National Conference on Rural Health

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NATIONAL CONFERENCE ON RURAL HEALTH

DR. F. S. CROCKETT, Lafayette, Ind., Presiding.

FRIDAY, FEBRUARY 7

The conference was called to order at 9:45 a. m. by the Chairman, Dr. F. S. Crockett, Chairman, Committee on Rural Medical Service, American Medical Association.

CHAIRMAN CROCKETT: We doctors and farmers are trying to improve not only rural medical service but also rural health. Rural health embraces everything that will promote better living conditions, better living standards and better medical service. We doctors can give good medical service wherever the conditions make it possible.

We may here reach decisions based on our experience and wisdom and embodying the fundamental principles that govern the solution of each problem. To make our labors really fruitful, the farm groups represented here must initiate in each county where they have a chapter the activity that will obtain, through community action, the results desired. But it is at this community level where many times it is most difficult to create an active interest in health measures that will carry through to actual accomplishment.

There are farm areas in many states where the people do not earn enough to pay for good health measures. These areas have a problem different from others only in the economic phase. Some form of outside help is needed, but, whatever is done, the principle of self help should be emphasized.

Address of Welcome

DR. GEORGE F. LULL, Secretary and General Manager, American Medical Association, Chicago: I want to tell you how much I appreciate your coming to Chicago to attend this conference. We feel that this material you are about to cover and which you have covered in the past is of vital interest to doctors all over the country, be they located in rural or in urban areas.

The Farmer and the Medical Service Program

MR. ALBERT S. GOSS, Master, the National Grange, Washington, D. C.: First let us look at the farmers' ability to pay doctors' bills under normal conditions. During the ten year period 1921-1930 the farmers' net income, as compared with nonfarm income, was $200 per capita as compared to $800 per capita for nonfarm people. During 1931-1940 it was $150 to $580. During 1945, which can hardly be considered a normal year, it was $740 to $1,260. You may raise the objection that the farmer has had free house rent and free food, but that is not true, for those items have been calculated and added to his cash income to obtain the income as I have given it. Thus we can see that the ability of the average farmer to pay for adequate medical service is substantially lower than that of nonfarmers.

On the average, farmers live a substantial distance from cities or towns where medical and hospital service is available. They cannot help that. The vocation of raising the food the nation needs requires some of us—lots of us—to live way off from "Main Street." Before the war in our thousand most rural counties there was only 1 medical doctor for every 1,700 people. In our big cities there was 1 doctor for every 650 people. In most rural communities there are less than 2 hospital beds per thousand people. In fact, 1,200 of our rural counties have no recognized hospital within their borders, and these counties have a total population of 15 million people. Hospital workers tell us that we should have 3.5 or 4 hospital beds per thousand rural people.

Let us look at the accident rate among farmers and those employed in industry. The accident death rate per hundred thousand workers on farms during 1945 was 53, as compared with 19 in manufacturing industries. When it comes to less serious accidents, but those still requiring medical care, farm experience will show that most farm workers have one or more such accidents every year. Even the farm children are exposed to innumerable hazards. In considering farm accidents we must not forget that the farmer who suffers an accident is usually far from a doctor or a hospital, while most industrial plants have medical service and hospitalization facilities on the premises.

For generations we have believed that our strongest and healthiest boys come from the farm. Figures released by the military service during the late war have awakened us with a rude shock. We found that the farm boy was not nearly so fit physically as the city boy. It was found in 1943 when 18 and 19 year olds were being drafted that, for the country as a whole, 25 out of every hundred were rejected, whereas for farm boys alone 41.1 boys per hundred were rejected. In addition, infant and maternal mortality rates are 25 to 30 per cent higher in rural than in urban communities.

We appreciate the need for maintaining high standards in the medical profession, but the fact remains that over a vast section of America the cost of medical service has increased enormously and the availability of service has become poorer and poorer. Whether rightly or wrongly, we believe it is a simple statement of fact that the feeling has become more and more general that the medical associations, instead of devoting their chief efforts to the improvement of medical standards, have been more interested in eliminating competition in the medical field. Certain it is that medical service is not only much more costly but much more difficult to secure, and rural America is rapidly getting up in arms over the inadequate service.

More and more people are turning to cooperative medicine. It has many advantages, not the least of which is adequacy. It is preventive in character. It is more economical and does not require that farmers be classified as paupers in order to secure adequate service at prices they can afford. It combines the advantages of the specialization of group practice with the efficient use of personnel and facilitics. However, in many sections we have faced a storm of resistance on the part of the medical profession against every effort to organize cooperatively to improve conditions, although happily this seems to be diminishing.

I do not want to leave the impression that the physicians are solely responsible for an unsatisfactory situation. The health service, the schools and the farm organizations all have their responsibilities. The point I have tried to emphasize is that we have been trying to meet the situation by the cooperative medicine route but have not had much help; in fact, have met a good deal of resistance.

With the inadequacies of the service and the resistance against change, it is not surprising that more and more farmers are turning toward government help and state control of medicine, including compulsory insurance.

My organization does not believe in state control of medicine; we believe there should be a better way.

Summing up, there is a real problem which must be met if we are to avoid statism in medicine.

Methods of Bringing and Holding Doctors in Rural Areas

Dr. Fred A. Humphrey, Chairman, Colorado Committee on Rural Medical Service, Fort Collins; Member of the National Committee on Rural Medical Service: Before rural health can be intelligently discussed, some mutual understanding of what constitutes a rural community must be accepted. A rural community may vary in size from one with a radius of a few miles to one with a radius of 50 or more miles. Its population may vary from a few hundred to a few thousand persons.

It is generally conceded that there is no distressing problem of medical care and no difficulty in getting and keeping medical personnel in the more populous rural areas, so our attention and efforts can therefore be concentrated on the larger more sparsely settled areas, where neighbors are far apart, and towns which are large enough to support a doctor are widely separated. It is in such communities that it will be difficult to convince the younger doctor to locate and establish a practice. Some better system of professional, educational, religious, social and economic relationship will have to be established in order to hold doctors in such rural communities, once they have located there.

The two groups, working as a team, can furnish the necessary leadership to put into operation that part of the program which would apply to their individual area. No rules of procedure can be made which will not have to be revised to fit some unusual condition, since there are so many diverse types of rural areas in the United States. A specific program drawn to the measurement of conditions found in the corn belt of the Middle West would of necessity need some revision to meet the entirely different type of person and occupation present in the cotton belt of the South or the mining areas of either the Eastern or the Rocky Mountain states. However, a start must be made and a general plan outlined which is flexible enough to allow the changes needed to meet the different conditions found in the various sections of the United States.

In drawing up such a plan, the first things to consider are the changes which should be made by the individual farmers and business men in the small towns which will increase their chance of having a doctor locate in their community. The suggestions made are not unreasonable or difficult of accomplishment. More time, money and energy should be spent on such things as good roads, especially from farm to market, improved sanitary conditions, safer water supply and storage and similar local projects than in trying to get a hospital located in their community under the provisions of the Hill-Burton act. Such a hospital should rightfully be located only after a scientific and practical interpretation of a thorough survey of hospital and health needs. The many "ghost towns" scattered in the mining areas of the Mountain states do not present a pleasant picture, but an even more depressing sight would be "ghost hospitals" appearing over the United States in the next few years because of poor judgment now in choosing their locations. If a town and its surrounding trade territory is large enough to support a doctor adequately and wishes to have one, then every effort should be put forth by its citizens to obtain that desire. The initiative is squarely in the lap of the local people, and to secure the goal they may have to offer even further inducement such as the physical facilities which are so essential to a doctor if

he is to care properly for the sick. In some cases it may be necessary to take still another step and subsidize the doctor on a monthly basis in order to make his income commensurate with his education and ability. Such subsidies should be financed locally, if at all possible, before application for state or federal aid is made. By all means, after a doctor has located in a rural community its citizens should show their loyalty to him by using him in case of illness and not go to the larger, but more distant, towns for their medical care.

Universal participation in prepayment insurance by farm people will be of definite assistance in bringing and keeping doctors in rural areas and should be incorporated in any plan devised for that purpose.

The medical schools of the United States should be asked to cooperate and join in the attempt to solve the rural health problem. There is no other instrument in organized medicine which can or should lend itself to such a service as easily and efficiently, but a definite program must be submitted to them which will enhance rather than jeopardize the prime purpose to which they owe their existence.

Other medical schools should follow the example of the Colorado university which has established a residency in general practice following the usual rotating internship of one year. In this residency the graduate will study six months each in medicine, in pediatrics, in obstetrics and gynecology and in surgery, with allied specialties included under the four main heads. After this training it is expected that the doctor will be capable of caring for better than 90 per cent of the patients coming to him should he locate in one of the small towns. Possibly other schools have instituted the same program. If not, they should be advised to do so.

Another change in policy which would relieve materially the present shortage of doctors in rural areas is the requirement of from three to five years in general practice before resident training is begun. Such a plan would be of great benefit to the individual by broadening his clinical knowledge and by giving him a better understanding of the difficulties encountered in general practice and a finer appreciation of the economic features involved. A doctor after such an experience would be more mature and better qualified to choose the specialty for which he has the greatest aptitude and in which he has developed the most interest. Later, should he wish to become certified, some credit should be given for the time spent in general practice. It would also be beneficial, at least in the immediate future, by opening many residencies which could be and would be filled by qualified men who have served in the armed forces and who are now attempting to obtain residencies in order to become certified by special boards. These men have seen the advantage in the last war, at least as

far as rank is concerned, of being certified and have obtained their desire for special training partially from that observation. In many instances recent graduates of medicine and doctors returning to civilian life want only to be a specialist and have no particular aptitude or desire to practice a particular type of specialized medicine, as evidenced by their acceptance of training in some other field if the one of their first choice is not available.

The final suggestion to the medical schools originates from the statement "You can take the boy out of the country but you cannot take the country out of the boy." In the present condition of many applicants to medical schools to one admission a certain definite proportion of them should come from the rural areas. A boy who has been born and reared in or near a small town is much more likely to return to it than a boy who has experienced nothing but city life.

As methods of "Bringing and Holding Doctors in Rural Areas," suggestions have been offered both to the rural communities and to the medical profession. The recommendations to be carried out by the rural communities are:

That they build and maintain good roads from farm to market.

That they educate themselves on public health matters and put into practice known disease preventing measures.

That they improve their living conditions.

That they have in their area persons trained in first aid and home nursing.

That in some instances they furnish for the doctor the needed facilities, such as equipment and office headquarters; in some localities even a subsidy may be necessary.

That they apply to the proper agency of their state for assistance under the provisions of the Hill-Burton act if financial aid is required to carry on their program.

That they participate in prepayment insurance.

That they patronize their local doctor and whenever possible conserve his time by going to his office.

The recommendations to the medical profession are:

That they require three to five years' general practice before resident training is begun.

That certification boards give credit for such time spent in general practice.

That hospitals establish residencies in general practice.

That students from rural areas be encouraged to study medicine.

That hospital staffs be open to men in general practice.

That the system of medical care to soldiers be adapted to rural medical care.

That the rural practitioner be kept informed on advances in medical science by contact with other medical men at county medical society meetings and short refresher courses held in the rural districts.

Methods of Bringing and Holding Doctors in Rural Areas

MR. CHESTER G. STARR, Director of Rural Health, Missouri Farm Bureau: I recognize very keenly that the problems and conditions vary from state to state. The problems affecting California may be very different from those encountered in Missouri, and those in our own state will undoubtedly be varied from those found in Minnesota. There are some problems more or less in common, such as trends in medical education, trends in nurses' training, federal aid in building hospitals and medical centers, farm income and like matters. However, often in many states, and I have found this to be true in my own state, the peculiar state problems may offer an opportunity for united action that may be secured before long range national issues can be solved.

The day when every Missouri hamlet had at least one doctor taking care of the farm families of the community has gone with the horse and buggy and will never return. We shall have to think and plan on large community units. At the low point in Missouri, when the armed forces were draining the better practitioners into their services, it was estimated that apart from our metropolitan centers there were not more than 800 doctors of medicine in rural Missouri. From that low point, according to information given me by the Missouri Medical Association, there are now in the same rural areas a total of 1,110 doctors of medicine, or a gain of 39 per cent over the low point. We are further encouraged to know that of about 150 doctors locating in Missouri this past year—over and above those returning to their former locality from the armed forces—98 of the 150 have located in some rural area. In a recent tabulation I found that twenty-six of our rural counties had at least 1 doctor of medicine for each 1,500 people, which I am told is a reasonably good ratio.

We also have some 600 osteopathic physicians in rural Missouri, and in many counties these persons have built a feeling of confidence and reliance on their sevices. There are ten of our rural counties that have at least 1 osteopathic physician to each 1,500 people. When we add both schools together, we come up with some interesting figures of having seventy of our rural counties, or 64 per cent, with 1 physician to each 1,500 people. In the tabulation, I found in one county that there appears to be 1 physician to each 430 people. Naturally, competition in that area is rather "hot."

The greatest problem in Missouri (and it is one requiring our attention) is the increasing age of the practicing doctors of medicine. Quoting again from the data kindly given me by the Missouri Medical Association, in 1946, 43.7 per cent of all rural doctors were above 60 years of age. Eight of our counties do not possess a doctor who is under 60; in eight more 75 to 99 per

cent are over 60; in twenty-nine more from 50 to 74 per cent are over 60. Definitely, Missouri needs more young doctors to locate in rural areas, both to take the place of the older retiring or dying members of the profession and also to give us a total larger than that reported for this past year.

Not to be overlooked is the fact that doctors are human beings, some more human than others. They are not to be shunted here and there on the dictates of some power—at least not in these United States. Favorable conditions must be offered for any doctor to locate in any given rural area. As I view the situation, there are certain definite favorable factors which either must be secured as rapidly as possible or must already be existing in any area. I do not wish to take unnecessary time to go into details, but I would mention (1) a rather high level of income for the community, (2) a system of good roads, (3) good living conditions such as modern homes, good offices, good schools and good community life, (4) confidence in and use of local doctors by residents of the area, (5) hospital facilities in or nearby for diagnostic and treatment purposes, (6) modern health centers doing a good job of health education and (7) good enrolment in hospital and medical prepayment plans. If most of these advantages are present in any given community, a doctor hunting a location will be human enough to be attracted to it. If they do not exist there is little hope of having a voluntary location. The only remaining solution would be a system of either county, state or national subsidization to remove through public funds some of the disadvantages.

At present I believe that subsidization is the last recourse and would prefer greatly to endeavor to correct adverse conditions through voluntary action by all interested groups and persons.

The Responsibilities of the People

A good level of farm income is a direct responsibility of farm organizations and their members. I think that we can say without any person denying the fact that the major farm organizations have gone a long way in securing parity income for farm people and protecting them against adverse price situations. Also it can be said that the farm organizations will continue to be a considerable factor in retaining a decent farm income.

In Missouri the Farm Bureau has taken aggressive action in reference to the farm road situation. In the last session of the legislature the Farm Bureau and other interested organizations were taking money out of the surplus funds of the state for what is called "milk route" building. They are over and above our own state highway roads. They are not going to be quite the high class roads the state highways are, but we are expecting to spend somewhere around 4 to 6 million dollars a

year for the next five years building roads from farm homes to the high class roads. While it will be impossible to have an all-weather road on every mile of the entire road system of the state, we are expecting to have a rather wide flung system that will enable practically every farm family to drive to the nearest community at any time in the year, barring ice and snow drifts.

As farm income continues at a good rate, better living conditions will naturally be found in rural areas and in small towns that live on rural business. Of course, at present, building supply shortages preclude much new building; but these will soon be corrected and small towns will have building booms in proportion to those of the large cities. It is definitely the responsibility of the people of any community to produce good living conditions.

The Medical Profession

I believe that there must be much more discussion with young doctors and those still in school concerning general practice. From the medical journals, from the medical school catalogues, from general medical discussion, too much emphasis is being placed on specialization. The instructors in many medical schools are specialists, command high fees for their outside work and naturally talk about their particular specialty as being the one to follow on graduation. Many medical schools, from information I have picked up, are strongly headed toward making specialists and actually discourage any student from being a member of the general practice group. I sometimes wonder if the specialization is not being carried to the point that good medical diagnosis is being badly overlooked for lack of some sane, well grounded physician to coordinate the findings of the many specialists. I also believe that, provided the medical education is overhauled, more young graduates might find lucrative and more enjoyable practice in some rural area being a general practitioner rather than battling for years in some city to establish himself as a specialist in this or that.

I am also thinking of a system of rural internships whereby those students who have either come from rural areas and retain their liking for rural life or those from towns and cities who might possibly be bitten by the "rural bug" would have an opportunity to become closer identified with rural hospitals and rural life. I wounder if we are going too far afield in this suggestion.

Definitely, a great deal of good could be done by aggressive county medical associations. Many of the shortcomings of the medical profession charged to it by many people and much of the unfortunate propaganda of recent years are due to the lack of aggressive leadership in health education by local doctors. In my work in Missouri I have often found some of the medical men in a county either lukewarm in supporting health improvement or even actively combating the movement. I don't want

to be too specific, but I think I am going to use the illustration of one county in southeastern Missouri where a medium sized hospital is acutely needed. I have done considerable work in that county, and I am stymied by the active opposition of four doctors of medicine who are practicing in that county who have gone up and down the roads and have written letters saying that a hospital is not needed in that county; and the nearest available hospital is 40 miles away. I won't tell you the county. Some of our Missouri folks here know it. I do not wish to level this accusation against all county medical associations, but there is a decided lack of aggressive leadership in many areas. Possibly the American Medical Association and the state medical associations can overcome this fundamental difficulty and inculcate into many county associations a spirit of public welfare and leadership in worth while health movements. In this connection there has been in some areas a feeling that many people bypass the local doctors in many instances, going to large centers and to specialists, leaving the local doctor high and dry. In areas where there has been little attempt by the local doctors to participate in local affairs, especially in local health improvement, can we blame persons for not having confidence in their local physician?

Responsibilities for All Groups

There are some favorable factors in inducing doctors to settle and to remain in rural areas that are responsibilities of all. One of these, much in prominence today, is the matter of building or enlarging the doctor's workshop—the modern hospital. The people of any community will have little incentive to build a hospital unless the physicians and surgeons of the community are willing to practice in the hospital. No doctor or group of doctors can successfully build and operate a hospital unless the people of the community are willing to share in the expense of building and be patients when built. In the areas in Missouri where the Farm Bureau has successfully led movements for the building of modern county public general hospitals this past year the people and the doctors have worked together. In 1946 our people voted between two and a half and three million dollars for building new hospitals in rural Missouri. The same teamwork is needed in health education. In Missouri we have a new act by which people of any county may build and support public health centers. With the third horse, the State Division of Health, we are hoping to have many of our counties equipped with educational health centers.

The third part of the united responsibility is the encouragement of enrolment and use of the prepaid hospital and medical plans. Without the enthusiastic support of hospital management and the medical profession, the Blue Cross and other prepaid hospital plans would be tough sledding. Without the same vigorous support of the medical profession, a prepaid medical plan would be most difficult to make a success. Most rural

people are rather closely tied to their family doctor—much more than the average city dweller. If the family doctor tells John or Mary that Blue Cross is good and that in case of illness or accident the medical service will undoubtedly pay for the costs and that he, the doctor, is a member of the Blue Cross and belongs and gives service under the medical plan, then John and Mary and many other Johns and Marys enroll in the prepayment plans.

Hospital Facilities and Health Centers for Rural Areas

MRS. ROY C. WEAGLEY, President of the Associated Women of the American Farm Bureau Federation of Hagerstown, Md.: Although the telephone and improved roads have made their contribution toward relieving the rural health situation, I think that with their advent rural health suffered from an exodus of rural physicians into the cities. For many years both the Associated Women and the parent organization, representing 4¼ million farm people, have been vitally concerned with the inadequacy of medical care and hospital facilities available in rural areas.

Our organization has promoted group health associations and hospital insurance as a means of securing more nearly adequate care at more equitable cost to rural people, but the progress of those plans has been impeded by the lack of facilities to service such plans, and the lack of facilities is greatly responsible for the lack of physicians and nurses in rural areas.

Opportunity for health in rural America equal to that enjoyed by people in urban areas can be obtained only through close cooperation between the various groups of our system and the medical profession.

Although metropolitan areas are in the main fairly well supplied with hospital beds for general medical care, many are planning to expand the present facilities by taking advantage of the national hospital construction act. This in some instances is unwise. In my opinion it would be far better to lighten the present hospital load than to expand facilities. I am not prejudiced to expansion as was the stout lady who deserted her political party because she was against expansion under any consideration. To relieve the existing pressure on overcrowded hospitals, health centers should be coordinated with them. Rural health centers should be established within reasonable distance from the existing hospital. Rural health centers would serve a dual purpose. They would lighten the load in the metropolitan area and they would bring medical care to many rural people. By establishing health centers in rural and needy areas, the effectiveness of the very limited number of medical and nursing personnel now rendering service in those areas could be multiplied.

With a well managed health center, the greater proportion of the approximately 20 babies born to each thousand of popu-

lation in rural areas could receive adequate care. At the same time the lives of many babies during that first year could be saved. Many mothers too could be spared great suffering from complications.

Essential equipment must be provided for the practice of modern medicine, for the conduct of routine tests and for x-ray service. Without such facilities it is impossible to expect our trained physicians and nurses to consider working in the rural field. It is reasonable to believe, however, that with a better distribution of hospital facilities and health centers will also come a better distribution of physicians, nurses, dentists and medical care generally.

Experience has revealed that the quality of services can be raised by the use of consultants and the facilities of accessible hospitals. My interpretation of the purpose of the hospital construction act is to promote the building of hospitals and related facilities in proportion to the need. In other words, I would say that rural areas, where the needs are greatest, should be given first consideration; otherwise the maldistribution of medical and nursing personnel would be intensified rather than improved. Likewise, if the funds are used mainly for new construction and expansion of existing facilities in metropolitan areas, that would cause even greater disparity between rural and urban opportunities for medical and hospital care.

Construction of Hospitals

Mr. Lloyd C. Halvorson, the National Grange, Washington, D. C.: About all I have to report is what we have been doing in the National Grange. We have sent a letter out to all our state offices, sending them a summary of the hospital construction act, pointing out what responsibilities they can take on the state level to get the legislation through. We suggested that they might want to include state aid toward the construction of the hospital, possibly one third, which would leave only one third for the local community. We pointed out that they need a local hospitalization plan. In some states there will be a law to permit counties to go together and cities and counties to go together in providing the necessary money. Some of the people have written in to us, being somewhat familiar with the law and knowing there is money to spend, asking what procedure they should take. We have to report that as yet most of these states haven't progressed that far in their planning. In other words, as yet the hospital district center hasn't been set up, so we have referred them to the health department for the present. We have suggested that they get in touch with the health department and find out how far they have progressed; and also there might be some tentative plan as to what procedure a local community will have to go through to get this money. We have told our people to make sure that they have farm members. It

will be important to farm people to know that they are given some recognition in the laws and procedures that will be laid out.

We have a great deal of hope in these rural health centers as a way of bringing doctors to rural communities. I think there is some fear on the part of the medical profession that these centers will not provide a high standard of medical care. I think that can be taken care of so that the really urgent cases can be referred to the bigger hospitals. When it comes to the rural community, of course, there may have to be some means to provide one third, or possibly two thirds, in operating the hospital.

Cost of Operating a Hospital

DR. ROBIN C. BUERKI, Dean, Graduate School of Medicine, University of Pennsylvania, Philadelphia; Member of the Federal Hospital Council: As a member of the Federal Hospital Council, at the first meeting I said I had an open mind on everything except one question and one problem; and that is within the confines of the law. I refused to go along with anything suggested that made poor medical care more easily available to the public because that essentially was dangerous practice.

The average cost of operating a hospital is one-third the original cost of the building. So that if you are planning on raising a sum of money for the hospital, be sure that that community each year, from one source or another, can find one third of that original cost to operate the hospital. If you have a quality hospital there, if it can be adequately supported, then it will attract the type of doctor you want to your community and to that hospital. I happen to be dean of the largest and the oldest graduate school of medicine in this country, and more and more I see these young men who are coming up as specialists. I think we are training too many specialists, but today you do need certain specialists represented in the hospital of your community if it is going to do the job the public has a right to expect.

The question of the general practitioner having the hospital open to him and in having greater opportunity in a rural community I have no quarrel with if the board will see that he limits the type of work he does to the field in which he is competent to work. He may be ever so capable an obstetrician and yet, if it came to removing a cataract, he might well be a plumber.

Voluntary Medical Prepayment Plans as They Apply to Rural Communities

MR. EDWARD MERTZ, Administrative Assistant, Department of Education, Farmers Educational and Cooperative Union of America, Denver: The base of the problem is economic and means a lack of rural income and medical purchasing power. In 1943, with farm prosperity at its highest in years, income of

persons on farms was only 9 per cent of national income, while farmers made up 20.5 per cent of the national population. The last Census of Agriculture showed about two thirds of our farm families had gross income under $1,000 a year and one third of these had under $400 a year. In 1940 states with 70 per cent or more rural population had per capita incomes of only $300. Even if there were plenty of doctors, nurses, hospitals and health facilities, many farmers still could not afford to use them.

Many rural families cannot participate in voluntary prepayment plans because they have insufficient income—lack of health purchasing power, if you please. Many others will not because they don't have to! Unfortunately in many cases this group includes those who most need help both from an individual and from a community point of view.

Whether the reasons for lack of participation be economic, geographic or psychologic, the fact remains that fewer than 5 per cent of our whole population now receive general medical services on a prepayment basis. Less than 3 per cent of all farm people are covered for even Blue Cross hospitalization. There is much greater coverage in states with predominantly urban population.

Is there any question that a comprehensive health service plan which would provide physician and specialist care, hospitalization, dental services and prescribed drugs cost a farm family at least $100 per year? The next question is "How many farm families could or would invest $100 in medical insurance on a voluntary basis?" Before answering this question optimistically one should remember that in 1941 half of all farm operators had annual net cash incomes of less than $760 per family, including incomes from all nonagricultural sources. These plans do not and will not provide adequate and complete health for rural people.

This should in no way be construed to mean that the Farmers Union is opposed to the development of voluntary prepayment plans of hospitalization and medical services. On the contrary, we are currently engaged in the promotion and building of the Farmers Union Triangle Health Insurance Plan, which is essentially such a plan. At present this low cost plan provides primarily for hospitalization for specified periods. And many farm families use it. We hope soon to extend the hospitalization periods and include medical services, which will of course increase the cost. While many farmers will continue to use it, many will be unable to continue their prepayments because of the cost.

The National Farmers Union builds cooperatives. Some are built to increase the economic income of farm families. We hope this type of enterprise will help make possible a decent standard of living for every farmer, which will raise the levels

of health facilities to help answer the health needs of our people. We hope that eventually increased income and cooperative organization will provide adequate health services for farm people.

We recognize that voluntary prepayment plans will not solve the problem. The record of experience clearly indicates how far we have come and probably how far we can go if we continue to disregard economic inability to pay and psychologic refusal to participate. We are not afraid of the word "compulsion" because we do not confuse freedom and responsibility.

We have long since learned that individual freedom is subordinate to the freedom and welfare of all and that public health is the total of individual health. Who now questions the "rightness" of quarantine or compulsory health education? We don't permit part of our citizens to contaminate water and milk supplies deliberately. We have rigid, compulsory laws against major crime. Do you think the Social Security Program is here to stay?

We know that voluntary plans have not and cannot do the total job for many years to come. We know the limitations of these plans. We know the health problem of farm people. We also know their ability, or rather their inability, to buy health at prevailing prices. We know our health problem will become increasingly worse unless we do more.

Therefore the National Farmers Union will continue to build our Triangle Health Service Plan and to cooperate with others in developing this type of program. We will continue to improve our economic ability to buy health services through our cooperatives. And we will continue to build cooperative hospitals and health services.

But we will also continue to use our resources to bring about a universal, compulsory, complete, public health insurance program at a cost which will permit all Americans to live in health. Farm people want more than hospitalization and medical insurance. They want everything it takes to maintain good health.

MR. J. S. JONES, Secretary, Minnesota Farm Bureau Federation, St. Paul: To me it is one of the most healthful indications that I have seen that a group of professional people, medical men, and a group of leaders representing rural organizations will take the time from their busy days to come to a conference like this to discuss this important problem in its various phases.

The first real impetus given to the plan was the success obtained by Blue Cross hospitalization service plans. One of the resistances offered rurally to Blue Cross was "Why not medical care?" With this as a backgroud, state medical associations and laymen took notice and began to develop similar plans relative to prepaid medical care.

The lack of health facilities and health plans among the low income groups led to the development of a philosophy of governmental care among segments of our population. However, the opponents and proponents of that philosophy in the discussions that I have listened to are now living in the past, owing to changed economic conditions. In 1929 the average per capita income for the nation was $686. "Not much there for any kind of medical care." In 1945 the average per capita income was $1,150. Our big problem is trying to maintain that kind of an income. This improvement in the economic picture should be a source of gratification. With the improved economic situation and the increase in the per capita income, rural people in particular have turned to those factors which make for better living. That's why we have this tremendous interest now in better rural schools and better rural institutions.

Group prepayment plans for hospital service and medical care have been organized, stimulated and developed to a great degree by farm organizations. Farm organizations in a large manner have set the pattern for rural people. While these plans are not complete or perfect, they have shown the way to attack the problem of securing against illness and accident. In rural health we have arrived at a place where we have need of coordination of these plans.

The additional value of farm organizations is of great significance. We, the people, are a part of such enterprise; and the people know they are superior to the government purveyed, subsidized attack on the problem. I like to think, in regard to the Blue Cross movement, that we truly have done as much rurally for Blue Cross as Blue Cross has done for farm people in rural communities. When improved relationships develop and are in existence among present health facilities, hospitals, physicians and lay organizations, all existing health facilities can be fully utilized and, by working together, recognize the need, the time and the place for additional facilities which may be better observed as well as more economically offered and administered. In the organization that I happen to represent we were forced to go into a hospitalization plan a few years ago. We went the Blue Cross way. To my mind, one of the greatest benefits that comes to a member is as soon as membership in that plan is established he has somebody close to home that he can go to with his gripes. I think sometimes they get their money's worth by relieving themselves of their gripes.

While the early prepaid plans were successful, including practically all medical service plans, experience has indicated that rural people generally were not ready to pay the premiums for such protection contracts, with the result that development of prepaid rural health care plans progressed slowly. We have felt it preferable to begin operation with restricted contract and expand the services offered as we develop and proceed.

Voluntary prepaid plans may be largely set out in two groups, one known as the insurance group through the insurance way handled by insurance companies. It has its advantages and disadvantages, as I see it. One of the advantages, however, as seen from that standpoint, is this: That the more people that are out talking about it and selling it, so to say, the sooner we are coming to an appreciation on the part of all rural people of the value of that kind of program. In the insurance business, in life insurance and other types of insurance, we have a multitude of companies writing that business. Some companies dislike competition. They don't like to be in competition with one another, but to my mind the thing that has sold life insurance to America is the fact that there were a large number of companies and a large number of agents out talking and selling the insurance plan and we should not object to the competition.

On the other hand is the association plan. In the association plan we have some advantages in the low cost of acquisition, especially as applied to rural people where it's done voluntarily. I think the success of Blue Cross among rural people is attributable very largely to the fact that they go out and do it themselves.

The development of the Blue Cross has given interest to the matter of this prepaid medical care plan. Those who are participating in prepaid hospital plans now know that they are capable of taking care of the problem themselves by putting their health bill on an annual budget basis and prorating the cost on an actuary basis, and with the increase in the per capita that was mentioned earlier this morning, capable in a large way of taking care of their own health needs in a better manner than heretofore.

DR. JAMES R. MCVAY, Vice Chairman, Council on Medical Service, American Medical Association, Kansas City, Mo.: A review of voluntary medical prepayment plans reveals that in their modern concept they are strictly American. The oldest of American plans is the Northern Pacific Railroad Benefit Association, which was organized in 1882 and has operated continuously since that date. Prepayment plans have developed through industrial establishments, universities, consumer and cooperative groups, various governmental units, Blue Cross and medical societies or groups of physicians. In addition, insurance companies have offered various types of health and accident coverage to the public. The medical profession has contributed to the successful operation of all these plans.

Efforts are being made to obtain accurate figures on the number of people covered by these various voluntary prepayment plans. At present any figures must be considered as estimates, as no way has yet been devised to eliminate duplications when people have subscribed to two or more of these plans.

I am indebted to Mr. L. S. Kleinschmidt, Division of Prepayment Plans, Council on Medical Service, for the factual data given in this paper. The closest estimates obtainable today indicate that the total number of persons covered by the various types of voluntary prepayment plans are as follows:

Number of Persons Covered by Voluntary Prepayment Plans

Type of Plan	Total Coverage	Year of Information
Industrial	1,516,000	1945
University student	100,000	1943
Consumer and cooperative	504,000	1943-45
Governmental	580,000	1945-46
Blue Cross	25,000,000	1946
Medical society and physicians groups	5,000,000	
	32,700,000	
Insurance companies, hospitals, surgical, accident and health coverage	44,000,000	
Total	76,700,000	

Progress was slow in the beginning. Expansion of plans as we know them today has occurred largely during the past ten years and the major increase in enrolment in the past three years.

The prepayment plans for medical care received their first impetus as a result of the phenomenal success of the Blue Cross Hospital Service Plans. With both the hospital and the patients in need of some sort of program to ease the burden of hospitalization costs, these plans grew rapidly. Today the term "Blue Cross" is recognized by almost every one in the United States.

Using the earlier experience of prepayment hospital plans as a guide, a number of state medical societies undertook to develop medical care plans. The first statewide plan was the California Physicians' Service, organized in February 1939. Within a year Michigan Medical Service was organized. These two plans, together with the county medical society bureaus of the states of Washington and Oregon, gave the medical profession the necessary experience on which to build what has now become a nationwide movement.

The growth of medical care prepayment plans since 1939 has almost paralleled that of the hospital service plans. It took Blue Cross between five and six years to place thirty-eight plans in operation. This compares favorably with the six years it took to develop thirty-seven medical care plans. The same comparison can be made with reference to enrolment. In their first seven years medical care plans enrolled 2,845,000, while Blue Cross enrolled 2,870,000.

The development of prepayment medical care was in many ways more difficult and complicated than that of hospitalization. Hospital care is a more unified service with relatively few procedures involved, whereas medical care included an almost unlimited variety of services. The problems involved in the payment and handling of claims for medical procedures are far more difficult than those for hospitalization. Years of experimenting with various methods has resulted in definite progress toward essentially sound advancement. Hospital care plans deal with a relatively few institutions, whereas medical care plans deal with several hundred or even thousands of doctors. A medical care plan then to be practical must not rely on a relatively uniform institutional point of view but actually on a host of individual attitudes if we are to retain a high quality of medical care.

The growth of voluntary health care insurance plans since 1939 has been most remarkable. Counting the twenty-eight local plans in Washington and Oregon as two statewide plans, there are now fifty-eight medical care plans sponsored by medical societies or Blue Cross. Plans are now in operation in thirty-three states and are in the process of formation in thirteen more states and the District of Columbia. This leaves but two states, Mississippi and South Carolina, without some development reported to us. The fact that not one of the medical society prepayment plans has failed since 1939 and that the rate of growth has been rapid and steadily increasing attest to the application of common sense and to the desire of the medical profession to have prepayment medical care of a high quality available to all the people.

Methods of Expansion

With the experimental phases of medical care plans well under way, more attention can now be devoted to expansion of enrolment and expansion of benefits with special attention to reaching rural subscribers. The Council on Medical Service has established a Division of Voluntary Prepayment Medical Care Plans which acts as a clearing house of factual information, experiences and successful practices of all operating plans and, by the constant interchange of this information, enables the rapid correction of unsatisfactory practices.

The early plans in Washington and Oregon included practically all medical services, surgery, home and office care and even limitied nursing and dental care. Throughout the years this broad coverage has been continued. The plans organized in 1939 and 1940 followed this lead and also provided for reasonably complete medical care. In contrast to the experience in the Northwestern states, the experience of the latterly formed plans with full coverage was unsatisfactory. It was found that the public would not pay the premiums necessary to carry out such a broad contract. Whenever a surgical contract plus a

general medical care contract was offered to the public, the ratio of enrolment was more than 100 to 1 in favor of the surgical program. As a result the plans have generally preferred to begin operations with fairly restricted coverage such as surgical care, obstetric, x-ray and anesthesia in hospitalized cases. Now most of the services necessary in cases so severe as to require hospitalization are covered.

The tendency to limit services to those performed in the hospital is a natural one. In the first place most of the costly illnesses are those that require hospitalization. Secondly, there is going to be little abuse of such services. Thirdly, the actuarial experience in hospitalized cases is sufficient to provide plans with a more certain basis for determining adequate premiums. A recent study of fifty-one medical service plans shows that thirty-four of the plans offer surgical services, obstetric and specified medical services in the hospital. This same study shows that plans are continuing to expand benefits. Twelve of the plans provide for general medical care, such as home and office calls, and five plans provide almost complete coverage. The average premium for a single subscriber is approximately $1.25 and ranges from as little as 60 cents to $4.85 a month. Family coverage ranges from $1.35 to $10 a month, with an average of about $3.

Plans are still experimenting with benefits and premium rates. As one plan succeeds in some new idea, the basis for this success is made available to other plans. The same, of course, is true of failures. In this manner vertical expansion will continue to grow as actual experiences and public demand indicate.

Reviews of experience in rural areas have indicated that with the facilities available the rate of use under prepayment is higher than in the cities. The accumulation of physical defects and of chronic illness is greater. The risk of accidents is greater. Farmers are not usually covered by workmen's compensation insurance. All injuries and illnesses automatically come within the scope of the prepayment plan.

The success of a plan offering general medical coverage depends on meeting the people's need for medical care with proper control of abuses and on the maintenance of the costs at a point consistent with adequate standards of service and at premiums salable to rural subscribers. It is the job of the medical profession to keep its members informed. So too it is the job of the enrolling groups, whether they are factory, farm or community, to prevent the abuse of the benefits of the plans by their members. Equal interest in determining both coverage and premiums on a local basis should facilitate answers as to what additional medical serivces are needed, what the subscribers will pay and what the plan charge must be to remain financially sound.

Horizontally, the expansion of the prepayment medical care program is limited only by the ability and willingness of the

public to enroll as subscribers. It is true that most of the plans have tended to concentrate on urban areas where large group enrolments were possible. This was a sound method because the sooner the plan obtains an adequate risk spread the sooner it can expand its benefits and enrolment program. Large group enrolment provides this spread more easily and with less acquisition cost. However, the pattern is now changing and, having reached a reasonable enrolment and a sound financial level, ways and means of reaching all population groups—particularly the rural—are being explored. In general, the pattern has not been to deal with the farm group as a separate problem but to include it in what is called community enrolment. In community enrolment the farmer is considered a part in the area encircling a town or village. Usually the town is the center for trading. The whole community then becomes a group with premium payments payable at some central place.

A Method for Proceeding

A successful Blue Cross enrolment campaign in rural areas was carried out in Colorado by the Weld County Agricultural Health Association. Enrolment was on a community basis, reaching all elements of the community as a civic service. Weld County, the largest county in Colorado, is about three times the size of Rhode Island and has a population of 63,700. Greeley is the largest town in the county, with 15,900 population, and there are several smaller towns. Prominent businessmen, farm organization leaders and various club leaders met with the Blue Cross representatives and decided to form a health association under the Colorado law governing cooperatives. Twelve directors, each representing a definite district in Weld County, govern the health association. This division provided workable units in size and population for an enrolment and administrative program. Enrolment was not limited to Blue Cross, but each district was allowed to enroll separately in the Colorado Medical Service plan whenever 50 per cent or more of the families in the district had subscribed to the Health Association. To date Weld County has 8,000 participants enrolled. Colorado has organized ten other similar county health associations and thus far has enrolled one in every six persons in rural areas and one out of every two urban residents.

Iowa has organized fifty-five similar county health improvement associations. Other states are enrolling on a similar community basis with less formal organization.

Voluntary prepayment plans are growing rapidly in rural areas. A survey of Blue Cross rural enrolment reported in November 1946 by the Blue Cross Commission shows an increase of 200 per cent since 1944. The study shows a total of 1,637,533 subscribers and dependents now as compared with 500,000 rural members in 1944.

Many medical care plans have developed their organizations to the point where rural enrolment is being carried on or plans are being made by those reaching into rural areas. A study of these plans now under way indicates that about one half of those doing rural enrolment, twelve plans, have reported 304,542 subscribers and dependents. It is estimated that the study, when completed, will show medical care plans in a position comparable with Blue Cross of two years ago—or a half million rural members.

The problem cannot be solved at a national level. It must, to be successful, be worked out in the community where the need exists. There must be developed a community responsibility which will lend its active support if any effort is to succeed.

Continuing improvements in transportation and extension of better roads will accelerate the growing tendency of rural people to bring the patient to the physician. Thus the physician's care and the use of other health facilities can be extended over an area that includes a sufficient number of people to meet the costs of the services provided.

Use of the Insurance Principle

A study of the fees for medical services rendered by the rural practitioners shows that they are not excessive. However, there are times when illnesses strike and the severity of the cases cannot be predetermined. For this reason many farm families faced with severe illness find it difficult to meet the full costs from their income. This problem of meeting the costs is basically the same as it is with people living in towns. The only sound method so far devised is through the use of the insurance principle we have described. Prepayment medical care plans available to all people of a community, townspeople and farmers alike, tend to spread the risk and distribute the costs. Thus, having the cost known in advance, proper planning and budgeting for these otherwise unpredictable costs is possible.

Families or individuals unable to pay the full costs of medical care from their incomes and those now receiving public assistance should be called on to pay for their own medical care as far as is consistent with their incomes and provision made through locally administered public funds to pay the balance of the premium required to participate in a prepayment plan. Every effort should be made to help and not to pauperize or regiment the most individualistic element of our social economy—the American farmer.

The problem of the lower income groups can be solved by local communities and state actions in line with the rapidly developing voluntary prepayment medical care movement.

Division of Responsibility

Who carries the responsibility for the medical care program? The physicians because of their special training cannot escape the responsibility for the professional aspects of the program.

Experience has shown that they do not want to. The recipients of the medical service (the people) cannot escape the responsibility of paying the costs of the services. Both should do their full share in providing the needed facilities. With full cooperation of the medical profession and the people, working in mutual confidence, a medical care program can succeed by undertaking the various types of medical service one step at a time. As experience is gained, additional types of medical care can be included. Coverage may be as complete as is desirable in any community. Progress can be as rapid as experience indicates and the economic situation permits.

For ten years or more doctors have operated experimental plans in medical care insurance. On the basis of this experience they now feel ready to recommend prepayment plans to the people. The Council on Medical Service created by the House of Delegates of the American Medical Association has as one of its primary functions the fostering and developing of prepayment plans. The American Medical Association has rural health committees devoting their attention to the rural problem as do the various state medical associations.

It Can Be Done

Local representatives of farm organizations such as those present here today, together with business groups and local medical societies working in full cooperation and mutual confidence and understanding, are now in a position as never before to work out this heretofore difficult phase of delivering medical care to all the people. And unfettered by the totalitarian ideologies of the Old World we will continue to be "America, the land of individual opportunity."

SATURDAY, FEBRUARY 8

Hospital Facilities and Health Centers for Rural Areas

MR. GRAHAM L. DAVIS, Director, Division of Hospitals, W. K. Kellogg Foundation, Battle Creek, Mich.; Member Advisory Board, Federal Hospital Council: This Michigan project in a way grew out of the activities of the W. K. Kellogg Foundation. Its large interest for the past seventeen years has been a seven county rural health project in southwestern Michigan. The foundation believes that its resources can be used to best advantage in applying knowledge rather than in research or relief activities. So we have tried to find out what the rural health and welfare problems are in those seven counties, and that activity has been expanded to all of the state of Michigan. We are inclined to believe, based on our experiences there, that the large weakness in rural hospital and health service is the absence of good diagnostic facilities and services. In other words, to treat a patient successfully you

must find out what's the matter with him; and the modern doctor uses the x-rays and the laboratory to find out.

This Michigan hospital study was made by the Commission on Hospital Care as a pertinent study that other states might use in making similar studies and, as you know, now every state in the country is making a hospital study to comply with the requirements of Public Law 725, the Hospital Survey and Construction Act. The Michigan study has been published and widely distributed. The most interesting thing about the Michigan study was that the group of thirty-five persons the government selected to cooperate with the Commission on Hospital Care made a recommendation that the 292 general and allied special hospitals that we have in Michigan should be reduced in number to 110 located in seventy-one hospital areas.

The basic principle followed in defining these seventy-one hospital areas was that you shouldn't build a hospital where the need was for less than 50 beds. You cannot profitably use the services of a minimum of technical personnel needed when you have less than 50 beds averaging say 30 patients a day. A population of some 15,000 is necessary to support such a hospital. We also decided there should be hospital facilities within 30 miles of everybody in Michigan. When you get up here, you don't have 15,000 within a radius of 30 miles, so we had to compromise on a small unit; but the recommendation is that it must be supplied as a branch of the nearest large hospital.

The American College of Surgeons doesn't survey hospitals with less than 25 beds. It approves only 47 per cent of the hospitals with from 25 to 50 beds, but 93 per cent of hospitals with 100 or more beds.

The major weakness in rural medical service and hospital care is shown by the top half of Michigan. There are about half a million people there. North of that line there is only one radiologist, and there are no pathologists. The foundation located the first pathologist in the north peninsula at Marquette on the 1st of August. The major purpose of our program is to improve the quality of service in that area. There is one doctor 65 years old to take care of 10,000 people. At St. Ignace there is no hospital, there are 7 or 8 thousand people, one doctor over 80, and two osteopaths. Three of these hospital areas have no hospitals, and it seems that those three areas should come first. Rogers City, St. Ignace and L'Anse are the three. In fourteen other rural areas, ranging in population from 15 to 35 or 40 thousand, the hospital is an old house or similar structure. Under the act, preference must be given to rural areas. The 32 million dollars to be spent in the next five years in Michigan under this plan will take care of about one third of Michigan's needs for adequate hospital facilities. We need to spend about 90 million dollars to modernize and enlarge Michigan's total hospital facilities.

The major recommendation in this Michigan report is that the general hospital should be the focal point around which

you develop the community health service, in addition to its traditional functions. In this integrated system we add 181 so-called public health and medical service centers. In most instances they need not have beds at all, and they would operate as branches of the general hospital. These units would have the office of the public health nurse in the community, two or three doctors in this town of a thousand people, a certain amount of diagnostic facilities, the dentist's office might be there, and so on. In some of these more thinly settled areas it is 25 or 30 miles to the nearest hospital, and we anticipate that there should be beds for normal obstetrics and perhaps emergency cases and certain types of medical cases that the general practitioner in those communities could treat.

Report of Committee on Hospital Facilities and Health Centers

DR. ALLEN T. STEWART: The problem was divided by the committee under three general topics: 1. Is there a need for improved medical care in rural areas? 2. What is being done now toward improving that condition? 3. What further is there to do? First the committee debated the definition of the terms "community clinic," "public health center," "hospital" and "medical center." We recommend that the definition of these terms be clarified.

Dr. A. C. Bachmeyer, in discussing the first topic, said that, according to a 1940 census, from between 19 and 20 million people lived in the open country. In over 11,171 of these communities having less than 1,000 population there were only 151 hospitals, 85 per cent of which had less than 50 beds. In the open country outside of all villages there were only 90 hospitals in the United States. Over 50 per cent of these hospitals had less than a 50 bed capacity, and most were special type institutions.

Next was the question What is being done toward improving the condition? and Dr. A. B. Wilson of the Public Health Service was called on to explain the Hill-Burton bill, or Public Law 725. Dr. Wilson stated that before any funds are made available each state must evolve a long range plan based on its needs as ascertained by survey and have the plan approved by the Surgeon General. Mrs. Weagly informed the committee that Senator Taft had told her that under the terms of the bill such an approved community project would receive federal assistance to the amount of one third of the cost of construction and equipment, not including the cost of the site.

The third point concerns the establishment of interested farm groups. The committee believes that these needs can be handled in the execution of the following four point program: 1. Actual formation of individual state plans now being made, so that federal appropriations may be secured. 2. A campaign to educate the population in regard to the medical situation in rural

areas. 3. Community action. 4. Cooperation among community groups with the state plan.

Under community action falls the establishment of facilities for providing medical care. Even though 20 million people live in small towns and villages, it need not be assumed that all of these small towns must have hospitals. The danger to avoid is building a hospital that cannot be adequately supported and which therefore cannot render a high quality of service. Before any rural community builds a hospital, a careful study should be made. Hospitals should be constructed only where the size of the population, the availability of technical personnel, transportation and topographic factors and methods of financing justify the establishment and indicate continuous successful operation of such facilities. In this manner the medical profession would be brought into outlying districts on a consultation basis, the practitioner would have access to hospital facilities and the medical profession would exercise control over the quality of medical care in that area. These three points just discussed depend for their success on the fourth, the cooperation among community groups with the state plan.

ALLEN T. STEWART, M.D., Chairman.
MRS. ROY C. WEAGLY, Co-Chairman.
A. C. BACHMEYER, M.D.
MRS. JEROME EVANSON.
MRS. J. LANING TAYLOR. COMMITTEE.

DISCUSSION

DR. CARL F. VOHS, St. Louis: We shouldn't lose sight of the long range program of hospital construction. Some facilities for the care of the aged, from the standpoint of medical care and custodial care, must play an important role in the development of our facilities. From the standpoint of prepayment medical plans I think that the hospitals must create some facilities that are cheaper than the $10,000 program that is being planned.

ER. ERNEST E. SHAW, Indianola, Iowa: We need to know just why no hospital with less than 50 beds is important. I practice in a town of 5,000 and I have a collaborator who practices in one of 1,200 and he says I'm not a rural practitioner. I have seen a good many small hospitals which are very well run. I feel there is a place for a hospital of less than 50 beds. We have a group in the northern part of the state with a radiologist and a pathologist. Those men go out one day a week to five surrounding towns and spend a day. They also go out on emergency cases. Those hospitals of 20 beds are doing a bang-up job, that is, good pathology services; and it would be a shame to try to make a 50 bed hospital there. I believe in all those things being done, but 85 to 90 per cent of our patients can be taken care of any place where they have a bed. We get along very well. We can have good medical service at a cost much less than that required for these hospitals.

DR. ROY WOOLSEY, Salt Lake City: Yesterday I advanced an idea that is coming from the industrial commission in Utah. Because of the location of mines away from Salt Lake City and Ogden, where the only large hospitals in the state are located, the practice has been for a long time in mining communities and in small farming communities of moving patients into the large hospitals. From that I develop the thought that in these 10 and 15 bed hospitals if there were patients who required specialists how much simpler and more convenient for the patient and the family to send the specialists to the small hospital. Let him go out and do the surgery and keep the people at home. I went 150 miles one afternoon and the next morning did some work in a very small hospital. The three doctors in this area cooperated. One gave the anesthetic, another assisted, and the other one looked after the general work in the community while the rest were tied up. We had three major pelvic operations during the morning. I came back that evening and the patient stayed at home. In fracture cases it is reasonably easy to have an orthopedist go out and have the work done in a small hospital. It's a thought that I think is worth considering.

DR. GRAHAM L. DAVIS, Michigan: I want to say that as a member of the Federal Hospital Council, which has had under consideration Public Law 725 and the discussion of the regulations under which that law must be administered, this issue of the minimum size of the hospital was carefully considered by the council at its meetings. The Federal Hospital Council includes those familiar with hospitals and those familiar with community needs and the proposal which had been made that no hospital be approved for a fund unless it had 50 beds was definitely not approved by the Federal Hospital Council; and the regulations which have been approved by the Surgeon General, by the Federal Security Administrator, and which will now be disseminated do not require that a hospital of less than 50 beds be not approved.

Committee on Methods of Bringing and Holding Physicians and Dentists in Rural Areas

DR. H. B. MULHOLLAND, Charlottesville, Va.: As a result of discussions yesterday and deliberations of the leaders of the panel last night we recommend: 1. The development of state and county health councils composed of representatives of the medical, dental, farm and other organizations concerned with the rural problem. We urge that these councils study the health needs and develop plans and programs for improvement of rural health in each particular area. 2. The development of adequate health facilities in rural areas where a competent survey has shown that these facilities are needed. We recognize that in order to attract and retain physicians and dentists certain fundamentals seem necessary: (*a*) provision of adequate

medical facilities; (*b*) provision of a reasonable income for physicians and dentists in these areas; (*c*) stimulation of practice in groups; (*d*) a concomitant improvement of community educational and cultural facilities; (*e*) extension of good roads and the development of community understanding of its responsibilities with reference to all health matters. We also recognize that this whole problem is intimately tied in with the whole social and economic inadequacies in rural areas and the maintenance of a reasonable and stable income of rural people is the underlying factor in the achievement of these objectives. 3. The development through provision of funds in the various states of a program of medical and dental care, and this program should be best supplemented by a sound program of health education in the schools. 4. That the medical schools place more emphasis on the economic problems of medicine in the medical school curriculum. We suggest that medical students have practical experience in rural medicine in some point in their undergraduate courses. In our opinion a successful rural medical organization should include rotation of some interns through a coordinated hospital system including perhaps health centers.

J. S. JONES, Chairman.
NED BURLESON, M.D.
FRANK SMITH.
L. W. MORREY, D.D.S.
H. B. MULHOLLAND, M.D., Co-Chairman.
COMMITTEE.

DISCUSSION

J. S. JONES, Minnesota: I rise to amplify the first recommendation, that is, the meetings in the communities, in the counties or parishes, whatever they may be, of a joint group of the professional people involved and leaders of the rural organizations in order that this program may become effective. After we go from this conference we shall be in the same place we were when we arrived unless we do something. This should be multiplied out in every community, and we believe this first recommendation will be carried out by all the people here.

MR. ALBERT S. GOSS, Master, National Grange, Washington, D. C.: We would endorse everything in the report, but I'd like to call attention to one thing. The recommendation was made for the state and county councils. These will bring our program into a working position, but I do not believe that these state and county councils will happen unless there is some leadership nationally. We should also have a national council made up of the American Medical Association, the farm organizations, the Parent-Teachers Associations and people particularly interested in rural health. It is difficult to create a council here. This group has no authority. It seems to me that a practical approach would be for the group to request the Board

of Trustees of the American Medical Association to work with the leaders of the farm and other interested groups and organize a national council which could keep in touch with the development in the states and do other things at the national level to promote the worth while projects outlined in this report.

MRS. ROY C. WEAGLEY, Maryland: As a representative of the American Farm Federation, I should like to second the suggestion made by Mr. Goss.

MR. WILLIAM G. MATHER, Pennsylvania: As a rural sociologist, I wish to emphasize that in the organization of these councils and in the planning for the location of hospitals and health facilties it should be remembered that the county is only a political unit. The farmers do not have loyalties to counties. Farmers live in communities. If this program is to be activated, it will have to reach into the community as a community. There is a loyalty there that can be capitalized on. If that loyalty is arbitrarily disregarded by following county or township lines there is an opposition that will also be encountered. I urge you to go with the psychology of the farmer rather than against it.

DR. D. G. MILLER JR., Morgantown, Ky.: One point that has a great deal of bearing on bringing rural physicians and dentists into the community is to have a community where a doctor's wife is satisfied to live. I made ten attempts before being able to convince a young man and his wife that they could be happy in a town of a thousand population. Rural people adopt new ideas and new persons slowly, and you must live in a community two or three years before they are willing to accept you as one of them and follow your leadership in anything.

LLOYD C. HALVORSON, Washington, D. C.: I didn't notice any mention of scholarships for rural students who might want to practice in rural communities. That is something that needs to be considered.

ELEANOR PALMQUIST, R.N., Mississippi: We have done exactly that as far as the medical student is concerned. He has to sign a contract that he will come back to that community and practice a minimum of two and preferably five years. We make loans to a maximum of $5,000 to medical students when they come back to a rural community and practice. He cancels the entire indebtedness to the state if he practices five years.

Report of Committee on Voluntary Medical Prepayment Plans

DR. JAMES F. DOUGHTY, Tracy, Calif.: As a result of the round table discussion the committee wishes to present the following recommendations:

1. Development of voluntary nonprofit prepayment medical and hospital care plans should be extended on a statewide

basis, and such plans should meet the standards set up by the Council on Medical Service of the American Medical Association.

2. Prepayment medical plans should put on an educational campaign to increase preventive medical care and to encourage the development of local public health districts.

3. The enrolment policy should be as broad as possible but actuarially sound.

4. The need for facilities should be studied and provided for by local, state and federal funds as they are developed.

5. To meet the demand of the facilities developed, adequate personnel must be produced.

6. We recommend that provision be made in medical schools and hospital staffs for the training of general practitioners and that local plans be developed to encourage their residence and practice in rural communities.

7. Farm organizations and prepayment medical and hospital care plans should give more study to the development of methods for the sharing of costs for the care of the medically needy.

8. It is recommended that voluntary nonprofit prepayment medical care plans be developed on a statewide basis predicated on local needs, and we base this recommendation on the experience in some eighty-five medical society sponsored plans and some eighty-seven Blue Cross plans throughout the country.

We urge that copies of these recommendations be presented to the Council on Medical Service of the American Medical Association and to the farm organizations for further action.

J. Frank Doughty, M.D., Chairman.
Mrs. Paul Palmer, Co-Chairman.
Carl F. Vohs, M.D.
W. E. Garnett, Ph.D.
Joseph W. Fichter.

Committee.

DISCUSSION

Mr. Graham L. Davis, Michigan: In the last few years laws have been passed in a number of our states which impose restrictions on the freedom to organize voluntary nonprofit prepayment plans. A typical law similar in form to laws which now exist in some ten states requires that the organization of such plans must have the official approval of the state medical society. In a number of states the law provides that the plan cannot operate in any county unless at least 51 per cent of the physicians of the county approve the plan. The earliest law was in New Jersey. Others were passed in 1945 following a similar pattern. Irrespective of the motivation, these laws will have the effect of restricting the initiative of state or local groups to organize voluntary prepayment plans for themselves;

and I think that the excellent effort of the American Medical Association in bringing this group together and in the endeavor to win cooperation between farm groups and organized medicine will not be promoted but will be put at a disadvantage by the establishment and continuance of such restrictions. If we are going to have voluntary nonprofit prepayment plans, let us have the broadest possible experimentation. I am not implying that initiative on the part of the people should not be accompanied by every effort to win and move forward with the cooperation of their physicians. Obviously, that is necessary; but a law that places control in the hands only of physicians of the money which is paid by the people for the benefit of those people and which is spent mostly on the physicians themselves is not a wise kind of law.

DR. NORMAN M. SCOTT, Trenton, N. J.: The law in New Jersey, which was the first of its kind, was not instigated by the medical societies in New Jersey. The medical societies of New Jersey simply expressed an interest in trying to solve this problem in their own way. That's what we wanted to do; and when we attempted to do it the Commissioner of Banking and Insurance and the Attorney General said "You will have to have an enabling act because this is probably insurance. If it is insurance and you start to operate or if we consider it this and you start to operate, we'll bring an injunction against you and take it into court. If the court rules that it is insurance, you come under our domination and we write the enabling act. If the court rules it is not insurance, we will introduce a law into the legislature making it insurance." The medical society did not write the act. It was written by the state authorities to allow the medical profession to attempt to solve this problem in its own way as an effort of organized medicine. These acts may all be proved to be unconstitutional. If they are, they are discounted and we operate under the law covering nonprofit organizations. The decision of the state authorities was that it would require an enabling act and they wrote it. That's the background on that act.

DR. B. J. BRANTON, Willmar, Minn.: In Minnesota we have an enabling act which covers all the various essential things. It says we must have a nonprofit prepayment medical plan under the enabling act. That word nonprofit to me means considerable. In our state association we spent a year and a half deciding what to do. We came out with two plans. The first plan was the one which would be nonprofit and therefore nontaxable in Minnesota. The second plan, which we are working on now, is to take all commercial insurance companies and bring out from them the finest contract which it is possible to get. We worked diligently on this. Many of us on that committee felt that a group that put on this sort of thing should be men of vision and know what it was all about. We have too many nonprofit voluntary and therefore nontaxable institutions in

Minnesota. We have two ways of solving this in Minnesota. The first one is by taking cognizance of the fact that the Blue Cross has done beautiful work and by using the organization to help us in the carrying on of this business. Another way of going in this is by using facilities already available to the people of the state in buying voluntary prepayment medical and hospital care through the insurance carriers who are already in their field and paying their money to take care of the tax which we have to pay in the state of Minnesota. It seems that certain of the nonprofit organizations feel that they do not come under the insurance commissioner of the states in which they propose to operate. To carry on on an insurance level successfully, we should come under the insurance commission. I would say that in the states where it is necessary to have nonprofit, nontaxable prepayment plans, let them have it; but where it is not necessary, it shouldn't be. I believe that that word nonprofit should be deleted from this recommendation.

Dr. R. W. Fouts, Omaha: I had hoped that Drs. Scott or Branton might have said something in defense of the medical profession in connection with the recommendation of Mr. Davis. If I understood correctly, the inference was that the medical profession who must deliver all of this medical service was standing in the way of the initiative the laymen and rural organizations might take in organizing prepayment medical insurance plans because we who must deliver this service insist that it be delivered under conditions that are satisfactory to the ethics and traditions of our profession. We have had in some parts of our country some experiences, and some of them are not ironed out yet so far as the Blue Cross plans are concerned or some of the medical services that they started out to render because of the fact that these Blue Cross plans are administered by laymen, and particularly hospital men who quite naturally will act to extend the scope of hospital activities in many instances to the point where it becomes the practice of medicine. That might easily happen to any medical service plan that might become dominated by hospital administrators or lay people who do not have the medical point of view. There is a reason why the medical profession insists that all medical plans receive the approval of the majority of physicians of that particular locality before they can receive the stamp of approval of the Council on Medical Service of the American Medical Association.

Mr. Joseph W. Fichter, Ohio State Grange, Columbus, Ohio: I share the sentiments of every one who has spoken from the farm groups that we feel that the American Medical Association has done a most constructive thing in inviting the farm organization representatives to participate in this conference and to represent a move that will bear fruit in a constructive way if similar meetings are held on a state or county level. However, I think the value of this kind of thing lies in

the possibility that every one concerned can feel that the other fellow is approaching it with an open mind. If I were to have the temerity to make a suggestion about a conference of this kind, it would be this. If they are called on a state or local level, the medical profession should be not too much concerned about getting the farm groups or anybody to agree for the moment with what the medical profession thinks ought to be done. All of us are a little too much concerned with who is going to control the general setup of our health care program. It doesn't matter much what recommendations come out of this conference unless the people who receive them have full faith that you and I have entered this conference with an open mind and that neither group has any desire to persuade the other group before it is ready to be persuaded to see the other's way. I think that is tremendously important.

The recommendation made by Mr. Davis is excellent. The following resolution was adopted in the National Grange meeting: "Medical prepayment plans should be primarily controlled by the consumer or patient." There we have it—the National Grange by resolution taking that position, the medical profession taking the other position. Those of us in the Grange until the next meeting are bound by this resolution. It seems to me that, meeting here for two days, maybe both of us can find it is worth while to make some concession. One of the most constructive steps the medical profession could take would be to join with the farm groups in recommending that if legislation is introduced in the legislature it is a census of this group that the restrictive legislation ought to be done away with and the field opened up for consumers of health service to set up some different plan.

MR. HARRY L. GRAHAM, Indiana Grange: The farm folk are interested in being able to pay for these services ourselves and we want a way over which we'll have some control. We don't want standards to go down. We know what it is to have poor hospital service or no doctors at all. We know what it is to go on low standards. We want them built up and expanded so the little people in the country get your kind of service; and I think the time has come when the medical profession should try to see our point of view on it and to have some faith and trust in the good sense and judgment of the farm folk. They faced this problem a long time when the medical profession didn't seem to be interested in it. We want to pay the doctors for their service but we must not and you must not sponsor legislation which will prohibit doing the thing which we want to do and what you need done for yourself.

MRS. JEROME EVANSON, North Dakota: The state level is where these suspicions are aroused. In the matter of state legislation, we were given the cooperation and the assurance that the medical association will go along on a bill to help

bring better health facilities to our rural people. Then our secretary sees fit to have brought before the legislature another bill nullifying all the work that we are doing and instituting a bill in which the medical group will have a veto over anything passed by lay people in an advisory council. The meeting here is going to do no good if when we go back to our states we have the same fights on and the lip service but not the actual cooperation that is necessary to get the job done.

DR. PAGE JETT, Prince Frederick, Md.: When we were fighting the great war we didn't say "Who is going to control it?" We doctors are delivering this service just as the Army and the Navy delivered service in the war. All we ask is that we shall not be hamstrung by lay groups who do not know the problem as we do, just as the Army was not hamstrung by people who did not know how to fight.

Report of the Committee on Nursing Needs of Rural Communities

MRS. CHARLES W. SEWELL, Chairman, and CHARLES W. HOLMAN, Co-Chairman: There is a shortage of nurses, and classes for schools of nursing this fall have enrolled little more than half of the number required. With a desire to improve this situation the Committee on Nursing Needs in Rural Communities makes the following recommendations:

1. Education for later life must begin in the home, where attitudes toward real service to humanity must be developed.

2. Expansion of home nursing courses in high schools and adult education courses should be encouraged. This not only helps individuals to help themselves in time of need but is a means of recruiting students for schools of nursing.

3. Education for nurses should utilize hospital service as far as this service is educational. Such programs might well be augmented by the use of public funds. On the basis of the experience of the Cadet Nurse Corps, the course might be shortened and consideration given to student nurses being assigned to rural hospitals for part of their experience.

4. Practical nurses are urgently needed. This health worker too should be trained and licensed for the protection of the patient.

5. Improve the status of nurses in rural communities in regard to working conditions, professional recognition, opportunity for advancement and continued professional development.

6. Give compensation commensurate with the education required and the quality of service given.

7. The rural people who pay for and use nursing services working with the nurses in local communities can do much to improve the situation. It will take the combined efforts of rural people through their organizations and the professional association of physicians and nurses to solve these problems.

DISCUSSION

MR. GRAHAM L. DAVIS, Michigan: In Michigan we think there should be two types—the registered nurse and the practical nurse, or nurse's aide. We can't recruit them under present conditions, so the approach we're making is through our state department of education. Our state universities and colleges have a definite responsibility in that field. So we're working toward these nurses being registered as students at the university and then using the hospitals, even the small units, for practical experience, but they're students at the university. In that way we shall introduce these nurses to our smaller hospitals and perhaps solve this problem of adequate nursing service for the communities that we have.

DR. G. F. MOENCH, Michigan: As a respresentative of the Health Committee and of the National Congress of Parents and Teachers I want to call attention to a problem that we run into when trying to develop our program, shortage of personnel and shortage of facilities. I have worked in a rural community all my life. These problems must be solved as a local problem as well as on a state and national basis. There are local resources at our command in every little community if we'll just look around. There are more millions of people represented in some 30,000 units of the Parents and Teachers Association; and in these communities there are schools. The school house furnishes a meeting place for people. Don't forget that the Parent-Teachers Association can be a valuable resource when it comes to working out programs.

DR. W. L. BURNAP, Fergus Falls, Minn.: I have a different view on the nursing problem than that presented. The lack of registered nurses presents a problem dangerous to the hospitals and physicians and the people. The girls are not entering nursing courses, and there are several reasons. One, the ease with which girls from high school can secure employment. There is poor pay for well trained nurses. This situation is the result of the war economy and will adjust itself. The chief cause, we in the rural areas feel, is the unnecessary demands made on the girls by the courses offered in a city hospital. Some years ago there were three year nurse training courses in many of our rural hospitals, two years at home and one in the city hospital. This arrangement provided adequate nurses in adequate supply. This desirable arrangement was arbitrarily terminated by some authorities at the top. There are two reasons why the rural hospitals are successful. The courses are so arranged that the girls can earn their own way. The present plan for licensing nurse's aides might help some but does not solve a real need for registered nurses. There is a solution. Establish a nurse training course in rural hospitals with affiliation with city hospitals. This plan has succeeded and is now succeeding where given the chance.

Report of the Committee on Health Council as Agency for Promoting Rural Health

DR. J. PAUL JONES: This committee believes that a health council should be composed of representatives from three groups: (1) those allied and auxiliary professional groups who render health service, (2) those who receive health services and (3) those governmental agencies officially concerned with health and medical care and also including those voluntary agencies manifesting a continuing interest in health and medical care.

Objectives of Health Council

1. To bring together medical and allied professional and citizen groups to the end that discussion, debate and interchange of opinions and planning of health and medical care may be effected.

2. To encourage, stimulate, foster and support the establishment of health and medical care councils in areas as deemed advisable within each state.

Functions of Health Council

1. To survey medical care and health needs.

2. To determine the existing and needed facilities and personnel for meeting the findings of the survey.

3. To recommend ways and means of providing adequate facilities and personnel to meet the constantly changing needs.

4. To disseminate as widely as possible information pertaining to health and medical care problems and programs.

5. To conduct or promote such meetings as may be helpful in effectuating the program.

This committee recommends that the Rural Health Committee, through the Council on Medical Service of the American Medical Association, provide cooperative assistance to interested state and local groups in establishing health councils.

J. PAUL JONES, M.D., Chairman.
LLOYD C. HALVERSON, Co-Chairman.
FRANK PECK.
MISS WINONA DARRAH, R.N.
V. V. MITCHELL.

DISCUSSION

MISS HELEN BECKER, College of Agriculture, Nebraska: The existing agricultural agencies on the state and local level actually bring to the people education of a health nature. The existing facilities to which I have reference are the land grant colleges through the extension service. In Nebraska we have already done a great deal. The Nebraska State Health Planning Committee, which is actually a health council on the state level, brings together the best thinking of the state

university college of medicine, the state department of health representatives from the organizations such as have been mentioned and others. Through this committee we disseminate information through the extension services, the 4-H Club and the women's project clubs. In the next two weeks I shall go on seven community health institutes—one day institutes—in the state of Nebraska. I believe that, because we have some 5,000 county agents in the United States, all states may use these facilities to great advantage.

DR. CHARLES R. HENRY, Little Rock, Ark.: In Arkansas in developing our prepayment health program we consulted with the leaders in the farm bureaus, the FSA and the extension service of the University of Arkansas. The extension service and the farm bureau in Arkansas have been studying ways of bringing better health to the rural communities. Last summer the director of the extension service called a meeting of doctors, dentists, hospital administrators, community leaders, public health workers and others. This group eventually will develop into our state health council. The group recommended that a health specialist be employed by the extension service to provide leadership in the communities in the development of a rural health program. This health specialist has been working since last October and conducts such institutes as Miss Becker says they are conducting in Nebraska. This health specialist interprets to the various groups and organizations Public Law 725. He interprets to community leaders and the people of these institutes prepayment health programs and also the existing health facilities in the community. He points out the need for rural boys and girls entering the health field and, above all, community responsibility in utilizing the facilities that are available. In Arkansas we have already completed the health and hospital survey.

MR. ALBERT S. GOSS, National Grange, Washington, D. C.: It is important that the American Medical Association has brought these groups together. I think the same thing can be done on a county level. I worked with farmers for thirty-five years. Much of it was in the field of insurance. Farmers do not want poor insurance, or poor or unpractical health programs; if competent medical men will participate in these county councils and state councils, the doctors need not have any fear of the kind of program which will develop. The reports of this committee and of committee two for setting up these county councils are the answer; and if we actually want the county councils in the spirit we have here, I have no doubt the whole field of prepayment of medical service will be advanced and these differences which have been expressed today will disappear.

MISS ELEANOR PALMQUIST, R.N., Washington, D. C.: The Joint Committee on Community Nursing Service has prepared

a guide that I think will be of help in your local councils in considering the nursing problems. This pamphlet can be secured from the Joint Committee on Community Nursing Service, 1790 Broadway, New York 19.

MR. JOHN H. DAVIS, Washington, D. C.: I represent the National Council of Farm Cooperatives. I want to endorse everything Mr. Goss has said and the others who have spoken for the county council. I think we need them rather soon. When the farmers of the country begin to demand something new as they are now, something better in the case of health and medicine, it is easy to look on that as an attempt to take over. Actually I think it is very different; it is a challenge to do a better job. If we succeed in bringing to those people something better, the end result will be more and better jobs to the medical people.

DR. W. E. GARNETT, Virginia: In Virginia we have had for years the state council, which has something over forty statewide organizations supporting it. We have sponsored and conducted a study of rural medical care needs. We have under way an intensive study of the insurance needs from the rural point of view. The important thing that we have found through this council is a very intensive educational campaign with meetings in communities over the state and circulars widely distributed. We are hoping to move to the county level shortly.

MR. EDGAR A. SHULER, Michigan State College: I think one of the basic problems is an educational problem. Dr. Hoffer at Michigan State College has prepared a report on this work that he has been doing for the past year, which I think might be of interest to you. This schedule or questionnaire attempts to help farm people know when they are in need of medical attention. It doesn't attempt to diagnose the condition, but it does attempt to point out that often we need to go to a doctor early before we're flat on our backs.

DR. CHARLES H. LERRIGO, Topeka, Kan.: I am a physician who has been in Kansas for forty-seven years, seventeen of which were spent almost entirely in rural practice. No one seems to have recognized the great help that will come to you from the tuberculosis and health associations. I suggest that you call in your tuberculosis and health associations as representatives at all your councils. They can give you a lot of health literature. They will provide health education circulars.

FATHER E. D. BUTT, Tennessee: I am rather surprised that nothing has been mentioned about using the churches as a means of disseminating information. In a rural church of which I was pastor in Tennessee we had a rack for pamphlets relating to the Christian life, such as one finds in all churches. Also in this rack we put pamphlets which we got from the county health departments. By having these available in the church

we were disseminating them among people who never have got these pamphlets from the health department. As one who has spent most of twenty years in the rural pastorate, this conference is to me one of the most uplifting experiences that I have had recently. I think that on every state or national or county health conference there should be a competent delegation from the churches and that news about this conference, about the plans of this conference, should be put into the hands of every rural pastor of every denomination of every church.

Report of the Committee on Medical Care for Lower Income Groups

MR. OWEN COOPER, Jackson, Miss.: The findings of this committee are based largely on the discussion yesterday by a distinguished group of men who joined this round table. The group met to discuss the medical needs of lower income farm groups. Medical care was defined as preventive, diagnostic and curative services. Lower income groups were defined as those unable to pay the full cost of complete medical care. This broad definition led to difficulty later in determining the means by which such a group might best provide itself with medical care. The following methods and factors were discussed as ways medical care is now extended to the lower income group: 1. Sliding scale of fees whereby physicians adjust their fees in accordance with the patient's ability to pay. 2. Prepayment medical care plans. 3. Tax supported systems for the care of the indigent. 4. Philanthropic and other private agencies. Following discussion of the factors enumerated the group acting as a committee of the whole made the following recommendations: 1. Expansion and increased effectiveness of state and locally supported public health programs, implemented when necessary by federal funds. 2. Expansion and improvement of tax supported systems providing adequate medical care for the indigent and medically indigent. 3. Development of prepayment plans as a contributing factor in the solution of the problem. 4. That there should be no difference in the standards or adequacies of medical care regardless of the income of the patient. The committee makes the following suggestions based on the discussion which was not solidified into definite recommendations:

1. That the health of this lower income group depends in a large part on economic factors such as the provision of adequate housing, adequate clothing and adequate food, and that the correction of this defect depends on the raising and maintaining of the economic level of this group.

2. The committee calls attention to the fact that the definition of the lower income group as given by the conference would probably include about 85 per cent of the population.

3. That a comprehensive study be made of the effective medical care tax supported plans now in operation.

4. That cooperative health associations be expanded and developed on a community level to meet local problems.

5. We believe the issue now facing us is the choice between a system based on voluntary plans supplemented by tax subsidy, applied to the individual, involving a means test, or the adoption of a national personal health service program, supported by taxation. (This may mean income tax, pay roll deduction, or other personal assessment, combined if necessary with some general tax funds.)

OWEN COOPER, Chairman.
EDWARD MERTZ, Co-Chairman.
MISS ELIN ANDERSON.
CLYDE YORK.
NORMAN SCOTT, M.D.
COMMITTEE.

DISCUSSION

MR. W. E. GARNETT, Virginia: As a representative of the Virginia Agricultural Experiment Station, a few years ago I made an intensive study of this question. In many states the extension service reaches relatively few. I want to emphasize the importance of following up the report of this committee as well as of the committee on prepayment medical care. We found that the poor group averaged more than a third more children than an equal number of families of higher standards and that much of the future population of the country is being reared in these poor homes, where there is only inadequate medical care. We have found that this group needs better medical care than most and are least able to provide it.

REV. ANTHONY J. ADAMS, Rural Life Director, Institute of Social Order, St. Louis: The farm organizations for the most part have their health programs, and they have met opposition on the part of the state health boards. I have in mind a number of instances where the people have the committee, they have a couple of doctors on the board, they had nurses, they were prepared to start a cooperative hospital. They sent in their petition. They got no word for several weeks. They finally got their check back and a note saying that the state legislature could not permit a cooperative group to set up a hospital. The directive had to come immediately from the association—the medical association—which stymied the whole thing. The Catholic priest who was pastor in that town, the Methodist minister with his group, the local doctors and nurses had all worked on that. A central committee could iron out some of those difficulties. While I endorse this idea of a central committee, let us use it to strengthen our local committee. The more we centralize control the more likely we are to end up

with socialized medicine. We'll fight to the last ditch with the American Medical Association in trying to forestall socialized medicine; but we want to see that cooperation in fostering local groups who are willing to help, who can give the help and who will give the help if they are permitted.

DR. F. S. CROCKETT, Chairman, Committee on Rural Medical Service, American Medical Association: On the national level here we can plan; but to get action it must go out into the states and counties. For that reason we have asked each state medical society to appoint a state committee on rural health; and some thirty-five or thirty-six have done that; and many of them have sent delegates to this meeting. It is expected that within each state that committee will get into close cooperation with the organized farm groups of that state. None of us know the answer to these things. We are trying to find them out, and we will probably find them in the hard way. We look forward eventually to success.

Mr. Goss speaks of a National Council of Rural Health. Tonight when my committee meets I can take that up with them and see what we can do with the idea. I am very grateful to Mr. Goss for making that suggestion.

Following the end of the formal program I want the doctors who are here from every state, members of all local state committees on medical service, or other doctors who were sent probably to represent that interest, to talk over among ourselves what we can do and what we might be able to do in the states and in the smaller subdivisions of those states. We're impressed with the fact that so many from many different walks of life are interested in this problem. I am grateful to you who have expressed your views.

Address of J. Melville Broughton, Ex-Governor of North Carolina

Dr. Crockett then announced that Ex-Governor J. Melville Broughton of North Carolina could not be present. However, he sent an abstract of his talk, and Dr. George F. Lull, Secretary and General Manager, American Medical Association, read the address.

DR. LULL: At the request of your chairman I will read this abstract of Mr. Broughton's address.

The good health of our citizens is a state and national responsibility. Any program for our national economy that omits health as an essential factor is unbalanced and unsound. The most important "next step in a health program" is to obtain general acceptance of these and related principles by state and national legislative bodies and by the public. Good health is not only a vital part of our national economy; it is our first line of national defense.

These factors were responsible for the passage of the Hill-Burton Federal Hospital Construction Act in July 1946. It is the first time any federal appropriation has ever been made for civilian hospital construction wholly under state or community management and control. It may well mark the beginning of a new era for good health in America.

Doctors and medical associations who have, with justification, opposed "socialized medicine" or "federalized medicine" have with almost complete unanimity accepted the principles and provisions of the Hill-Burton Act. Thus has been laid the foundation for a broad program for good health. Among other steps which should ensue may be the following:

1. The provisions of the Hill-Burton Act should be broadened and appropriations increased in a manner to make certain that full benefits will be experienced by rural areas.

2. Public schools should be required by state laws to give adequate instruction in health and personal hygiene and in home and community health and sanitation. Such instruction should extend to elementary, grammar and high school grades. The selection of textbooks for such instruction should not be left to politicians or even wholly to teacher-boards or commissions. State or other competent health authorities should participate in such selection.

3. Every child in a public school should be physically examined annually by a competent physician at public expense. Where such examination reveals the need for medical or surgical treatment, the parents should be notified. Where poverty or inadequate income prevents the parents from obtaining needed treatment for the child, it should be provided at public expense. In such programs the principle of individual selection or designation of physician or surgeon should be preserved. The fullest cooperation of medical groups in the instructional and clinical phases of the program should be invited and will undoubtedly be given.

4. State legislative bodies should make adequate appropriation for adequate medical care and hospital programs, with full provision for all rural areas and other sections not now adequately served. Appropriations so conditioned as to be unavailable to rural or other areas unable to provide a pro rata contribution, by tax or otherwise, will not solve the health problem. State legislation should be so designed as to take full advantage of the provisions of the Hill-Burton Act and other similar federal enactments.

5. In such a broad health program there can be no place for racial, religious or other discrimination.

6. The widest encouragement should be given to so-called Blue Cross hospital and medical care plans and similar agencies in various industrial groups. Such plans or agencies when

adequately regulated and supervised in the public interest are a protection and at the same time encourage thrift and self reliance.

7. The word "indigent" or "charity" should be eliminated from the good health program. It carries something of a stigma that tends to keep away many people who should have the benefit of hospital care.

8. Increasing emphasis must be made on local responsibility and opportunity. The time for looking to Washington for the solution of all our problems is past. The relationship between nation, state and community should be one of cooperation and coordination. No community without a hospital or health center should think of any other form of memorial for the war heroes.

9. The shortage of physicians in rural areas threatens our whole standard of health in the nation. Inducements, gratuities, scholarships and the like may help some, but ultimately the only solution will be more hospitals and health centers in rural areas.

Comment by Mr. Watson Miller

Dr. Crockett then introduced MR. WATSON MILLER, Washington, D. C., administrator of the Federal Security Agency, who said: It so happens that for about two decades I have been on the threshold of medicine. I have been the beneficiary of an unusual amount of skilful surgery, medical treatment, dentistry and effective nursing. I have had sense enough not to try to invade the profession and not prescribe for other people or myself. I am very zealous for American medicine. I shall never consciously do anything to delay it or harm it. On the business of health in rural communities, I don't think that differs in any important aspect from what we are all considering—just more medicine for more people.

Maladjustment in Medical Service

DR. H. H. SHOULDERS, President, American Medical Association: There are many causes or factors which play a part in bringing about the state of maladjustment in individuals and in the conditions with which we are concerned today. Obviously it is not a specific disease for which a specific remedy is available—a single remedy which could be administered with assurances of a certain and speedy cure. It is therefore appropriate for us to think for a moment on a few of the causes which have contributed to the state of maladjustment which exists in medical service. All I can hope to do at this time is to contribute a few thoughts to the thinking that is going on and the questions that are being raised at this conference. I certainly do not hope to give you a specific remedy, for the simple reason that no such remedy exists. It is a situation which must be dealt with symptomatically. Many different means may be required in the management of the situation. At one time it may require sedation of various sorts and at another time it may require stimulation of various sorts.

One of the causes of our problem is illustrated by a story I heard from a reliable source some time ago. It is about a country doctor who was located at a country crossroads in one of the states in the Middle West. He was happy there and busy, but the roads over which he traveled on horseback or by buggy became paved roads. The farmers bought cars and so did he. In a short while he was not busy. He discovered that his patients were going to the town a few miles away for their medical care. He then posted a notice on his office door that he was going to town. The people in the community made a loud protest. His reply to their protest was that many of them were going to town for medical care, since the roads had been improved, and that they were calling him only at night or in emergencies or when the snow was too deep for the town doctor to visit them. This fact they could not deny. He did move to town and the people of that community became his patients again and he served them from and in the town.

This story could be repeated times without number, and this is one of the causes of the maladjustment we have at the present time. It is a cause also for the sense of maladjustment where no serious maladjustment exists, for the simple reason that the convenience of medical care often receives more emphasis in the minds of some people than the efficiency of medical care.

Another factor of great importance is the progress that has been made by science and invention. The whole pattern of rural life has changed, and the whole pattern of medical care has changed also, owing to science and invention.

The country doctor went on horseback or buggy. He often raised the feed for his horse. He carried most of his equipment with him. He was a good fellow, devoted, kind and generous and, I say, capable. I would not detract from his memory. I have respect, yes, reverence, for his memory. He was near the people and very successful. The sense of nearness was satisfying. They measured distance in miles then and not in minutes. But in all this I must not forget and you must not forget that the country doctor of whom I speak could not prevent or cure typhoid. He visited his patient daily for a period of six to eight weeks, and the mortality was high in spite of all he could do. He could not prevent or cure diphtheria. He had a fracture case occasionally, and he set fractures of arms and legs without the aid of an x-ray. He got many bad results but was not blamed for them. He did the best he could. Today he would be sued for malpractice if he gave the same treatment with the same results, not only that but the people themselves would not stand for it. Today the doctor cannot carry all his equipment with him. A diagnosis may involve many laboratory tests. He travels by automobile and can reach a point 10 miles from his office in less time than he could travel 2 miles on a

country road. At that time a woman in labor was sent to the hospital occasionally for a complication. Today it is the rule for women in normal labor to go to the hospital.

Years ago many doctors in towns throughout the country built their own hospitals, equipped them and operated them as private institutions. They did two jobs, furnishing both medical care and hospital care. Many communities were slow to develop a sense of civic duty. They were not quick to develop facilities for their own interest and care. I could name many small institutions that have closed in the last ten to fifteen years.

The pattern of medical practice has changed in another important way. The diseases that required most of the time and interest of the rural practitioner many years ago have disappeared. You rarely see a case of typhoid now, but, on the other hand, fractured arms, legs and backs from automobile accidents occur with increasing frequency. I noticed in the paper a few days ago that there were 100,000 deaths from accidents last year, to say nothing of the millions who were thus injured and survived. In addition to this, many diseases which were rarely ever recognized and treated in those years are recognized and treated effectively today, though the diagnosis and treatment involve the use of facilities and equipment and knowledge unknown to the doctor of early days.

So the location of a doctor at every crossroad in this country would not, in my opinion, solve the problem of efficient medical care. It is a good, well trained doctor, plus equipment and plus facilities which are reasonably accessible by modern methods of transportation which will make adequate and efficient care available. We must not allow our sense of convenience and our desire for convenience to impair our appreciation of efficiency.

This fact was impressed on me some months ago as a result of a conversation with a man I regard as a great farm leader, a man many of you know, Mr. J. Frank Porter, who was president of the Tennessee Farm Bureau until a short time ago. He and I were discussing this problem, and he remarked with great emphasis that the town of Williamsport, Tenn., was in urgent need of a doctor and he gave apparently logical reasons for the statement. At one time three doctors were there. One moved away, one died and the remaining doctor was getting old and feeble. Mr. Porter lives on a fine farm near the village of Williamsport. . This town has a population of 112 people. It is surrounded by a thickly settled community in one of the best farming sections of middle Tennessee, and in one of the best counties in Tennessee, Maury County. It is just 12 miles from Columbia, the county seat, which is a town with more than 10,000 population. There are many fine doctors in the town of Columbia and a good hospital and a full time health unit. Mr. Porter has an office in the town of Columbia.

A fine paved road connects the two towns, and he covers the distance between them in twenty minutes traveling at a moderate rate of speed. There are, of course, no modern facilities for medical care at Williamsport.

I think Mr. Porter gave a very natural and laudable expression of a community interest as well as a personal interest, but I don't doubt that his thinking was colored to some extent, at least, by the convenience and satisfaction of having a country doctor near at hand even though he patronized the doctors in Columbia and in Nashville when the occasion arose.

Another factor to be considered is that patients, even seriously ill patients, can be moved long distances with speed and comfort and receive better care at the end of their journey than they could have received at home in the old days. Modern inventions have produced modes of patient transport that are efficient, speedy and comfortable. The location of a country doctor at Williamsport would not, in my opinion, solve the medical problem of Williamsport. It would satisfy a sense of need but not supply a complete need regardless of the individual capabilities of the doctor.

This whole idea of allocation of funds was begun for the purpose of demonstrating to the people their benefits and with the idea that the aid could be withdrawn, once an effective demonstration had been conducted. Mind you, I do not recommend the abandonment of the full time health unit, but I must urge the abandonment of a policy which governs the allocation of funds. At frequent intervals we see reference made to the approximately twelve hundred thinly populated poor counties without a full time health service, and this fact is cited as a reason for more appropriations when it is in fact a reason for the alteration of a policy.

I will say also that any opinion to the effect that the people in a county or area without a full time health unit are for that reason without preventive medical services is a very erroneous opinion.

The fact is that, when science developed and perfected means for the prevention of several diseases by vaccination or inoculation, the private practitioners of medicine began their extensive use. I dare say that more preventive medicine of this type has been administered by private practitioners of medicine than by all other agencies combined. It was not the simple regulation which required children to present a certificate of successful vaccination on entering school that accomplished the control of smallpox in this country many years ago, it was the continuous preventive efforts on the part of the general practitioners of medicine.

I wish to make this further observation—that the two groups of people who, in my opinion, should work out the treatment

of this maladjustment are at this conference table. They are the representatives of the medical profession and the representatives of the rural people. From this conference then should grow and develop a type of consideration and cooperation which will in time determine what the local needs are, their character and the amount. The matter of voluntary prepayment medical service and insurance plans, in my opinion, can serve a vital function in the financing of the major costs of medical care, and they can accomplish it without hardship on individuals and with the complete preservation of individual independence and without destroying, or even impairing, the vital relationship between patients and doctors. The voluntary hospital prepayment movement is accomplishing the same thing.

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