most readily in the annual expenditures per person for medical care by median income families. Studies show that in 1941 median income urban families spent $26.76 per person for medical care, while median income farm families spent $14.37 per person, or hardly more than half the urban expenditure.

It is not surprising that there is so close a relationship between purchasing power and the distribution of physicians, dentists and nurses and of general and other types of hospital beds. Modern medical services of high quality cannot be provided without adequate resources in personnel and facilities.

Before we set out to solve the whole problem of payment for medical services on a voluntary basis we must not only face these cold factual income and expenditure figures but we must remind ourselves that fewer than 5 per cent of the whole population now receives general medical services on a prepayment basis. Less than 3 per cent of all farm people are covered even for Blue Cross hospitalization and, taking whole states, the states which are over 70 per cent rural had just 4.2 per cent of their population in Blue Cross plans last July 1 as against 18.7 per cent in the states over 70 per cent urban. We must note too that in voluntary plans offering general medical care—aside from those sponsored by the Department of Agriculture—the greatest urban-rural disparity is found with respect to medical care insurance sponsored by medical societies. As of 1945, medical society plans covered 3 per cent of the population of the twenty states that are over 50 per cent urban, but in the twenty-eight predominantly rural states they covered only one half of 1 per cent of the population.

Before we look at the voluntary prepayment approach with optimism, we must ask ourselves frankly how many farm fami-

lies can afford to join comprehensive medical service plans. There is general agreement that a plan offering physicians' and specialist care, hospitalization, dental services and prescribed drugs would cost at least $100 for a family of average size. Studies show that farmers had to have net cash incomes averaging well above $2,000 in 1941 before they made average expenditures of $100 or more for medical care. The fact is that not more than 20 per cent of all farm operators had such incomes in 1941, counting income from all sources. The great majority of farm families throughout the nation simply cannot afford to purchase adequate health protection on a voluntary prepayment basis.

We have a choice to make. Each road we may choose has its toll. One road winds for a time through the field of voluntary health insurance. Although this road is an improvement over the past, its toll is one we should calculate honestly. It has its cost—in almost certain failure to bring anything approaching maximum health opportunity to the majority of our 57 million rural citizens. There is also a hidden cost behind these phrases that we must face. There are people living out over this broad land—people on farms and in villages—people whose babies get sick, whose children break arms and legs, who get every physical and mental disorder known to American medicine. These people want competent physicians nearby; they want a modern hospital within reach; they want certain specialists closer than the metropolis 200 miles away. And they want a simple and sure method of paying their share for the support of these essential resources. I, for one, am unwilling to say to representatives of the farm population that these objectives are utopian. On the contrary, they are realistic, they make sense and they are attainable. But it will take more than the road winding through the tempting pastures of voluntary health insurance to reverse the inexorable trends dictated by economic laws. We may choose this first road—for five years, for eight years or for ten years—but if we do, let us count the cost along with any gain.

There is another road we can choose today, the road charted by President Truman. It is broad and it is direct—the way of compulsory health insurance. In one sweep it cuts through the economic barrier, bridges the uncertainties of individual medical costs and stretches out into the future a solid economic foundation for all the challenging measures we can devise to build good health. This road also has its toll, but of a different sort. If we choose this road, the cost we shall pay will be found largely in the taxing of our minds and our imaginations to build, and build promptly, on the solid and unaccustomed economic base the system will provide.

Think for a moment what it would mean if we had this central core of national health legislation. Medical purchasing power would be spread evenly the country over. Hospital plan-

ning and construction proposals would suddenly have real meaning for rural people, for hospitals could be placed where needed once their maintenance was assured. The urban-rural double standard would be wiped out—rural people would be assured the number of hospital beds they need and not just those they can support today. Something like ten dollars per person would suddenly become available to pay physicians' bills each year—$10,000 for every 1,000 rural people, $20,000 for every 2,000 people. Think of the opportunities this would create in hundreds of underserved rural counties. Picture the flow of veteran physicians and new graduates into rural districts under these changed economic circumstances and with the assurance of hospital or health center facilities.

Farm leaders have a responsibility to see that farmers know all the facts when they make their choice. They should know all the strong and weak points about voluntary prepayment plans. They should know the facts too about the President's program. They should know that the day to day administration of the President's program will be local. They should know that in this program local people and their doctors will serve as consultants in their localities. They should know that—as always—they would choose their own doctors and their hospitals. And they should know the cost of either course in terms of money. Under the President's proposal for a national health program the farm family would pay from 3 to 4 per cent of net income for personal health services. The average percentage of net cash income spent by farm families in 1941—for inadequate services—was actually 8.7 and the percentage spent by low income farmers was higher yet. It seems unlikely that farmers will miss the point or will fail to recognize the clear advantage to farm people and to entire rural states of pooling the resources of the whole nation to tackle this problem.

DISCUSSION

DR. VICTOR JOHNSON, Chicago: The small enrolment in voluntary plans for hospitalization and medical care cited by Dr. Mott is deceptive, since the absolute figures do not include the important factor of expansion and growth. For example, a few years ago only 700,000 persons were enrolled in hospital prepayment plans. In a few years this figure has been multiplied more than twenty times, so that today there are twenty million people enrolled in one system alone, the Blue Cross, which is the largest of the hospitalization insurance plans. Again, in the state of Michigan the medical care plan sponsored by the state medical society has grown to nearly a million subscribers, or one in five to six of the population, in a relatively few years. We may look forward to growth of medical care insurance coverage in other states on the basis of the experiments in Michigan, so that in a few years there may be many more people insured for medical care than are now enrolled in the Blue Cross hospitalization plans.

To be successful and to meet the needs of the country it is essential that prepayment medical care insurance be expanded greatly and provide a wider coverage. First, this must be done for those who can pay their own premiums. Such expansion should include the farm as well as the urban population of the country. Negotiations are now under way between the California Physicians' Service and the Grange in California for group coverage of farm people. Such arrangements should be consummated elsewhere as well, so that farmers and city dwellers will enjoy the benefits of medical care insurance. Secondly there must be efforts and experiments directed toward the inclusion of some of the indigent and the medically indigent in these programs. How this can best be done presents a serious problem. Many of the indigent have chronic illnesses, and in many instances the illness may be the cause of the indigence. Patients with such chronic illnesses as tuberculosis or mental and emotional derangements are soon likely to find their funds exhausted in the course of the illness. Perhaps such groups must continue to be provided medical care as special problems outside the scope of prepayment insurance plans. Certainly the inclusion of considerable numbers in these categories is likely to threaten the financial structure of any prepayment medical care plan. On the other hand there is probably a large group of indigent or medically indigent people whose inclusion into medical care plans would not disturb the financial soundness of the programs or impose unduly high premiums on every one.

Perhaps information concerning the best way to include such groups will be forthcoming from another major experiment in improved medical care being conducted in the state of Michigan under the auspices of the Michigan State Medical Society. This experiment deals not with the indigent but with another group for whose medical care the federal government has assumed responsibility. This group is that of the veterans with service connected disabilities. The Veterans Administration has entered into contracts with Michigan Medical Service to provide care for this group, employing the fee schedule of that prepayment insurance plan. The physician collects his fees from Michigan Medical Service, which in turn bills the Veterans Administration. This plan for veterans is also being organized in other states and may well provide a formula on the basis of experimentation for a considerable increase in the coverage of the lower income groups of this country by prepayment medical care plans.

In our efforts to solve the problem of improved medical care it would appear wiser to proceed along these experimental evolutionary lines than to make sweeping revolutionary changes. Experiments should be conducted even with compulsory medical care insurance in circumscribed areas or communities. One such

experiment is already under way in the state of Rhode Island, where compulsory insurance is employed in industry, with contributions by the state, by industry and by the insured employees. Much has already been learned from this worth while experiment. After the first year of operation of this plan certain significant conclusions were reached by all participants, including the physicians. It was found that red tape was excessive, interfering with the quality of medical care. It was also found that the costs of administration were more than was anticipated. Finally it was found that there was need for decentralization of the program. The latter finding was particularly significant in the light of proposals for nationwide compulsory insurance, since Rhode Island is one of our smallest states, with a relatively small population of both physicians and patients. Such illuminating experiences promise to provide much valuable information for the extension of our experimentation into further methods for improving medical care in this country.

Throughout all such efforts it is imperative that we keep ever before us the necessity for maintaining a high quality of medical care. It would serve no useful purpose but rather produce much harm if extension of medical care to all geographic areas and to all the citizens of the country was to be accompanied by a deterioration in the high quality of medical care now being provided.

Health Program for Small Communities

MR. HOWARD STRONG, Washington, D. C.: Rural health service may be broken down into three categories: (1) medical service by physicians in private practice, (2) service through hospitals, medical centers and clinics, and (3) public health service through official agencies.

The distribution of service by private physicians varies widely. It is generally assumed that the proper ratio is about one physician for each 1,500 people. Cities and metropolitan areas have the largest number of physicians per thousand of population, while the rural areas have the smallest proportion.

The most immediate need is the supply of physicians for rural areas, and there the situation at present is not too encouraging. Sixty thousand doctors were called to the service. These men are now returning. The majority are going back to their old practice. But a sampling made by the Procurement and Assignment Service shows that only 23 per cent of this former practice is in towns of less than 5,000 and in the rural areas. Between 15,000 and 20,000 of the returning physicians are young men who had established no practice before going into the service, and these men want to go to cities ranging between 25,000 and 250,000. There is a very definite reason for this preference for the larger city. The younger men who have graduated more recently from the medical schools have been trained in the use

of all the hospital, technical and clinical facilities of the larger city. With the development of diagnostic and clinical technics and equipment, and of increasing specialization, practice without adequate clinical and hospital facilities is becoming increasingly difficult and unsatisfactory. A physician hesitates to go into smaller towns and rural areas which do not offer these facilities. He will go to the larger city where they may be found. This brings us to the possibility of increasing these facilities in the rural areas, and here we find some encouragement.

The National Commission on Hospital Care inaugurated by the American Hospital Association is making, in cooperation with state health departments, a study of hospital facilities and needs throughout the nation as a basis for a national hospital program. This is the most complete study that has ever been made and out of it will come, it is hoped, a national program which will have the cooperation of all health and hospital agencies, public and private, and of the medical profession, throughout the United States.

A small community or a sparsely settled rural area cannot afford to employ full time health officials and provide adequate service. A recent nationwide study of health department facilities indicates present local facilities and needs and proposes the development of a system of health administration under which several rural counties may combine in the employment of a health staff and the maintenance of a central office. This proposal contemplates a total of 1,197 health units for the country. It would make adequate public health facilities available to every section of the country—cities, towns and rural areas. A town of 15,000 or 20,000 with county, multicounty, state and perhaps federal assistance usually can build and support a 15 to 40 bed hospital with necessary medical and nursing care, provision for the practice of internal medicine, obstetrics, minor surgery, dentistry and some other specialties and with simple laboratory equipment. Such a small institution can serve a majority of the hospital needs of a small community with its rural area, if it has the opportunity to refer complicated cases to the larger hospitals. And great promise lies in the recent activity toward the provision of nationwide medical care on a prepayment basis. Congressional bills propose a universal, tax supported medical service. The American Medical Association proposes a nationwide voluntary prepayment plan based on the action of local medical societies. These proposals represent two widely divergent schools of thought, and the proponents of each are vigorous and sometimes acrimonious in their support. But all this does not mean that health service is going to be presented on a silver platter to every community and to every rural area. The larger political units, federal and state, are not going to do it all. County and town communities must participate with citizen enthusiasm and with tax and voluntary funds. And this is where you, representing most of the farmers and rural areas of

the country, and we, representing small as well as big business-men and their organizations, come in. You have the responsibility for convincing the rural population that health is a sound dollar investment as well as a human asset. We, for eighteen months, have been seeking to stimulate interest in the smaller communities of the country to provide more adequate health service. The response has been beyond our expectations. Smaller communities all over the country are seeking ways and means of providing more adequate health and hospital service. And definite action to this end is increasing. We expect to intensify this effort in cooperation with the American Medical Association and to help in bringing to these areas the importance of local action if adequate health provision is to be made.

Health Education for American Farmers

LELAND B. TATE, PH.D., Chicago: The Farm Foundation which I represent is a private, philanthropic organization whose objective is the stimulation of research and education for the improvement of rural living conditions. Our policy is to work with various agencies, organizations and leaders interested in the general welfare of rural people and to stimulate activity where needs are great and progress is slow. Hence some of our chief concerns are better medical care and health services for farm folks, and health education of a broad nature which brings (1) knowledge and understanding of what is desirable for maximum health and (2) insight into ways and means of getting and paying for adequate health and medical services.

In our rural health work we have stressed particularly ways and means of getting more personnel, facilities and services. We have used both regional and organizational approaches. From a regional point of view we have concentrated our efforts mainly in the Northern Great Plains from Nebraska to North Dakota and in the Southern states from Virginia to Texas. Various measuring devices show these as predominantly rural regions in need of many more and more widely distributed doctors, dentists, nurses, hospitals and health centers. On a somewhat informal basis we have worked with farm organizations, research and extension divisions of agricultural colleges, the National Extension Service, public health people, medical colleges, state and regional health planning committees and various medical, health and lay leaders, both private and public.

It seems to us that any one who plans an educational program for American farmers about health services and medical care should know at least five fundamental things: (1) the meaning and significance of health and education, separately and in combination, (2) the characteristic facts about farm people as a segment of the total population, (3) the forces that prompt farmers to think and act as they do, (4) suitable subject matter content and (5) appropriate appeals and teaching technics.

To us health education is considerably more than giving instruction and having people learn about health rules, routines, safety, sanitation and other traditional topics. A comprehensive educational program about health matters might well attempt to (1) create awareness, (2) overcome inertia and indifference, (3) soft-pedal fear complexes, (4) explain the basic factors affecting health in a positive way and in a negative way, (5) describe existing health situations, (6) make known available facilities and services—how obtained, when, where, by whom, under what conditions, and (7) clarify alternative ways and means of getting more facilities and services: their possibilities and limitations, their advantages and disadvantages.

An educational program for farmers about health matters should take into consideration the forces that prompt farmers to think and act as they do. This covers much of what commonly is called farm psychology. It is apparent that many factors influence the prevailing ideas which farmers and others have about health services and medical care. Among these are traditions or handed down beliefs, customs or handed down procedures, attitudes or feeling tones toward certain things and persons, experiences with biologic objects such as growing plants and animals, self employment and what it implies, and economic uncertainties due to the great dependence on weather in farming operations. These factors need particular emphasis and consideration in developing plans for educational programs about health matters as far as farm people are concerned. Failure to recognize these factors may jeopardize maximum progress toward desired objectives.

The economic factor is a very important one to consider when appealing to farm people. For example, it can be stated positively that sound health means productivity for making money. Ill or half sick persons with impaired strength and will power mean costly waste in most rural communities. This situation is a barrier to economic efficiency even though no direct payments are made to doctors and hospitals. Labor represents more than half of the farmers' cost of production. If this labor is of low quality because of sickness or impaired effectiveness, every day lost is reflected in lower earnings. Hence good health becomes a prerequisite for full time employment on efficient farmsteads. Emphasis too may well be placed on present high costs for medical and dental services to rural people out of proportion to their paying ability. Together these two economic considerations—one direct and the other indirect—make a strong appeal to most persons.

Summary Discussion

Mrs. Charles W. Sewell, Chicago: Today, in a realization of the great needs in rural America for more adequate health programs, more doctors, nurses, hospitals, equipment, better roads, economic improvement and more education to meet these

problems intelligently, we come as doctors to a clinic. Here we have counseled together, exchanged opinions regarding new or controversial treatments and now should determine our course and throw the high powered x-ray of knowledge on hidden causes of unsuspected malady.

Perhaps the first of these would be the scattered population—the disproportion of organized farm families to those found in unorganized groups. The low income of such large numbers of rural population is another tremendous handicap. A third is the irregular income, since great numbers of farm people do not have a source of revenue except from the sale of products three or four times in any given year.

Farm people are proud and conservative and as far as possible are anxious to pay their own way. In twenty-six states, members of our organization who are residents of a territory not too far removed from some of the larger metropolitan centers have been able to work out satisfactory arrangements for hospital insurance and in some instances complete medical care.

The principle of insurance through mutual benefit associations, for hospital and medical care, appears to us to offer a plausible solution. As rapidly as possible, workable plans already in existence should be extended until they reach the remotest parts of rural America. However, we are not blind to the frailties of humanity, and rural people are not greatly different from those of any other group. A program of education for this type of insurance must be carried forward until health and hospital insurance provisions become just as well known and as genuinely accepted as fire, automobile and life insurance.

The American Farm Bureau Federation has favored the objectives of legislation providing that the federal government should reasonably extend its public health program with respect to maternal and child health, rural hospitals, public health services and medical care for those unable to provide such care for themselves. Such legislation should safeguard the rights of the states to develop their own programs to meet their own local needs. The federal government is not justified in assuming the burden of supporting the health and medical facilities that the states can and should bear, but only to the extent necessary to bring about equalization of health and medical facilities among the several states.

The proposals of the Hill-Burton bill, now before Congress, designed to establish commissions to study health needs and to set up hospitals in rural communities, is one of great interest to us. It is to be hoped that if such arrangements are completed the utmost care will be taken to place the hospitals in communities of greatest need, and not only the problem of building, but that of maintenance and location, receive careful

consideration. Again it is imperative that there be an adequate number of trained personnel, doctors, nurses, technicians and laboratory assistants.

We are disturbed by proposals designed to provide compulsory federal hospital and health insurance. Our chief concern is to get more adequate medical care and hospitalization for our farm folk. We are wondering if the personnel set up to administer such a health program would know no more about the subject than those placed in positions of authority in other governmental bureaus dealing with agriculture and who recommended "taking the shoes off a horse at night to save critical steel as a war measure." We wonder if it would require as many trips to the county seat to secure stamps for medical care as it has done to get gasoline, tires, farm machinery and rubber boots in order to carry on agricultural production. We wonder if the stork could delay his visit while the necessary red tape was cut or if we might receive a directive such as the sheep men were presented, advising them in the face of shortage of herders for the critical lambing season to "postpone the lambing until more favorable weather." We have repeatedly expressed our opposition to compulsory insurance plan by resolution. In answer to the statements that we are not moving rapidly enough with such a program we point to the growth of Blue Cross. Like a Chinese scholar who taught the famous Chinese marching song to groups of soldiers ten at a time and then in twenty minutes had an army of ten thousand singing "Many hearts with one mind, Brace the enemy's gunfire—March On—March On," a song heard round the world, we believe it can be done through voluntary effort on a broad educational program.

Our organization is particularly interested in the development of plans that will permit of bringing the cost of medical care more in line with the prices which are obtained by farmers as they exchange their products for the labor and services of health agencies. It is one thing to pay $150 for a surgical operation when wheat is $1 per bushel and an entirely different one to pay the same cost with wheat at 50 cents per bushel.

The prevailing cost of a bedside call in most rural communities is still based on the practices established during the horse and buggy days, necessitating longer absence from the doctor's other patients or office than is now necessary.

Dr. Harrison H. Shoulders, Nashville, Tenn.: I should like for you to think of medicine as being entirely preventive. When a department enforces sanitation measures it's to prevent the transmission of disease. There has been entirely too much segmentation of this whole problem of medicine. As science has progressed it made apparent the fact that there are preventive measures that require the use of the police powers of the state. There are many other preventive measures which are placed in the hand of the individual physician and individual citizen. An individual cannot enforce a quarantine. The execu-

tive department can. A state department can. I cannot enforce a sanitary and milk order. An executive force can. For that reason and for the time for that reason only, public health departments were created. And they did a fine job when they confined themselves with these particular powers. We are for public health, but the question comes down sometimes to what is meant by it. Diseases have disappeared under public leadership, under public health departments and with the prudent use of the powers covered beyond them. Today such diseases as diphtheria and smallpox could be prevented by individual effort, I mean by inoculation to a large extent, in the hands of individual citizens and individual doctors. With that broad, simple division of activity then the question comes up Shall we pursue in this American way of life to use our individual efforts and our individual genius and our individual financial aid? It comes down to the economic situation. Let's consider the cost of such things in a rural county. These public measures serve their purposes largely when cities realized that they required sewerage, sanitation and similar benefits. The farm community is still an individual unit. Any public agency must perform most of the activities on an individual basis. In a city it is different. People become congregated and congested. Geography and location have a lot to do with the problem. In a county of 30,000 with a birth rate of 25, it costs $15 per child to inoculate against five preventable diseases. A suggestion made this morning would require a dollar per head, $60,000 a year, to carry out the public health measure of the country.

Application of Medical Knowledge

HON. J. PERCY PRIEST, Nashville, Tenn.: How to make rural life in the United States sufficiently attractive and sufficiently stable to permit the production and utilization of essential farm and related products within a pattern of intelligent conservation of rural resources—both human and natural—is not merely a question for emotional appeal to the humanitarian. It is one of cold, calculating, hard headed economic significance—yes, even political significance.

Every one is agreed that the health record of the United States is—on the whole and relatively speaking—good. There is agreement also however that it is not as good as it should be, not as good as it is possible for it to be. Indeed, for certain areas in the country and for certain groups of our people it is agreed that the record itself is definitely not good.

One of the issues that is repeatedly before the Congress is whether the benefits of proposed health legislation, whatever it may be, will eventually be realized by the people who need them most. It is impossible to conceive of health legislation that would apply with equal benefit to all parts of the country. As a result we are faced with the question as to whether we should legislate down to the least advanced areas or up to the most

advanced. It is my opinion that the only way to progress is through the latter approach. It is only in this way that government can meet its responsibility of assuring the whole population, as far as possible, the full benefits of good health care.

Even though science has yet to give us the cure for many maladies, the full application of what is known would do much to prevent or minimize the effects of illness. The real problem, then, is to devise the instruments of organization through which all the benefits of present medical knowledge can be applied to the needs of all the people. Before we can even begin a full attack on that problem we must determine how we can best provide for all the people anything approaching adequate medical care. One vital question must be resolved—this is How can we pay for adequate medical care for the whole population? The President has suggested that we accomplish this by spreading the cost over the entire nation through expansion of our existing social insurance system. It is my belief that only through application of the insurance principle to the risks of illness can we make possible equal opportunities for health in every part of the country.

Students of medical care seem to be in accord in the opinion that prepayment by groups for medical service is more efficient and hence more satisfactory than postpayment by individuals. Here, again, there appears to be no area of serious disagreement. One finds controversy only on details of how the insurance principle can best be applied. One of the major issues today is whether group prepayment should be on a basis of local control and voluntary participation or on a basis of national control with universal participation.

Health services to a large portion of our rural population are alarmingly deficient. There are far too few physicians and other health personnel, far too few hospitals, public health services and sanitation facilities in rural communities to serve the 57,000,000 people who live in these areas. Since I have proposed remedies to the problems of hospital and mental care, let me take these two fields of need as examples of inequities that exist among rural and urban areas. Adequate numbers of psychiatric personnel and clinical services are exceedingly limited throughout the country. They are nonexistent in rural communities. While the hospital facilities problem is not as acute, the disparity between urban and rural areas in the hospital field is almost as great. Rural areas have about half as many hospital beds as do the metropolitan centers—less than half the number they need to serve their people adequately.

In the field of preventive services these disparities continue. Despite the progress that has been made under the impetus of the Social Security Act, there are still about fourteen hundred counties lacking full time health departments. Practically all of them are rural counties. There are gross deficiencies too in sanitation facilities. The reason is simple. People in rural

communities and rural states do not have the purchasing power with which to avail themselves of the facilities and services that are essential to good health care. The year 1943 was unprecedented as a year of farm prosperity, yet the income from farming amounted to only 9 per cent of the national income, while farm people made up about 21 per cent of the population. According to the latest census of agriculture (1940) about two thirds of all farm families had gross incomes of less than $1,000, with one third under $400. States predominantly urban (70 per cent) had an average per capita income of $800, states predominantly rural (70 per cent) of about $300. It is basic to our economy that some solution be found to this grave imbalance, and I applaud the Farm Bureau Federation for its efforts to obtain greater equalization of rural and urban incomes. Until that time has arrived, justice demands that the urban states, which are, in a sense, draining off the wealth of their rural neighbors, help to extend into our rural communities those facilities and services which are necessary to good health care.

For the nation to meet its obligations in a field as broad, as complicated and as fundamental as health, it is of the greatest importance that the public agencies administering the program be maintained at the highest possible degree of competence.

Rural Medical Services in Alabama

DR. J. PAUL JONES, Camden, Ala.: People in rural areas want all the benefits of first class medical services or science that they have read about; they want more doctors, nurses and all facilities for good medical care. They want an easier and a more economical way of paying these bills, even if it means subsidizing of medical services by state or federal agencies. The day of rugged individualism in rural medicine is passing; the people are demanding better care. In its place is appearing the belief that good medical services can be obtained in areas of low economic income either through taxation or through subsidies. The public is slowly becoming convinced that improved medical care and more hospitals are a public responsibility in the same class as good roads and good schools.

While it is true that improvement in farm income and rural living conditions, including education and sanitation, would of course go a long way toward solving the rural medical services problem, there are certain objectives we could aim at right away: 1. Some way to ease the payment of medical services and hospital expenses, through prepayment insurance for those able to pay, and subsidizing of indigent medical services and hospital expenses by the community or state. 2. Construction of facilities such as hospitals and diagnostic and treatment clinics in those areas where need is found, through grants-in-aid, if necessary. 3. A better cooperation between our medical, dental and nursing schools and this system of hospitals, so that doctors, nurses and technicians could be trained to staff

these facilities. 4. Broadening of preventive public health services and sanitation programs. This problem of better medical services to all the people of Alabama has been recognized by the Alabama Medical Association for several years. In 1944 a committee was appointed by our president to investigate a method of securing a broader and better type of medical services for our people. At a meeting of the committee a definite program was sponsored.

Action of State Rural Health Committees

DR. A. S. BUCHANAN, Prescott, Ark.: Our program was instigated in 1942 by the county medical society or by the Farm Security Agency and had the cooperation of the county medical society. This little program has succeeded very satisfactorily. We have had no trouble in the organization or in the management as to whether it would suit all communities and neighborhoods in the state. To make it possible there would have to be some changes made to suit each community. I think that would be true in the organization of a national program. It has been satisfactory in that county. There has been one in Texas, one in Mississippi, one in Arkansas and perhaps one in Georgia. I understand that these other counties have been equally satisfactory. There was some question as to whether we would as a county medical society have the management of the program. We were accused of cooperating with those in favor of socialized medicine. I want you to know that is not true. It is a very good program. It takes care of all the people, not only farmers. I think the majority of farm families that really need the assistance of others are on the program.

DR. FRED A. HUMPHREY, Fort Collins, Colo.: In Colorado we have attempted to solve the rural problem by prepayment health insurance. This is working under the Colorado Medical Service, Inc., and we are at present trying to scatter that all over the state. The previous speaker mentioned the Farm Security Agency. In western Colorado that was a complete flop. In eastern Colorado it worked fairly well and people got fairly good service. Dr. Mott stated that they were working from the top down. In Colorado we have five counties without medical service. In my opinion that is the place to start, where they do not have good medical service, and work up, not down. I belong to a county which is of 36,000 or 37,000 population. We have from thirty to thirty-five doctors. Medical service there is very good. The state and national public health services are doing their best to force us to put in a county health unit. What we would rather do would be to have them go into the counties that do not have medical service and do some good there. It is a mining problem rather than a rural problem in Colorado. We have only about five counties out of some ninety-five that have full heal.h units.

Dr. Harlan A. English, Danville, Ill.: The Rural Health Committee in Illinois is a new committee. We plan to have one meeting a year in each rural medical society, at which meeting representatives of all farm organizations in that county will be invited to discuss their rural medical and hospital problems.

Dr. E. E. Shaw, Indianola, Iowa: Many counties in Iowa wish to put across a bond issue and build a hospital. Whether they can support it is a question. They don't feel that every county should have a hospital. Ours is one of the counties that hasn't a hospital. We don't need a hospital. It is healthy to see the Farm Bureau feel that a hospital should be built only where one is needed. We are also devising a medical care plan for farm groups. We have organized units for collecting agencies for hospital insurance. Many men are going into it. We have the medical service plan just getting started. We are already putting out a hospital plan in two rural counties in the state. They want statistics as to costs. We are anxious to enlarge medical and surgical plans. We shall in the next few years be able to put it in rural areas. The Farm Security Agency is very unsatisfactory. During the first year it worked fine. Doctors were almost 100 per cent in favor. In the second year the agency man came in and changed the thing completely.

Dr. A. R. Hatcher, Wellington, Kan.: We have not tried any of the plans discussed here. I'm from Sumner County, which has a population of 27,000. We have about twenty-two doctors. There is a part time county health officer but soon we shall have a full time county health officer taking in a county adjoining us to the west which will make it possible for us to have a full time county health officer, sanitary engineer and nursing staff. We have forty-seven counties in Kansas, some of which have one doctor, some two, some none. There are a great many osteopaths. It is the intention of the hospital survey committee, of which I am a member, to give that part of our state the first attention in the way of building small community centers with offices, reception room, laboratory, emergency operating rooms and a few rooms for the doctor who may desire to locate there along with a full time county health officer. These other programs that have been discussed I am sure we haven't any particular reason in Kansas for even experimenting with. Even with the shortage of doctors, many people have not suffered want of medical care. Roads are available, hospitals there are good and even though you are 50 miles from a hospital you can get there in an hour. We're going to give our attention chiefly to the rural districts and get some real doctors, young doctors in health centers and try to apply the Hill-Burton bill, if it passes.

Dr. Clark Bailey, Harlan, Ky.: Two years ago the medical economics committee reported to the House of Delegates that

we should have an enabling act that would enable us to take part in a prepayment plan. We went before the legislature, and last week the governor signed the bill enabling us to go ahead and set up an organization to have a prepayment plan for the people of Kentucky. The medical economics committee asked the legislature for a revolving fund of $75,000 that would put two students through medical school if they will agree to practice in some designated rural community for the next five years after completing the internship. That passed but was vetoed by the governor. The medical association and the state association made donations to start a fund of that kind to take care of some rural counties that do not have doctors.

Dr. Guy R. Jones, Lockport, La.: We have, as you have throughout the United States, a scarcity of doctors. We have tried the Farm Security Agency and found it to be a complete flop. Doctors have refused to work under that plan. We shall advocate a prepayment medical and hospital plan. The parish health officers are being urged to support state medicine, but they are working with Louisiana State Medical Society and fighting it. Those gentlemen are not for state medicine. In Louisiana osteopaths and chiropractors are prohibited by law. We are well organized and ready to follow any plan advocated by this meeting.

Dr. H. B. Zemmer, Lapeer, Mich.: Whatever has been done in Michigan has been done with the medical society as a whole. We are getting organized and will have some suggestions to make when we get back. Some three hundred farm groups and many grange groups are cooperating with Blue Cross. Michigan Medical Service is separate from the Blue Cross and we are proud of its accomplishments. It has had its greatest memberships in industrial groups and is now being extended to farm groups. We feel that it has done a splendid job in rural groups. We are hoping that the Hill-Burton bill will help us solve the problem of hospitals. Another thing we have obtained in Michigan is a uniform fee schedule for all government agencies, worked out by the council of the Michigan State Medical Society after much discussion. Adoption of this schedule made it possible to cooperate with the Veteran's Administration. On this program the service is for service connected disability. Before the war there was a preceptorship with the university. Juniors and seniors were assigned to doctors throughout the state. This was a splendid idea. It gives the student a fine chance to get some bedside manner and gives doctors a chance to come in contact with newer technics. I hope it can again be established.

Dr. B. J. Branton, Willmar, Minn.: Minnesota is a state with two and one-half million people and eighty-four counties. About two thirds of the people are in the rural population, one third being urban. In the eighty-four counties of the

state there are only three, four or five not having hospitals. Roads are excellent throughout. The need for the Hill-Burton bill is evident in some places. We have in Minnesota the number of hospitals we need at the present. The prepayment medical plan is going to serve a fine purpose. We have worked closely with the Farm Bureau. It has been a wonderful and friendly feeling to have people who control the destiny of some 60,000 farm families in the state behind us in our work. We are working with and in conjunction with Blue Cross, which now has about six thousand contracts in the state. We have put over a health education program.

DR. R. W. KENNEDY, Marshall, Mo.: We have plans for the extension of prepayment medical care and prepayment hospital care, information on placement of hospitals and enlarging the state university to four years with the final year in Kansas City to provide more doctors. We have a plan for extension of public health. To promote health among farm folks we have provided a committee in the woman's auxiliary and a speakers' bureau. Doctors in this area are called on to make health talks to farm people.

DR. E. M. GANS, Harlowton, Mont.: There has been a prepaid medical service established in Montana. There is a low bracket group, up to $5,000 a year.

MR. M. C. SMITH, Lincoln, Neb.: We do not have a rural health committee. There is a Nebraska Health Planning Committee as part of the extension of the Agricultural School in Nebraska. The state medical association has had representation on that committee. We are another of those states that have four counties without a physician. The committee has established, with the approval of the state medical association, a cooperative health plan in Thurston County, where there has been no physician. This cooperative plan has worked with a varied degree of success. The greatest difficulty is to keep a doctor out there. It is very difficult to keep a doctor in sparsely settled areas. A doctor wants a better educational opportunity for his children. People up there have plenty of money and are willing to spend it to have a doctor in their own community. They took an old hotel and built a hospital there. The plan worked, except that they can't keep a doctor there. We went through that area with the Farm Security Agency and organized eighteen or twenty plans operating all over the state. As soon as the farmers had raised two or three crops they didn't like the Farm Security Agency. Farmers were the ones that wanted to discontinue the plans. The farm bureaus, the farmers themselves, want to pay their own bills. As to the Hill-Burton bill, we do need some hospitals in Nebraska. We hope we shall have the opportunity to place some hospitals in Nebraska. Our greatest problem will be where to build hospitals. In this state we have a number of towns where they have started

local campaigns to build hospitals, have raised money and want their own hospital. This committee will have the problem of going to the town and say here is the reason why the hospital will not be successful in this territory.

DR. DAN MELLEN, Rome, N. Y.: Our state is well organized for the prepayment insurance plan. It seems to be successful, and recently a committee made a survey in the rural districts relative to the hospitals, the laboratory equipment and staff and the number of physicians. As far as placing physicians, we have been working in conjunction with the committee on veterans' affairs. As we get calls from these areas mostly in the northern part of the state we try with the committee on veterans' affairs to place these men.

DR. W A. WRIGHT, Williston, N. D.: We haven't the constructive program that we have had people tell us about today. There is a misconception as to the practice of medicine May I tell you how we think rural medicine should be practiced? It should be clustered around certain metropolitan centers where people go to buy things. There is no future in trying to put a doctor in every hamlet, as was felt thirty years ago. It is easy for a patient 50, 60 or even 100 miles away to get to a doctor with present methods of transportation. Perhaps it is a hardship, but I would rather travel 80 miles in North Dakota than 1 in Chicago. Doctors should be educated for rural practice. The tendency of the medical schools is to look down on the general practitioner and exalt the specialist. If it was made more honorable, more young men would become general practitioners. We need more good general practitioners. It takes a large area to support a specialist. If we are going to have good general practitioners we must have more trained in college days to be just that. We realize that it is a hardship not to have a doctor in a county. But the county is no longer a unit. It is the natural trading center. In the next county or over, there may be a good health center. I deplore using the county as a unit.

DR. CARL S. MUNDY, Toledo, Ohio.: For years we have had a health subcommittee of the planning committee, composed almost entirely of laymen, but the state association has had a representative on that committee since its beginning. Through that representative our state association has been in touch with the thinking of the farm groups. This committee attempted a year ago to put into effect a prepaid plan on a small scale in one of our counties. The plan did not succeed, although it was supported generously by our state association. In the last few months we have started our prepaid medical service plan, which we call the Ohio Medical Indemnity, Inc. We are just now beginning to sell contracts. It is our intention to push the sale of these contracts in rural areas as rapidly as possible. We found the same thing in Ohio—an inertia among farmer groups

to prepaid medical service. We are able to sell contracts to only about 30 per cent of their membership. We cannot determine the exact reason.

MR. KENNETH G. MANNING, Portland, Ore.: We do not have a rural health committee in our state. I have been sent here representing Oregon Physicians' Service, the association approved and sponsored by members of the state society. The setup has approximately 50,000 subscribers under the hospitalization plan. In the state of Oregon about 140,000 are covered. As for rural problems in that area, surprisingly I have not heard the name of Dr. Shadid in this meeting. Dr. Shadid comes from Oklahoma. He has been in Oregon and has sold one or two areas in the state on the idea of organizing a cooperative health center, hiring doctors and setting up health centers selling prepaid medical and hospital care. He is particularly interested in farm areas. In Salem, Oregon, they have adequate staff doctors. The Farmers' Union and other farm agencies have caught hold of the thing and are trying to sell membership. We don't have a serious problem in Oregon so far as medical service is concerned. We had experience with the Farm Security Agency in Oregon. The thing has been quite a flop. Doctors refuse to work for a percentage which is substandard.

MR. DICK GRAHAM, Oklahoma City: Dr. Shadid will run his chosen path and get little distance down the run. I have heard reference made to the Hill-Burton bill. According to statistics only two states do not have a very liberal surplus in their state treasuries. And you call on federal aid to do that which the local community should do. There has to be an end to this federal spending. I doubt if there is a community anywhere in the United States which cannot finance its own health needs. In Oklahoma we started with $100,000; we have already completed our survey, and if the Hill-Burton bill becomes a law on the basis of that division we should get only 175 a year I have talked to many veterans who have never been in private practice. They went out of medical school into internship and then into the army. For four or five years they have had the finest medical facilities to work with. They had technicians and nurses. Those boys are utterly scared to practice by themselves. I would not suggest that the medical associations lower their standards but I do believe that the medical schools should take cognizance of the fact that those students may have to go into areas from an economic standpoint alone and practice without the help of the Hill-Burton bill and the technicians and the nurses and I hope that that day will come.

DR. AUGUSTUS KECH, Altoona, Pa.: We do have our rural problem. We're not organized. It belongs now in the committee on medical economics. The state society in conjunction with the state college of health and voluntary agencies selected three counties to survey. The Farm Security Agency has had

some problems. Several communities have been organized, and we have felt that the physician would not get anything out of that practice. We have 236 state aided hospitals. Hospitals are covered within 30 miles. Good roads exist on which to go to and fro We do not need new hospitals; we do need extension of every hospital in bed capacity. Our medical service has had a poor start but now since last year has grown. It has doubled the number of members and participating doctors. It is going it alone and not with connection with any other agency.

Dr. A. W. Browning, Elloree, S. C.: We have good roads, schools and easily accessible hospitals. Our splendid state board of health is doing good work. Every county has a county officer and nurses. We have in our county the tuberculosis examination for schools, x-ray units in the county and x-ray at the tricounty examination. We have clinics there every week and in two or three towns every week We have been trying to get a medical college in Charleston for years. Last June the legislature passed the bill for one and one-half million dollars for a doctors' hospital and also gave us two and one-half million dollars for a survey of the state and for medical centers if needed. I don't know any one in my section who can't get medical care or hospital care when needed. We have a publicity man to watch out for our interests and have a permanent committee, one from each district, to watch the political affairs in our state. We have Blue Cross insurance passed by the legislature and are trying to bring it into effect. We need more hospital beds, hospitals and small medical centers. We are thinking of subsidizing some students while at South Carolina Medical College at Charleston to serve two years in outlying places, also Negroes, as Virginia is doing, at the college in Nashville, Tenn. We believe in the American Medical Association plan of approved insurance, prepayment hospital and health insurance such as Blue Cross. We are having meetings all over the state with speakers discussing the Wagner-Murray-Dingell bill.

Dr. A. P. Peeke, Volga, S. D.: Our problem is the same as in Nebraska and North Dakota. We have about half a million population, 342 doctors, 142 over age 65, and 90 per cent of the medical profession are in small cities of 15,000 or 20,000. The big problem in our state is that we have 60 osteopaths practicing.

Dr. H. H. Shoulders, Nashville, Tenn.: When the dislocations of a war period are still with us, it is no time to do permanent planning. The county as a unit is not a basis for location of hospitals and a county society. That should be considered on the basis of the logic of the situation rather than on county boundaries. The people in rural communities complain that doctors charge on a mileage basis. I think that was a good basis for the period when it prevailed. It seems to me that the time factor

or some other factor should be used. Our profession within ourselves might present some correction. The general practitioner of medicine deserves a great deal more dignity and attention than he has received from the profession. We must improve the concept of the practitioner, and we have done so in Tennessee by an education program. The rural health problem is as different from the city problem as it can be. The farmer's home is a unit with individual water supply, individual all the way through. In Tennessee we would make some studies, and this helped get the appropriation. The doctors were alert doing immunization of all diseases and getting reasonable fees for it. By doing that they had to keep a nurse. Doctors discharged nurses because they hadn't enough practice. That has influenced the economics of rural practitioners. We made some studies of counties with equal population in the same general area. Rural counties with an alert profession well trained showed a mortality rate no different from that of a county with an equal population with a full time health unit. The solution of the rural health problem resolves itself with getting a qualified doctor into the area. If immunization will control a lot of diseases, it becomes individual medicine, both preventive and curative. Probably we have sold the idea, and that has been made possible by the fact that we have never drawn any sharp distinction between public health activity and individual health activity. If we do that most of our problems will be solved.

Dr. Crockett: In the state of Indiana the house of delegates has organized a committee which is setting up the machinery whereby men who are first class general practitioners will be so certified by the state society after due examination. In that way we hope to do that very thing—give every man in the general practice of medicine an opportunity to stand apart on account of the excellence of his work.

Dr. B. E. Pickett Sr., Carrizo Springs, Texas: Our executive committee passed a resolution to accept any plan that met with the specifications set up by the American Medical Association. Mr. Ketchum from Michigan suggested that the medical and surgical plan as offered by the state, paralleling the Blue Cross, be accepted and we commended him. This plan is getting under way. We have some 15,000 subscribers. The Blue Cross is quite active in the state, and there are few communities that are not within 30 miles of a hospital.

Dr. K. B. Castleton, Salt Lake City: We inaugurated a publicity plan in which we made use of a local newspaper having the largest statewide coverage. Since then we have had articles published dealing with medical problems and case reports. In these articles no reference was made to doctors' names, hospitals or communities. We feel that the articles have done a great deal of good in combating adverse publicity received in the last few years. We also use radio for this purpose. We are form-

ing a speakers' bureau to supply speakers for civic groups, women's groups and schools. We need more hospitals or more beds. We need more hospitals where distances are great and doctors scarce. People in Utah don't want federal money for this; they are not interested in the Hill-Burton bill. The church offered help for supplying different hospitals needed. Several hospitals were built and are maintained by the Mormon Church. This plan is endorsed by the Utah State Medical Society and we hope it will fill our hospital needs without calling on federal funds. We have a prepayment plan based on the experience of Michigan and California.

MR. JOHN W. BROWNLEE, Rutland, Vt.: We have a governor's advisory health council on which the medical society is represented, dentists, public health, public welfare and various other organizations. That is a temporary organization and is to develop a program for better health in Vermont. It is the hope of the medical society when that work is completed in the next few months that a permanent health council will be set up to embrace all health agencies and also business and labor. We don't have the problems in Vermont that some of you have. We are inaugurating a medical care plan.

DR. H. B. MULHOLLAND, Charlottesville, Va.: In 1940 it was realized that the rural health situation was bad. A committee was formed of members of most of the farm organizations and members of the medical, dental and nursing professions. This committee was instrumental in having a legislative advisory committee appointed who reported to the governor and legislature, made recommendations, instituted a survey for needs of health centers and hospitals and appropriated $10,000 for a survey. We think it is important to go ahead with that because so many communities now have been stimulated tc erect health centers and hospitals that are not warranted. We shall have extension of the health departments. We also got $600,000 for examination of school children. This is an important start for the health of the people living in rural areas. We hope to have school children examined four times during their school life. We got an enabling act so that the state can lend some of the money it has to invest for construction of health centers and hospitals in areas where they are needed as shown by the survey, the loan to be at a small rate of interest and to be a long term loan. The rural health committee is also backing the state health council composed of thirty-five or forty organizations in the state, including all farm organizations in the state. The legislature also took our advice to continue the study of health problems and particularly the extension of prepayment insurance plans to the medically indigent. We feel that we can solve these problems on a state and county level.

MR. JAMES P. NEAL, Seattle: This program in Washington for setting up a prepayment plan was organized in 1917 and

has been growing until some twenty-one units have been set up coordinated through the state bureau, all under the sponsorship of the Washington Medical Society, covering more than a quarter of a million people. In 1944, in order to avoid any insurance laws of the state, the doctors created and chartered the insurance company. The insurance covers all the subscribers of the local organization. This group has been approached by the executive committee of the state farm bureau for a contract which would cover their farmers. Arrangements have been made and contracted now in effect in one area on a trial basis providing hospital and medical care for a man and his family for $7 a month. In another area quite a number of families in the farming area have complete medical and hospital care as far as the head of the family is concerned but with just hospital care for members of the family, the rate being $4.55 a month. These two plans are paying doctors a reasonable fee schedule. The Farm Security Agency started in our state. All moved out with the exception of one county. The price for that was $35 a year. We are also caring for service men, beginning the first of the month, under contract made with the Veterans Administration, serviced and handled through the state association.

Dr. C. N. Neupert, Madison, Wis.: If groups are to meet the suggestions in his program, I would propose that there must be some required reading. Whatever you think of some of these things, if you are planning to go into rural health conferences, be ready. Know what they are thinking. Farm folks are acquainted with what is going on. Wisconsin people in rural areas seem to be doing just as well as in urban areas. We have no health centers. I have been wondering if that might not be a good development in Wisconsin. We have our survey under way. We have a statewide medical and hospital care insurance policy in connection with the state insurance companies. Another in Milwaukee is going along with Blue Cross. They are both developing. As far as the Farm Security Agency is concerned, it is in two counties and is working all right. In this year of operation we have paid out 100 cents on the dollar. Don't overlook health agencies. Get close to them.

Dr. H. N. Smith, Brookville, Ind.: We have had a rural medical care committee for three years. We tried this farm security program in several counties in Indiana. It didn't work out so well. It was tried in the county I am in, but as soon as the people were able to pay for their medical care they dropped it. Doctors didn't like it, and patients didn't seem to care much for it. I know there is to be a prepayment medical plan in the state of Indiana.

Dr. James F. Doughty, Tracy, Calif.: We don't have many people worried about rural medical care. The indigent are taken care of in county hospitals by a paid staff. The non-

indigent rural farmer in California is a very progressive person who appears as though he was poor and dies rich and the doctor dies poor. There is a California Physicians' Service for non-indigent people. It offers service to employed groups and is now offering it to the rural families through the Grange of California. We service them and they pay for service plus the cost of administration. I am impressed with the need for more country doctors of good qualities. Unless doctors are educated for general practice instead of for specialists in the city we shall not have good medical care for rural areas. An average well trained general practitioner can well take care of most ills.

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