Rural Health

MEDICAL CARE IN RURAL SECTIONS

Suggestions for Local Managers of Resettlement Administration

A. Procedure

1. Local managers should gather information concerning the needs and wishes of the people for whom they are responsible with regard to medical care. In securing such information, the suggestions prepared by the Medical Section of the Resettlement Administration and the United States Public Health Service should be utilized.

2. A tentative statement should then be prepared indicating the needs for medical care which it is believed should be met. This statement should have the understanding and approval not only of the project manager but of a committee or group of the homesteaders.

3. Conference should then be sought with the medical society of the locality (the county medical society). In the study of needs information may be secured from individual physicians, but discussions as to ways of meeting the needs and desires of the people should be held with the medical society or its representatives, preferably a committee designated by the entire group.

4. Plans or suggestions proposed by the society or its representatives, together with the local manager's comments, and his report on needs should be referred for consideration to the Health Section of the Resettlement Administration; local managers will await advice from the Health Section before action.

5. A person designated by the Health Section will, as a rule, be available for personal consultation on the spot in determining what plans shall be adopted for the locality.

B. Principles

1. In general the purposes in view are:

(a) To make available and if necessary to provide the professional and other personnel and the material facilities required for the furnishing of essential care in sickness.

(b) To establish arrangements whereby care will be accessible to the people on financial terms which they can meet.

(c) To maintain a good quality of care through the selection of well-qualified professional personnel and the maintenance of an interested personal relationship between physicians and patients.

(d) To maintain close association between medical care in sickness and the measures for the control and prevention of sickness.

2. In judging the merits of plans for medical care, consideration should be given to the following elements: (1) Adequacy: how fully is it likely to meet local needs? (2) Cost: is it within the means of the locality? Would a smaller expenditure according to some other plan be likely to yield equivalent service, or would the same expenditure under another plan yield more service? (3) Control: is the financial aspect of pay for care adequately under the control of those who pay the bills? Is the professional aspect of furnishing service adequately under the control of the professional individuals or agencies furnishing it?

3. It is important to create understanding on the part of the people as to the desirable scope and standards of medical care from their own point of view. It is desirable that the organization of the homesteaders shall include a committee on health or that the general executive committee of the settlers shall pass on the local needs and demands for medical care and on the general policies under which it should be secured. The conference with the local physicians should include this committee or other informed representatives of the homesteaders and not merely an administrative official.

4. Consideration should always be given to establishing close relationship between the public health department serving the county or the area in which

the Resettlement Administration project is located, and the system of medical care for the people of the area. Methods of such relationship will vary according to local circumstances and will be suggested as required by the Resettlement Administration Health Section.

5. In arranging for medical care, at least one physician living within the Resettlement Administration area or immediate vicinity should be arranged for if at all possible, although service from physicians residing outside of the area may properly be utilized as required.

6. Methods of remunerating the physician or physicians serving the area may be of several types, such as

(a) The usual fee system, paid by individual patients at the time sickness occurs.

(b) Group payment on a monthly or annual per capita basis, from each individual or family in the Resettlement Administration area, the fund thus secured being utilized to pay physicians and for other forms of medical care. Payment to physicians may be

(1) on a fee basis for services rendered;

(2) on a full- or part-time salary basis;

(3) on a capitation basis, i.e., so much per person per year for each individual cared for. One method may be more suitable for specialist or unusual services, whereas another may be more appropriate for general medical care.

7. Since the population in a Resettlement Area will often be insufficient to maintain a hospital, hospital care must be secured from a hospital in the vicinity. Such care may be paid for by arrangement, preferably on the basis of an agreed sum for each day's care furnished a resident of the Resettlement Administration area. An additional arrangement must be made to pay reasonable amounts for

the professional services rendered by physicians or surgeons who care for Resettlement Administration residents in the hospital.

8. Provision of dental service may present great difficulty in small communities or isolated areas, because of the lack of available dentists and because of the expense involved. Resettlement Administration managers should, as a rule, not undertake any plan for dental care without the approval of the Resettlement Administration Health Section.

9. Nursing care in the homes should be furnished, if practicable, when required by the physician treating a case. Arrangements for such care can best be made with the public health nursing service of the local health department serving the area unless some other home nursing service is available.

MMD:U:McK
1/16/36

Copy to December
Olesen
1/16/36

Rural Health (Subj)

TWENTY FIVE QUESTIONS ABOUT THE MEDICAL NEEDS OF FARM FAMILIES

These questions are intended to help a farm organization, a local women's club, a Parent-Teacher Association, or other public spirited bodies to study the health needs of their own county or community.

This list of questions is not meant to be sent around by mail. It is intended for use by members of committees and others who are trying to get facts in order to make plans for meeting local needs for medical care and public health work more fully.

In going over these questions it will be observed that:

Some of the questions (like Numbers 11, 18, 21, 23) can be answered by "yes" or "no."

Some (like Numbers 1,7, 12, 13, and 20) must be answered by figures which will be matters of common knowledge.

Other answers in figures will need calculation (e.g. Number 2) after certain other figures have been obtained.

Still others will need inquiries in person or by mail to secure the needed figures (such as Numbers 6, 18, 19, 22).

Some (like Number 25) can only be answered by the best estimates that people who know the locality can make.

These questions have been prepared by Michael M. Davis, Julius Rosenwald Fund, 4901 Ellis Avenue, Chicago, to whom requests may be made for additional copies or for information about the general subject.

1. How many doctors are in the community or area?

2. How many people are there per doctor?

3. What is the average age of the doctors?

4. How many of the doctors are over 60 years of age?

5. Which doctors have within the last ten years taken courses of post-graduate study?

6. How many of the doctors are members of the medical society of the county?

7. If there is no doctor in the local community, how many miles away is (a) the nearest doctor? (b) the next nearest doctor?

8. How many hours or mimutes does it take to get to the nearest doctor when the roads are in (a) good condition? (b) bad condition?

9. What are the usual charges of doctors for (a) home visits during the daytime? (b) at night? (c) mileage? (d) a visit at the doctor's office? (e) a confinement case delivered at home?

10. What proportion of the farm families in the area can reach a doctor by telephone from their own home or that of a near neighbor?

11. Do the doctors generally supply medicines to patients?

12. How many miles away is the nearest drug store?

13. How many dentists are in the community or area?

14. How many miles away is the nearest dentist?

15. What are the usual charges of the dentists (a) for extracting teeth? (b) for ordinary fillings? (c) for a full set of false teeth, upper and lower?

16. How far away is the nearest hospital?

17. How many beds has this hospital?

18. Is this hospital approved by the American College of Surgeons?

19. Of the surgeons who may operate on patients in this hospital, how many are members of the American College of Surgeons?

20. How many miles away is the nearest large hospital or medical center?

21. Is there a health department, headed by a full-time health officer, serving this county or area?

22. Is there a public health nurse in the community or area? If so, is she connected with the health department, with the public schools, or some other organization?

23. Are the school children given (a) regular instruction in health and hygiene? (b) examinations to discover diseases and defects which could be remedied?

24. What arrangements are made so that disease and defects discovered among the school children are actually cared for (a) for children whose parents can pay? (b) for those who cannot pay?

25. Of the farm families in the area, what percentage could probably pay without serious difficulty sickness bills of the following amounts: (a) $5 to $10? (b) $25 to $35? (c) $50 to $60? (d) $75 to $85? (e) $100 to $125?

Rural Health

File Mats

POLICY AND PROCEDURE REGARDING HEALTH EDUCATION

A. Policy

1. We are concerned with health education for children in and through the school, but cannot pursue this effectively without dealing also with

   a. health education for adults

   b. health services and medical care for the local community, including the school.

2. Certain material dealing with health can be used by the elementary school teacher in the school and will enrich the curriculum as well as furnish certain positive health values through imparting information and developing certain personal habits.

3. The school as a community agency must deal with the family as well as the child and can also play some part in stirring community interest to bring better public health facilities and facilities for medical care to the area.

4. It is essential to develop

   a. sound and usable material for health instruction and

   b. practical methods for encouraging rural public health and medical care facilities.

5. Preparation of teachers for health education in the normal school must include

   a. health service for the student teachers and other students of the school

   b. health instruction

   c. practical observation in rural schools which display somewhat developed health education and health services.

6. Health education in the elementary school, the community, and the normal school must be correlated closely with home economics and agriculture. The demonstration agents in these two subjects must be enlisted to work together with the teacher and other agencies.

B. Procedure

1. The immediate step is the formulating of a tentative statement of policy involving

   a. the rural schools

   b. rural communities

   c. the development of rural health and medical care facilities.

2. Following the preparation of the tentative statement a conference should be held with our selected rural school people and perhaps a very few other persons to discuss the practical application of the policy.

3. The policy will then be reformulated.

4. Meanwhile progress should be made in developing materials of instruction

   a. a reading book

   b. a syllabus for teachers.

5. Conferences should be held with the USPHS, the Children's Bureau, and other people in public health and related fields to develop plans for enlarging rural facilities and services.

6. Attempts should be made to apply the policies and try out materials of instruction in our experimental areas and in some other areas, particularly those which are to be used as practice teaching areas in connection with the normal school program.

7. A formulation of policy and a practical program for the normal schools should also be prepared to serve as a basis for discussion with the normal school heads after visits to these schools and study of their conditions.

MMD:McK
2/26/36

Under a.:

Activities centered around health knowledges and attitudes. The development of garden projects; the feeding, care, and breeding of rabbits or pigeons; the repair and care of well or other source of water; etc.; will assist the children in actually living improved health ideas. Pure subject matter won't do it! They'll "learn" it, but won't practice it as children or as adults.

b. Adult education should also involve actual construction of healthful conditions. Wells, manure piles, diversified crops to permit balanced diet, better cows for better milk supply, etc., present varied possibilities in health education.

A program of this sort, guided by health officials and sponsored through local committees inspired by the teacher, will accomplish wonders!

Excellent! — You ought to apply for membership in my "Cultural Mission" Club — (composed of those who are socialistically mute to the point of wanting the School to get its feet muddy in current social problems!) H.D.

In accordance with general policy of making the school the center of the community, the health educational program should also look to the specific needs of the community. This calls for two types of programs:

a. Relatively simple, for the pupils of the school, physiology, modes of infection, hygiene, etc.

b. Slightly more ambitious for parent education. Really the more important program, prosecuted through medium of lay committees in the community, who shall assume the responsibility of making contacts with state and county health departments, county agents, state educational directors, and Jeannes teachers. The local teacher is given the responsibility of beginning the organization and shall act as secretary of the local committee, until organization gets going.

Plan for organization is placed in her hands. She is given half-days (say Friday afternoon) for five or six weeks, or more, to set up organization, interest parents, form clubs, see that officers are elected and regular meetings arranged for. By laws should be set up for guidance of these groups, all with approval of state educational and health departments. May be necessary to study local types of organizations which have succeeded, but it is important that the units be well set up.

All this with the idea that parent education in health, as in other things, is even more important than for children.

Program for parents must conform somewhat to resources of the county health unit, but may stimulate too, especially educationally where there will be little in local program.

1. Tuberculosis, prevention and cure
2. Syphilis, prevention and cure
3. Gonorrhea, prevention and cure
4. Maternal and child care
5. Sanitation
6. Diet

These are the greatest needs in all rural communities and general procedures for prevention, correction and care are known in every case. Simplification of material fitted for consumption of children and parents may be only possible after experimentation, but with a set up which will make it possible to reach the people it can be done on a wider scale than heretofore has been organized. The business of breaking down each one of these subjects is the big job.

If this general plan is good, it should be studied for possibilities.

Rural Health

HEALTH TEACHING FOR NORMAL SCHOOL

1. Health Service for Students

   Curative
   Preventive

   Correlate with Home Ec. and the dietary of the group and with the athletics and recreation.

2. Health ~~subject matter~~ instruction

   Course in biology

   Course combining physiology
   personal hygiene
   community hygiene

   Course in teaching of health

3. Practice

   Observation in rural schools

   Health conditions, needs, resources.

   School health service and health teaching

4. Responsibility of teacher

   Health instruction)
   Health practice) for children

   Education in health)
   needs and services) for adults

   Working for adequate)
   health and medical)
   resources) for community

   Development of community demand for health

MMD:MLU 2/12/36

Notes used in Rural School Conference
New Orleans, January, 1936 MMD:MLU

RURAL HEALTH EDUCATION

1. Rural life and medical facilities.
   a. Number and age of doctors. Hospitals. Health Departments. Dental service, nurses, medicines.
   b. Population base for medical care.
2. Medical care and preventive work not only a matter of facilities but of popular understanding and attitudes.
   e.g., use of doctors, medicines, hospitals
3. Concept of health work as
   a. care of serious disease
   b. care of other diseases
   c. control of disease)
   d. prevention of disease) environmental - personal
4. Concept of health work
   a. Sanitation) done for people
      Communicable disease control)
   b. A way ~~and level~~ of life by and for people
5. Bases of 4 b.
   Food
   Rest and sleep
   Activity
   Disease Care and control
6. Educational aims
   a. Utilize basic interests in
      (1) food; (2) comfort; (3) bodily strength and beauty
      (4) economic effectiveness (body or mind)
      (5) freedom from pain

6. b. Develop understanding of

(1) body as a machine; (2) "germs": (3) nutrition;

(4) scientific attitude toward disease compared with magical (typhoid, malaria, stomache)

(5) play and bodily development in puberty and adolescence.

c. Development of certain health habits in children and families. Medical care if facilities available. Problem of teacher's own ideas and habits.

7. Method

a. Analysis of local resources in (1) environment; (2) medical personnel and facilities (3) school facilities for nutrition and exercise; (4) agricultural facilities.

b. Analysis of local problems of (1) diseases; (2) food production and consumption; (3) medical personnel and facilities and especial attitudes of doctors; (4) working and living conditions of adults and children.

c. Analysis of existing curriculum and school activities with reference to health content and possibilities.

d. Preparation of syllabus of (1) technical subject matter;

(2) advice and instructions to teacher as to utilizing local resources especially local doctors, and modifying existing curriculum; and utilizing new material and activities.

8. Mode of preparing syllabus

a. Report on existing conditions and teaching in areas selected or under consideration.

b. Suggestions of our best teachers as to 7 (d).

c. Experience of other rural health programs.

d. Secure special person to assemble above and to draft outline.

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RURAL HEALTH AND MEDICAL CARE

The problems of rural health and of medical care in rural areas are often presented as arising from lack of sufficient physicians and hospitals in the country districts. It is true that most rural areas in the United States have fewer physicians in proportion to population than do the cities; that many are without available local hospitals; and that the great majority have no organized health departments. But medical care and public health in rural areas are more than a problem of insufficient facilities; they are also problems of economics, they are also problems of insufficient demand from rural people for the preventive and curative services which other people think they need.

In considering the rural health service and medical care, therefore, we must study not only the supply of technical facilities but the psychology of demand for them and the state of rural economics. These three aspects - facilities, demand, and economics -- are, moreover, related to one another. Disease diminishes or destroys productive capacity, and lowers paying ability and economic status. Preventable disease, when not prevented, means not only needless suffering but wasted wealth. Low economic status, whether arising out of poor soil, unsuccessful agricultural methods, low market prices, lack of markets, or other reasons, renders it difficult or impossible for people to pay for the facilities which need to be locally available, and for the use of these facilities when they are needed. Lack of knowledge as to what preventive and curative medicine can accomplish, ignorance of hygiene, carelessness about health, fear of hospitals, style customs and fresh demands which perpetuate the use of the rabbit's-foot and patent medicines - these and other psychological elements keep some people from

securing benefits which others obtain, or withhold them from spending personal income or tax funds for medical services even ~~though~~ where medical facilities are ample. Statistical studies show that ~~these~~ medical facilities are distributed geographically, much as wealth is distributed. Physicians and hospitals are most numerous in the centers of wealth and population; they ~~are scanty or absent~~ degree wherein they are deficient in small towns or rural districts as closely in proportion to the economic resources of these areas.

These interrelationships between what ~~may be called~~ facilities, economics, and psychology may make either a vicious circle or a wheel of progress. ~~To~~ People in comfortable circumstances in cities find doctors and hospitals ~~in~~ are plenty and use them sometimes ~~almost~~ too plentifully. Poor people in poor country districts have insufficient facilitie s and use even these less than they should because of poverty and misunderstanding. Uncared for malaria, typhoid, heart disease, and other illnesses among them people tightens the vicious circle further.

Poverty and insufficient demand are not confined to rural sections. These are prevalent in cities among people who live within a stone's throw of great hospitals and many doctors' offices, and about whom the same vicious circle also rings. The question in these city districts is why don't these people use the doctors and hospitals and the public facilities which are nearby? The question in many rural areas is double: first, why do the people have so few doctors and hospitals and public health facilities nearby? Second, ~~and also~~ why do they often make insufficient use of what little they do have?

1. ~~The~~ Study of ~~greater~~ demand.

People accept sickness which more sophisticated groups would not accept as inevitable.

People seek medical care chiefly in emergencies when pain or fear or death are dominant.

People use medicines instead of doctors.

Patent medicines instead of prescribed medicines.

Magic.

People make little use of hospitals even when they are available, and half or less the use which more sophisticated populations show.

They make little use or oppose the use of preventive measures, such as immunizations, and pay little or no attention to much well-meant hygienic advice when offered.

2. Study rural economics.

Make some contrast of distribution of (a) per capita wealth (b) physicians, hospital beds ~~as well as~~ per capita, comparing urban and rural sections and comparing rural sections in different parts of the U. S.

Then compare the distribution of facilities, doctors, and hospitals, with the distribution of wealth.

Note especially the problem of replacing the aging rural doctors.

Consider preventive service and health education service.

3. Study paying ability and rural economics. Not total rural income on an annual basis, but available cash income is the chief determinant of paying ability for medical care and hospital service. The size of some sickness bills in relation to the cash income of many

rural farmers.

Summarize interrelationships

Develop the five-point program

MEMORANDUM - ARTICLE ON RURAL HEALTH

The rural health situation needs to be viewed from four points:

1. Insufficiency of personnel and facilities for public health work and for medical care.

2. Extent of and character of demand in the rural population for medical care and preventive work.

3. Paying ability of the rural population on

   (a) individual fee basis
   (b) tax basis

4. Extent of organized public health services in rural areas, and degree of their development. Where established.

The article should review the situation of each of these four points of view; should then consider what action is needed, and the order in which action should take place. This order is the following:

1. Extend preventive work through established public health departments on a county or regional basis, with state and federal aid.

2. Extend health education primarily through school and secondarily among adults.

3. Develop cooperative plans of organizing payment for medical care.

4. Establish educational facilities for local doctors.

5. Increase when necessary local personnel for medical care by (a) bringing additional physicians, and (b) by establishing hospitals or more frequent medical buildings.

MMD:MLU

2/6/36

REORGANIZATION OF RURAL HEALTH FACILITIES

I was in a county in North Carolina a few years ago in which there were 18,000 people and four doctors. A friend visited me recently from a county in Georgia which has 6,000 people and four doctors, the youngest of whom was 55 and the oldest 70. There are 1300 rural counties in the United States which have no hospital. While improved roads and the automobile have made mere distance less significant than it was formerly, medical care and hospital service in many rural districts remind me sometimes of the scene in "Alice in Wonderland", in which the party was at dinner, and the Mad Hatter said to Alice, "Have some wine." "I don't see any wine," said Alice." "There isn't any!" said the Hatter.

I do not wish to burden you with figures, but a few statistics always seem to increase the respectability of any address. In the large cities of this country there is about one physician to every 540 people. In the rural areas and the small towns in which over 50 million Americans live, there is often only one doctor to every 1400 people, and in many places the ratio is still less. Moreover, the average age of physicians in rural areas is over 52 years. This might be taken to mean that the wisdom of years and experience is at the command of the country people, and I have personally known enough country doctors to appreciate the skill and the devotion which many of them bring to their patients. But on the average, the country doctor is a man who has not been financially able to keep abreast of the advances in medicine since he was graduated from medical school 15 to 35 years ago, and the country is not drawing the young doctors to any extent. They are overwhelmingly settling themselves in the cities.

Hospitals are concentrated in cities and in large towns, to an even higher degree than are physicians and dentists.

Now I do not quote these figures to cast criticism upon physicians in general or country doctors in particular. By no means. The whole population in the United States during the last thirty years has increasingly moved cityward; that is a matter of common knowledge. In 1906 towns of 2,500 population and less and the rural areas contained 53 per cent of the population ~~to~~ a 41 per cent of the physicians; 23 years later, in 1929, they contained 48 per cent of the population, 5 per cent less, but only 31 per cent of the physicians, 10 per cent less. On the other hand cities of 100,000 people or more constituted 22 per cent of the population in 1906; 30 per-cent in 1929, an increase of 8 per cent in the concentration of general population of the cities, but the proportion of physicians in the cities of 100,000 or more people was 30 per cent in 1906 and 44 per cent in 1929, an increase of 14 per cent in concentration. We find a reasonable explanation for these figures in the analysis of the distribution of physicians and hospitals in relation to the economic status of different parts of the country. The number of physicians in proportion to population varies closely in proportion to the per capita wealth of each state or section. Considering the extensive training now required of a medical student, and a period of education longer and more expensive than that demanded of any other profession, it is not unreasonable that physicians should seek to locate where they believe they can make a reasonable living. But this explanation does not make medical care any more accessible for the farmer.

An even more serious deficiency in rural areas is the lack of organized preventive medicine. Science has given human beings power to prevent and control many diseases to a degree unknown a generation ago. The causes and the method of preventing or controlling some of the greatest scourges of humanity are now well known. Typhoid fever, malaria, hookworm, diphtheria, small pox, scarlet fever, are examples. Tuberculosis, infant mortality, and deaths of mothers due to child birth can be greatly reduced by known methods. The diseases due to insufficient ~~diet~~ or faulty nutrition, like

pellagra and rickets, are now controllable, but these measures of prevention and control must be based upon organized effort. They require a public health department of the government with a trained staff cooperating with the local population, the physicians, the hospitals, and the schools and other agencies. The pity is that outside of our larger cities most of which have organized health departments there are only about 500 out of 2500 counties in the U. S. which have organized health departments worthy of the name, that is, with a salaried full-time health officer. The well-organized county health department staffed to apply modern knowledge of preventive medicine costs not over $2.50 per capita, and a great deal can be accomplished for half this sum. Yet people spend millions for care when this would bring prevention. Two years ago the U. S. Public Health Service estimated that (section on malaria)

A study published in 1931 by the Oklahoma A and M College estimated that diseases which are almost completely preventable - typhoid, diphtheria, malaria, and small pox - cost in preventable deaths over $2,000,000. This was about $1 per capita of the population of the state of Oklahoma, which up to that time was spending about 30 cents per capita for all the public health work of the state, city and rural areas taken together. Spending 30 cents when you might save $1 is not good business.

Insert brief word about social security public health program.

A great deal of disease is beyond present powers of control and has to be treated when it arises. Whether country people can get medical care in sickness depends not only on whether the doctor is within reaching distance; it also depends on the ability to pay for care. I know, and you know, that physicians give their services with traditional and wonderful generosity to people who can not pay them, but there are limits beyond which the charity of a physician can not go if he is to make a decent living for himself and his family, and most Americans do not seek medical or other kind of charity if they can possibly avoid it, so the cost of care is a barrier.

A study made by the Farmer's Wife magazine reported that in 1929 the average charge for a home call by the doctor including, of course, the necessary mileage, was $7.63 among the 860 families reporting. The automobile makes it possible to get the doctor from a distance, but the doctor must charge mileage or he can not make ends meet. If the farm family could get in to see the doctor at his office, the average charge was $1.50. The Oklahoma A and M. College reported in the study above referred to on 19 studies of medical care in rural sections between the years 1926 and 1931. Farm families in different states reported wide differences in the amount of money spend for care in sickness per year. Families in a mountain county in Kentucky averaged only $16. One study in Minnesota farm families gave an annual expenditure per family of $108. As a rule, in most of the farming districts studied the expenditures per farm family ran around $75 per year, of which $25 or so was for drugs and patent medicines, about $10 for dental care, and $40 or so for doctors, nurses, and hospital care taken together. Such a figure is between three and five percent of the farmer's total living costs, but of course is a much higher percentage of the ~~family~~ farmer's cash income, and medical and hospital bills must, as a rule, be paid in cash. Of course sickness does not fall evenly. Average figures of family sickness costs mean very little. Thus while the average bill for doctors, nurses, and hospitals for the families studied by the Farmers Wife magazine was less

than $50, the family which actually had sickness had an average bill of over $155. A good many families could be in a given year with little medical care, and may spend nothing except for medicines, while on the other hand a certain number of families - 10 or 15 per cent of the total - have serious illness and run up bills of $100 and $200, which are burdensome indeed.

What to do about it. In the first place, we need to get doctors and hospitals accessible; in the second place, we want to be sure that the doctors are well trained and efficient, and that the hospitals are properly organized, staffed, and maintained. Poor doctoring and unsafe hospitals may be worse than none. In the third place we need to make it easier for the family to pay for medical care.

Some examples:

Indian Lake, New York

Washington Island in Wisconsin

Elk City, Oklahoma

Saskatchewan

~~Group Hospitalization, Grinnell~~

Notice that all of these plans involve first the principle of distributing costs by the insurance principle or by taxation. Second, they provide financial ~~insurance~~ assurance or inducement which will bring a physician to an area or support a hospital. What have they done about quality of care? Quality of care is mostly the problem of the doctors and the specialists in hospital management, but it is ~~not~~ a matter with which the patient is very much concerned. He can look after the following items in selecting or passing on the qualifications of a doctor.He can look upon the following considerations with respect to starting a new hospital or in reorganizing or improving an old one.

What is the first step to take? If this talk makes any point clear, it is that bringing better medical care to the farmer is a cooperative responsibility. It can not be done by the individual family alone. It can not be done by the government unless the people of the locality do their part, and that is a very large part. The first step is to get the interested people together, people who count for something in each community, in the farmers' associations, the Parent-teacher association, etc.

In the second place, it means getting facts, to define your needs and to convince others that something ought to be done about them. I have a list of 25 questions which may be useful in such inquiries. Then you have to canvass the facilities and resources of your area. If you have not a health department, get after your state health officer and see if he will cooperate with you in establishing one. In the third place, write the U. S. Public Health Service, which will usually be able to tell you about the location of hospitals, doctors, and dentists not only in your county but in neighboring counties, and some facts gathered from national studies which are now under way, and which will be completed before the end of this year.

The conclusion will mention that medical are and public health are not techniques which belong wholly to the doctor, the nurse, and the health officer, but they belong to the people, too. Use

Use of patent medicines and of quacks as an example of the waste of health and money due to ignorance.

Intelligence about personal and community hygiene is necessary if a health department is going to be efficient.

Intelligence to cooperate with the doctor and the hospital is necessary if they are to do their best for you when you are sick.

The place of the school in the picture in developing understanding about personal and public hygiene and in initiating needed medical services for young people

Rural Health

FARMERS COOPERATION FOR PUBLIC HEALTH FACILITIES

FARM AND HOME WEEK AT LEXINGTON

1. Needs of rural areas for medical care

   a. Doctors. Contrast between number of doctors in city and country. Doctors in country average 52 years plus. Few young physicians go to country. Increased accessibility of doctors, but increased cost due to mileage.

   b. Hospitals concentrated in cities. Counties without hospitals. Value of hospital to physicians as well as patients.

2. Need of rural areas for public health facilities. Only about 500 out of 2500 counties with full time health officers. Economy of prevention. What a health department means. Relation to public school. U. S. Public Health Service report on malaria.

3. Cooperative attempts to bring medical care to rural areas.

   Indian Lake, New York
   Washington Island, Wisconsin
   Elk City, Oklahoma
   Saskatchewan

   Group hospitalization and industrial medical care in small towns.

4. Public health work. Social Security Act.

5. The consumer's part in medical care.

   Ignorance illustrated by folk medicine and use of patent medicine. The very sick patient is a passive factor in the doctor's hands. The consumer in general must be an active factor and not expect to leave it all to the doctor.

6. Paying for care.

   The uneven distribution of costs. Cooperation and self help in paying for care.

7. Studying your community. 25 questions.

Rural Health

Malaria

Economy of Prevention

In fourteen southern states malaria is one of the major public health problems, it being estimated by the U. S. Public Health Service that there are approximately two million cases of malaria annually, involving an annual loss from death and economic disability of half a billion dollars.

Approximately two and one quarter million dollars was spent on public works appropriations for draining a number of areas. The Public Health Service reports: "It is conservatively estimated that not less than one-fifth of the population will be removed from the hazard of malaria if the drainage effected should be properly maintained in the future. It is believed that the economic benefit derived from the removal of this hazard will represent an annual saving of not less than $100,000,000. The actual saving probably will be considerably greater than the estimates here given." *

From Public Health Reports, U.S. Public Health Service, Volume 49, No. 33, August 17, 1934, page 963.

Rural Health

Elk City, Oklahoma

Elk City, Pop. 6,000

Com. Hosp.

3 doctors, 2 dentists on Staff, 15 nurses

Cooperative Farmers Union; Hosp. Ass'n

Stockholders pay $50 for 1 share.

No member can own over 10 shares nor have more than one vote -

Annual dues 25.00 (quarterly 28.00)

Provides care for family, exams, med diag + treatment, operations, obstetrics, dentistry -

Hospital care costs $1 per day extra, if + 30 days, then 2.00 a day

Membership growing

INDIAN LAKE, NEW YORK

In the Adirondacks of New York, there is a community where every child gets dental care and the dentist gets paid. This is in Indian Lake where the 300 children of the community were getting no dental care a few years ago and were living mainly on a diet that did not build teeth.

This was of grave concern to Dr. H. F. Carroll, the town's only physician and president of the school board, who examined the school children every year and found dental defects most common. Finally he hit upon the plan of inviting a dentist to come to practice in Indian Lake, guaranteeing him $1500 a year salary from the school board plus expenses of practice ($300 to $500 a year).

The school board agreed to this plan and in 1932 Dr. A. R. Beekman, a dentist from New York City whose health was forcing him to give up his city practice, moved to Indian Lake. In addition to his work with the school children's teeth, Dr. Beekman is allowed to practice among adults on the usual fee basis and from these he usually collects about $1,000.

Dr. Beekman found his child patients in dire need. All but 5 of the 300 needed dental repair. Dr. Beekman ruled that all school children should come to him twice a year for check-up. In addition he persuaded the school board to buy a pint of pasteurized milk a day for each child in the first 6 grades.

Indian Lake uses the same idea to provide other health services besides dentistry. It pays $3,000 a year bonus to Dr. Carroll as health officer to make it attractive for him to stay in practice there. It employs an eye specialist to come up for ten days each year and test the childrens' eyes at $25 a day.

1-27-36

From an article by Carroll Streeter
in The Farmer's Wife, September 1935.

Washington Island, Wis.

A farm & fishing community in Lake Michigan

Average family pays $9.00 to 12.00 a year

Provide $3000 yearly guarantee to doctor.
Doctor charges small stated fees for
his services.

Rural Health

Questions to Help in Studying Medical Needs in a Rural Section.

1. How many doctors are in the community or area?
2. How many people are there per doctor?
3. What is the average age of the doctors?
4. What is the age of the youngest doctor?
5. How many of the doctors are over 65 years of age?
6. Which of the doctors have within the last ten years taken courses of post-graduate study?
7. How many of the doctors are members of the medical society of the county?
8. If there is no doctor in the local community, how far away is the nearest doctor?
9. How far away is the next nearest doctor?
10. How long does it take to get to the nearest doctor when the roads are in (a) the best condition? (b) bad condition?
11. What are the usual charges of doctors for home visits in the daytime?
12. What is the usual charge for mileage?
13. What is the usual charge of a doctor for a visit to his office?
14. What is the usual charge for a confinement case delivered by a doctor at home?
15. Do the doctors generally supply medicines to patients?
16. How far away is the nearest drug store?
17. How many dentists are in the community or area?
18. How far away is the nearest dentist?
19. What are the usual charges of the dentists for extracting teeth? for ordinary fillings? for a full set of false teeth, upper and lower?
20. How far away is the nearest hospital?
21. How many beds has this hospital?
22. Is this hospital on the list approved by the American College of Surgeons?
23. Of the surgeons who may operate on patients in this hospital, how many are members of the American College of Surgeons?
24. How far away is the nearest large hospital or medical center?
25. Is there a health department, headed by a full-time health officer, serving this county or area?

26. Is there a public health nurse in the community or area? If so, is she connected with the health department, with the public schools, or with what other organization?

27. Are the school children given instruction in health and hygiene?

28. Are the school children given examinations to discover diseases and defects which could be remedied? Are the examinations by doctor, nurse, or teacher?

29. Are arrangements made so that disease and defects discovered among the school children are actually cared for?

30. Of the farm families in this area, what proportion could without serious difficulty pay sickness bills of the following amounts? $5; $10; $15; $25; $50; $100.

Rural Health

TWENTY FIVE QUESTIONS ABOUT THE MEDICAL NEEDS OF FARM FAMILIES

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Other answers in figures will need calculation (e.g. Number 2) after certain other figures have been obtained.

Still others will need inquiries in person or by mail to secure the needed figures (such as Numbers 6, 18, 19, 22).

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2. How many people are there per doctor?

3. What is the average age of the doctors?

4. How many of the doctors are over 60 years of age?

5. Which doctors have within the last ten years taken courses of post-graduate study?

6. How many of the doctors are members of the medical society of the county?

7. If there is no doctor in the local community, how many miles away is (a) the nearest doctor? (b) the next nearest doctor?

8. How many hours or minutes does it take to get to the nearest doctor when the roads are in (a) good condition? (b) bad condition?

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25. Of the farm families in the area, what percentage could probably pay without serious difficulty sickness bills of the following amounts: (a) $5 to $10? (b) $25 to $35? (c) $50 to $60? (d) $75 to $85? (e) $100 to $125?

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4. How many of the doctors are over 60 years of age?

5. Which doctors have within the last ten years taken courses of post-graduate study?

6. How many of the doctors are members of the medical society of the county?

7. If there is no doctor in the local community, how many miles away is (a) the nearest doctor? (b) the next nearest doctor?

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