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Two Medical Care Programs of the U.S. Department of Agriculture, 1935-1947

This report briefly reviews the experience of the Farm Security Administration with two types of medical care plans:

1. Prepayment health programs for low income farm families, and
2. Federal subsidy programs providing general medical care for migrant farm workers and their families.

Both types of programs were of an "emergency" nature. With the impact of World War II they were altered to meet changing economic conditions and manpower shortages. Both programs operated in the years immediately following 1935, and were essentially discontinued by 1947.

The Farm Security Administration established a partly subsidized, voluntary prepayment health plan which varied widely in different areas of the country. The peak enrollment was in 1942 when 613,854 persons from 117,460 families[1] were enrolled in 10,074 counties of 41 states. By 1946, the enrollment had decreased to 236,000 persons.

The federal subsidy plan for migrant farm families was designed to meet the health needs of citizens displaced from the Mid-west during the drought. In California and Arizona, the plan was organized as the "Agricultural Workers Health and Medical Association" (AWH&MA). Ultimately, six such associations covered farm areas throughout the United States. Enrollment fluctuated widely according to the season. In the course of a single year, over 150,000 persons were served by the health program.[2]

Low Income Prepayment Plans

Insurance plans were conducted for low income families on a voluntary basis, both for subscribers and physicians. All plans were started with the cooperation and consent of the local and state medical societies involved. Plans were based typically on the fee-for-service method of payment with free choice of physician.

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Benefits varied according to the funds available for payment. Under most of the plans, payment was on a pro-rata basis with premiums under the local plan being divided to cover, so far as possible, the cost of the medical services provided. Coverage was for all members of the family--typically for office calls, emergency surgery, and hospital expenses. The cost for this type of coverage was from $15 to $26 per year per family. In 1940, Williams described a typical payment schedule for physicians' care as being $18 per man and wife, $1 for each additional child up to eight, with a maximum payment of $26 per family.[3] In some plans, drugs, emergency dental care, laboratory and x-ray services, and some elective surgery were offered; such plans cost a family from $50 to $60 per year. The estimated annual family income for the group offered the plan, was between $300 to $1,000 per year.*

On the matter of itemization of costs under the plan, Mott reported the following:

> "The fees for professional services vary in different parts of the country, but here are some rough figures to go by--figures drawn up bearing in mind the lower average income of rural people. For the services of the general practitioner--office and home calls and maternity care--a family might pay between $15 and $20 a year. For the services of the surgeon in the hospital, and the specialist, they might pay between $7 and $10 a year. For limited hospitalization, they might pay between $8 and $12 a year. For basic dental services, they might pay between $6 and $12 a year depending on the services allowed. The provision of prescribed drugs could probably cost a family no more than $5 to $7 a year. Special nursing services might be covered by $1 to $2 a year. Administrative costs would come to about $3 or $4 a year (or more accurately five to ten percent of the total cost of services). A contingency fund for emergency conditions or for certain special services like orthodpedic appliances or eyeglasses, et al, might come to between $3 and $5 a year. The plan for all these services, therefore, would cost a family on the average between $48 and $72 a year or four to six percent (of the annual family income) depending on the section of the country."[5]

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*According to the U.S. Department of Labor's Consumer Price Index, an income of $1,000 in 1940, could buy approximately the same amount of medical care services as an income of some $2,077 in 1959.[4]

Some families received loans from the Farm Security Administration to pay the annual medical service premiums, just as these families received loans from FSA for expenses to keep their farms in operation.

Fees were deposited in a fund administered by a trustee. They were divided into 12 monthly accounts and pro-rated to cover as much of the bills submitted by physicians, dentists, and hospitals, as was possible. In 1941, the average payment was 61 percent of all physicians' bills throughout the country, 81 percent of dentists' bills, and 74 percent of hospital bills. Administrative costs under this insurance plan were less than 10 percent.[6]

In 1944, of 592 plans offering physicians' services, 504 covered one county, 57 covered two counties, 15 covered three counties, 5 extended over four counties, and 11 covered five or more counties, or whole states.[7] Enrollment seldom included more than 200 or 300 families in a county plan. In 1944, although over 363,000 persons were participating, the average plan enrolled only 92 families; the average area covered by a single plan was 1.3 counties. The highest percentage of plans operated as separately-administered funds, although some used Blue Cross and other hospital plans.

Several different methods of payment for physicians' services were utilized. As noted above, the majority used direct fee-for-service. Some provided a "capitation" flat fee for physicians' services for each family per month. Others had "time-fee-plans" under which physicians were paid by the hour or day. Experience showed that the latter plan yielded more services for the funds available. This plan was also subject to less abuse, and more conducive to the provision of preventive medical services. Several plans used salaried full-time physicians.

After the outbreak of World War II, enrollment in the medical insurance plans under FSA decreased due to a number of factors: physician shortage, migration of small farmers to cities to do war industry work, improved economic circumstances of farm families, and the improved ability of farm families to pay private medical fees. Dependence on the entire FSA lending program decreased sharply.

Strong Points of the Prepayment Plan*

1. An American Medical Association spokesman[8] wrote that these prepayment plans during the emergency brought "more or better, or at least earlier medical care" to many needy farm families.

2. Mott and Roemer point out that because of the importance of health to borrower families, government farm loans were protected by the health insurance program.[9]

3. Physicians approved the plans which they had assisted in designing, and implementing.

4. Rural physicians, in particular, favored the arrangements during the depression as they could depend on at least some reimbursement for their services.

5. Rural hospitals favored the plans for similar reasons.

6. These insurance plans assisted in the recruitment of health personnel for isolated areas.

7. Interest in improving rural health services was stimulated.

Weaknesses:

1. Limitation of the scope of such plans to simply the payment mechanism, and their failure to approach the basic goal of improving health service availability in isolated rural areas.

2. So few farmers chose to enroll that an adverse selection taxed the limited funds available to cover services. The plans as designed, were highly selective and only low income, high illness population groups were eligible and enrolled.

3. Plans which included hospitalization demonstrated that a county unit, with an average of only 92 families enrolled, was far too small to be sound from an actuarial standpoint.

4. Comprehensiveness of medical service coverage was seriously limited by the small amount of available funds. Some plans did not cover laboratory and x-ray services, consultations, and elective surgery; others offered little more than emergency coverage in a general practitioner's office.

5. The pro-rata payment system made it inevitable that the more medical services rendered by physicians, the lower would be the percent of payment.

6. There was little effort to use, coordinate, and take advantage of existing community health resources. This was particularly true of preventive services.

7. Some plans lacked adequate technical administration.

8. There was a notable lack of farm family participation in formulation and management of the plans; thus, a lack of consumer interest or support.

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*Strong points and weaknesses of the program are discussed by Mott and Roemer, see reference 1, pp. 408-409.

Though the overall Farm Security Administration insurance plans improved the level of services for enrolled families, that level remained below the average level of medical services for U.S. families. However, these plans provided needed medical and dental care to many farm families and stimulated farm people, as well as farm organizations, to take positive action on the problem of health services.

The Agricultural Workers Health and Medical Association

A sharp distinction should be made between the insurance program for low income farmers described above, and the outright federal subsidy for the medical service program designed to meet the health needs of drought-displaced, migrant farm worker families under the Agricultural Workers Health and Medical Association.

In the 18 months preceeding December, 1937, some 260,000 individuals entered California by automobile seeking manual labor.[10] Three-fourths of these people were from the 19 drought states of the Mid-west. One-fifth of the total were from Oaklahoma alone. These families did not meet California's county or state residency requirements for public medical services. The migrants congregated at the outskirts of towns and their numbers presented an acute and serious health problem. California called on the federal government for assistance. The Farm Security Administration attempted to remedy the situation by developing direct relief services, special housing programs, and the medical care program described below.

When assistance was requested by California, the FSA asked for consultation from the United States Public Health Service. Representatives of the California Medical and Dental Associations, the State Health Department, and concerned local medical societies were brought together to develop a plan to meet the emergency. The first Agricultural Workers Health and Medical Association in the United States came into existence, organized as a non-profit association in California in 1937. It was later expanded to include Arizona.

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The California Agricultural Workers Health and Medical Association was incorporated in 1937. The Articles of Incorporation granted the Association the right to engage in any activities "involved in or related to the provision of medical and dental services, nursing or hospitalization, medical and surgical supplies and appliances, and such other services and supplies that might be incident to the convenience and preservation of the health of its members."[11]

Board of Directors

Control of the Association was vested in the Board of Directors consisting originally of nine, but later seven members. Three of the board members were designated by Federal government agencies; four professionals were designated by the California State Department of Public Health, the California Medical and Dental Associations, and the Arizona Medical Association. These directors, and specifically a general manager, and a medical director, appointed by them, were charged with general administration and policy making.[12]

Financing, Enrollment and Eligibility

The Farm Security Administration was chiefly responsible for financial support of the Association until July, 1943, at which time the War Food Administration became financial sponsors. The Association started off with a fund of $100,000. The cost for the year 1942-1943 was about $1,000,000.[13] In April, 1940, 14,594 families including 57,426 persons were enrolled by the Association.[14]

Eligibility criteria for participation varied throughout the ten-year history of the AWH&MA. Initially, the by-laws provided that only "low income farm owners, farm tenants, share croppers, farm laborers, drought refugees, or persons who when last employed, obtained a major portion of their livelihood from agriculture or other types of farming operation should be admitted to membership."[15] Later, as funds became severely limited, proximity of residence to existing Farm Security

Administration labor recruitment centers, dependence on FSA transportation or housing projects entered in. In the years after the outbreak of World War II, the chief beneficiaries were foreign contract workers from Mexico, recruited to meet the wartime emergency farm labor shortage. By 1946, under War Food Administration regulations, the AWH&MA was required to use funds first to provide health services for imported Nationals; legislation in reference to including domestic farm workers was only permissive. Consequently, American farm families received only such care as could be financed after Mexican Nationals were cared for.[16] In 1944, the California-Arizona Association membership included 33,000 Mexican Nationals, 2,000 Javanese, and 15,000 Americans.

Migrants made application for medical treatment at the Association's district offices or camp treatment centers. A certificate of membership in the Association, serving as an identification card, was issued to applicants on an annual basis. A great majority of migratory families certified for Association membership were found to be ineligible for other relief because of residency requirements. There were some members who were not in need of relief, but were unable to pay for medical care. In certain areas low income farm owner groups were allowed to obtain membership, and paid a small annual fee. The membership card included all members of the immediate family. Membership was honored in any of the Association's offices as long as eligibility was maintained. Membership carried an obligation to pay for medical services whenever possible. Some workers actually did repay a few dollars, but in most cases, the family's economic status precluded any expectation of payment.

Patterns of Medical Care

Types of medical service varied according to such factors as location, season of the year, and available medical resources. Flexibility of design to adapt to local health service needs and resources was the rule. There were variations between states, counties, and even within individual counties. The

seasonal program variation was notable. For example, in July, 1942, there were 17 diagnostic and treatment centers, and 13 referral offices, while in September, 1943, there were 29 diagnostic and treatment centers and five referral offices.

In the original planning, field clinics were dismissed as a procedure because of the desire to allow free choice of physician. However, as the volume of work increased, the physicians found that most of the patients had minor complaints and did not require the personal attention of a physician. It was found that in many areas, clinic care would be more practical for the migrant farm family. Arizona doctors first requested permission to establish clinic services. The clinics in Arizona worked so well that they were extended to California. Dr. R. G. Leland, Director of the Bureau of Medical Economics, of the American Medical Association reported that:

> "The seemingly satisfactory clinic arrangements in Arizona probably account for changing policy in California from the referral to a clinic basis. It is reported that the County Medical Societies in the area in which services to the Association's members are required, have indicated a preference for clinics instead of referral to physicians' offices."[17]

Physicians who were willing to participate in the clinic rotated according to available days and hours. Minor conditions were taken care of quickly with maximum utilization of nurses under physicians' orders. The patients who had more serious problems were referred to any enrolled available physician of their choice, and were seen in the doctor's office. Under the clinic programs, members applied at field facilities established at central points during the peak season. Where there were disorders too serious to be treated by the field facilities, patients were referred either to private physicians' offices or to hospitals. It was estimated that under the clinic type operation, nurses or doctors were able to care for between 70 and 90 percent of the patients at the field clinics. About half of the applicants referred from the clinics required hospitalization.

The following factors were used in deciding whether a district was adaptable for the clinic or required a referral private physician type program: volume of services required; the geographical distribution of the membership; the availability of doctors in the area; transportation facilities; and the attitudes of the members of the local medical association. For an effective field clinic operation, there had to be a concentration of membership sufficient to keep a minimum staff working at a productive rate. It was necessary that there be an adequate number of doctors in the area so that those doctors working in the clinics were not forced to refer the most serious cases to themselves. The clinic had to be centrally located with easy access by good roads and offer incentive to the patients to come for care at an early stage in their illness.*

In the four-month period, July-October, 1940, of 10,660 applications for medical care, received by AWH&MA, 6,684 were to clinics, or 62.7 percent; and 3,976 or 37.3 percent, directly to physicians' offices. About one-third of the cases referred to the clinics, and 2,270 other cases, were referred directly to doctors. During the same four months, in Arizona, out of 6,824 applications for medical care, only 10 percent were made directly to doctors.[18]

Dr. Leland stated that: "Good medical care for ambulatory patients is possible under either clinic or private office conditions, provided necessary facilities are available and requirements are not imposed in the clinic that would modify the procedures and judgment customary to physicians private offices."[19]

The population served by AWH&MA was of a younger age distribution than the general population. Comparison can be made with the National Health Survey population of 1935 in which one-fourth were 14 years of age or less, compared to the AWH&MA membership, which showed about 40 percent being less than 14 years of

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*For a further description of the medical program, see Schaupp, K.L.: "Medical Care of Migratory Agricultural Workers." Calif. & West. Med. 60,5: 1-12, May, 1944.

age.[20] Some 40 percent of the National Health Survey population were 35 years or more, whereas in the Association membership, only about 19 percent were over 35 years. Only three percent of the Association membership were over 55 years of age, while in the Health Survey population, 13 percent were 55 years of age or over.

Analysis of diagnostic group data reveals that one-fourth of referral illnesses under the Association were for disorders of the digestive system. About one-fifth of the illnesses were for disorders of the respiratory system; and one-tenth for pregnancy, childbirth and associated causes. Another ten percent were for accidents and external causes; and about six percent for disorders of the genito-urinary system. There was a remarkably high proportion of complaints due to accidents among the children.

Costs of Services

Expenditures for services varied for Associations in different areas of the United States and in different parts of California. There were variations as well during different seasons of the year. For the fiscal year 1939-1940, cost of care, at doctors' private offices averaged $3.26 per visit in most areas, although in one county it was $4.18.[21] Where clinics were operated, the average charges were consistently lower. The cost of drugs and other extras was found to be better controlled in the clinic type operation. In June, 1941, with more than 4,000 applications accepted for medical care, clinic costs for the year showed an average of $1.38 per clinic visit whereas referral cases to physicians' and dentists' offices (for more complicated conditions) cost the Association about $11.18 per case. Cost of hospitalization was some $37.39 per hospitalized case. The cost of medical care per person per month for the Agricultural Workers Health and Medical Association in California was $2.60 in 1943.* The cost figure

* When the program was altered to care mainly for Mexican Nationals, the cost per month per person was $2.36 in 1946, and between $1.50 and $2.00 in 1948.[22]

included care not only for general medical care services, but for the following services excluded by other contracts for general medical care at that time: 1. care of on-the-job accidents (AWH&MA paid 90 percent); 2. care of diseases not common to the two sexes; 3. veneral diseases; 4. care of maternity cases (no waiting period); 5. treatment of illness due to pre-existing conditions; 6. provision of drugs; 7. extensive preventive measures (immunizations) and health education; and, 8. extensive transportation of nurses, doctors and patients to treatment facilities. The May, 1945, monthly report of the California-Arizona Agricultural Workers Health and Medical Association, which shows breakdowns of services by unit value follows:

HEALTH AND MEDICAL CARE SERVICES, May 1945

AGRICULTURAL WORKERS HEALTH AND MEDICAL ASSOCIATION

Number of Services	Service	Value of Unit	Computed Value
	Clinic		
9,012	Visit to physician - - - - - -	1.5	13,518
10,629	Visit to nurse only - - - - -	1	10,629
2,771	Nurse's home visit - - - - - -	2	5,542
39	Meeting- - - - - - - - - - - -	5	195
0	Dental Service (Extractions, fillings, etc.)- - - - - - -	1	0
	Referral		
	Physician's call		
2,126	(a) Office- - - - - - - - -	2	4,252
2,057	(b) Home- - - - - - - - - -	3	6,171
	Physician's or surgeon's flat		
147	fee case - - - - - - - - - - - -	32	4,704
4,295.5	Hospital day	7	30,069
385	Dental Service - - - - - - - -	1.5	578
1,336	Drug prescriptions - - - - - -	1	1,336
		Total Number of Units	76,994

76,994 number of units @ 86¢...Total Charges $66,214.84

Source: Agricultural Workers Health and Medical Association: Report of Activities to War Food Administration. (Dr. S. Kerby-Miller, General Manager) San Francisco, Calif., May, 1945.

During 1946, for a caseload of 36,624 persons, there were 8,258 referrals to physicians, 1,213 referrals to dentists and 2,102 admissions to hospitals.[23] During the same period there were 126,595 nurse clinic visits, 21,397 nurse home visits, 74,472 physician clinic visits and 2,874 clinic dental visits. Clinic visits were handled by 59 nurses and 58 physicians while referrals involved 750 doctors and 180 dentists. The average population per month during 1946 was 18,324, and the average cost of medical care per man per month was $2.20, plus $0.16 administrative costs, for an overall cost of $2.36. Total expenditures that year were $640,895.

Comment on Experience with AWH&MA

Experience with this unique federally subsidized rural health program for migrant families during the pre-war and war years, showed that even with limited funds, (the shortage of funds by 1947 finally strangled the program), and with the then-existing critical shortage of trained personnel, medical services for migrant farm workers could be greatly improved. No one plan was found adaptable to all areas or for all seasons of the year. The remarkable success of the program rested most importantly on the initiative and dedication of the field nurses, and the interest and cooperation of practicing physicians.

Dr. Schaupp, President of the California Medical Association in 1944, who was an enthusiastic supported of AWH&MA, reported that when the Farm Security Administration program was about to be abolished by Congress in 1943, the California Medical Association approached members of Congress about continuing the health services to farm workers. As a result, although the Farm Security Administration was abolished, the farm health program was continued. Dr. Schaupp stated that this program was "eminently successful." He said that the program provided medical care sorely needed, protected other citizens by controlling the spread of epidemics, and served the doctor in two ways: by providing hospitalization and laboratory services to the doctors' patients, it "allowed him to practice a better type of medicine, and for the first time, he received compensation for his services."[24]

Flexibility and adaptability were the keystones to the program. As Dr. Leland noted, the plans were "something of an experiment." The eligibility and administrative problems though difficult, were resolved. Through the utilization of nurses and the clinic technique, costs of medical care for these families were reduced by an estimated 20 percent below the cost of available prepayment plan, a critical concern with the very limited funds available. Perhaps most important of all, in any health program, was the documented success of Agricultural Workers Health and Medical Association in developing particularly through the nurses' efforts a program of health education and preventive medicine. The program mobilized available community health resources, and there were remarkable increases in the utilization of medical care services and, thus, important improvements in the health of migrant farm families.

These two early plans provide a wealth of experience in the provision of health care to low income farm families. Their pioneer spirit and willingness to experiment, strongly suggest that methods adapted to present conditions can again be developed to meet the health needs of domestic seasonal agricultural workers and their families.

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[16] From the monthly report file of Dr. Sinclair Kerby-Miller, General Manager of the Agricultural Workers Health and Medical Association.

[17] Leland, op. cit., p. 48.

[18] Goldner, op. cit., p. 14.

[19] Leland, op. cit., p. 52.

[20] Goldner, op. cit., p. 22.

[21] Ibid., p. 63.

[22] Dr. Sinclair Kerby-Miller, General Manager of the Agricultural Workers Health and Medical Association, was kind enough to permit the use of his file. Cost data comes from "General Manager's Reports to the Board of Directors" and "Monthly Reports of Activities of the Agricultural Workers Health and Medical Association."

[23] Ibid., Report of AWH&MA for 1946.

[24] Schaupp, K. L.: "Medical Care of Migratory Agricultural Workers," (Presidential Address). Calif.&West.Med., 60, 5:7-8, May, 1944.