The Medical Care Program for Farm Security Administration Borrowers

(Digest of a paper presented at a meeting of the American Public Health Association by Dr. R. C. Williams, Chief Medical Officer)

The program under which more than 100,000 low-income farm families, borrowers from the Farm Security Administration, are at present obtaining medical care grew out of an economic necessity. It is an incidental by-product of a depression-born loan program for farm families unable to obtain credit elsewhere, and is designed to accommodate a special economic group only. The factors which created the program explain much of its organization and method.

I.

Five years ago, three million farm families were on the brink of disaster: flood and drought had played havoc with crops; depression had brought economic chaos to an unstable farm economy; credit had vanished; crops were selling at low prices. It was a period of foreclosures and "penny" auctions. Farm families migrated from one rural area to another seeking an opportunity for livelihood that did not exist.

For roughly one-fourth of the farm population, relief was the only means of living until the Farm Security Administration offered to make small loans to enable farmers to get a new start.

The Farm Security Administration makes these loans, repayable within five years at 5 percent, so that farmers may buy the feed, seed and tools necessary for the year's operations. Often, the loans must help the farmer to meet the expenses of clothing and feeding his family until he makes a crop.

Before a farmer receives a loan:

1. He must be unable to obtain either funds or satisfactory credit from any other source, public or private.

2. He must know how to run a farm or have derived the major part of his income for the previous six months from farming.

3. He must be approved for the loan by a local county committee, generally composed of two or three farmers and one or two business men who can attest character and ability.

4. He must be able to do the farm work.

5. He must be renting a farm or have an equity in a farm.

All loans are based on adequate guidance of the family during the period in which they are trying to re-establish themselves.

Farm Security Administration supervisors work with the farmer until the loan is repaid, helping him to plan his farming operations and advising him on more effective methods of raising crops or conserving the soil. Home management supervisors periodically visit farm-wives and advise them on their problems of canning, raising gardens, sewing and other work affecting the success of the family enterprise.

From county supervisors, constantly in touch with borrower families, came the first inklings of a serious gap in the program's early efforts. Difficulty in working with some of the families was traced to acute illness, abscessed teeth, hernias, malaria and other conditions. It was reported that loans were defaulted as chickens, hogs, or calves were sold to pay for medical bills. When families had no money to pay for physicians' services, avoidable deaths occurred and the Government lost the money it had invested.

Typical of many reports, a western state showed that 75 percent of its borrower-families were on the rehabilitation program because of financial distress resulting from illness in the family. Financial statements of these families recorded liabilities from $100 to $3000 owing to physicians and hospitals over a long period.

An investigation of a sample of Farm Security Administration borrowers who had failed revealed that 50 percent of the "failure" cases were directly traceable to "bad health". Aside from the wanton waste of human life and curtailment of borrowers' usefulness to themselves, the findings of this survey indicated the need for some kind of medical care program from a purely economic point of view.

The basis of the medical care program is simply that a family in good health is a better credit risk than a family in bad health. Economic security depends, to a large extent, on health security. The Farm Security Administration loan program was in jeopardy until some feasible plan for getting medical aid to its borrowers could be found.

There was no organized system of providing medical care for medically indigent rural families in most of the states. It was not possible to make small supplemental loans to Farm Security Administration borrowers for medical assistance because of the cost and delay involved in making a loan, and the additional difficulties of auditing and individually justifying expenditures for medical care by borrowers. A single loan to each family at the beginning of the year to cover medical care for the twelve months was precarious since the incidence of disease among individuals is not exactly predictable.

The only feasible approach to the problem was the grouping of families paying a flat fee per year for medical care, under a plan to include physicians agreeing to treat them at a uniform fee schedule which would take into account the families' low income.

Two facts argued the acceptance of the plan: borrower-families realized they had desperate need for such a service and wanted one; physicians -- especially rural physicians -- were anxious to re-adjust a system of compensation which left them after a period of years with thousands of dollars worth of unpaid bills.

State Medical Associations were approached with tentative outlines for medical care plans. The plans were framed so that existing local facilities would be used in every case and participation fees would be based on the ability of the family to pay -- a principle long recognized by the American Medical Association and put into practice by the medical profession. Not all State Medical Associations have yet been approached -- the present program only started in the Spring of 1937 -- but already 27 State Associations have approved medical care plans.

Although local plans vary, in general, they follow three patterns. In most of the plans, borrower families pool their funds and put them in charge of a bonded trustee. The trustee then pays all physicians' bills for the group as fully as funds will allow, on a monthly, pro rata basis. Under another plan which is gradually being discontinued, funds are placed with a trustee, but separate accounts are kept for each family. The third kind of plan provides that an association of Farm Security families -- grouped together on projects -- may employ one or more physicians on a

salary basis to provide necessary medical aid, if there are no physicians living nearby.

Before any medical care plan is set up, a memorandum of understanding or a guide to be used as a basis for developing local health associations within the state is prepared by the State Medical Associations, with the help of Farm Security Administration officials. When these memoranda or resolutions are accepted by the State Medical Associations, agreements are then worked out with local medical societies.

The agreements with the county societies recognize three basic principles: 1) the participation fee for borrower families is determined by their ability to pay as indicated by their farm plans; 2) there is free choice of participating physicians; 3) funds are set aside at the beginning of the operating period in charge of a bonded trustee.

Benefits covered in the plan usually include: a) ordinary medical care, including examination, diagnosis and treatment in the home or in the office of the physician; b) obstetrical care; c) ordinary drugs; d) emergency surgery as determined by the physician in charge of the case; e) emergency hospitalization. Forward looking counties have added dental services. In Arkansas, 40 counties have plans for dental care which are operated on a separate basis from the medical care program. For $4.00 a year for the man and wife and $.50 for each child, the participating family obtains emergency dental treatment, simple fillings, extractions, prophylaxis and cleaning.

The family under the most typical agreement usually pays from $15 to $30 a year, the amount varying according to extent of benefits, size of average farm incomes in the locality, and size of family. A typical payment schedule for medical care in a low-income county might be on an annual basis of $18 for man and wife plus $1.00 for each child up to a maximum payment of $26 per family. From the pooled funds, a proportionate amount is allocated for hospitalization and emergency needs, including surgical care, at the beginning of each period. The remaining fund is then divided into equal monthly allotments.

Physicians submit monthly statements for services rendered to the trustee. Bills are then reviewed by a committee from the local medical society. If the total bills for a given month exceed the amount available, all bills are proportionately reduced and each physician paid his pro rata share of the month's funds. If the monthly funds are sufficient, the bills are paid in full; if a balance remains, it is carried forward to the next month or to the end of the period, and then used to complete paying bills for months in which funds were not adequate.

Under many of the county pool medical care plans, the patients are formally organized into unincorporated associations; others are informal groups with the trustee responsible for funds and the reviewing committee of physicians responsible for checking the bills.

The individual contract plan works on an entirely different basis. Funds for each participating family are kept separately and the physician of the family's choice agrees to render medical service for a certain sum a year. If the family has no illness that year, the money is refunded or

applied to the next year's account. If the family needs more services than are covered by the fee paid, the physician continues his services free of charge during the remainder of the period.

Experience with the two plans clearly indicates that for low-income families the first plan is preferable, that is, a plan providing for pooling of the individual fees. The individual contract plan is hard on the physician when a protracted illness develops and too often, families will avoid going to the physician in order to save the money they have set aside for medical purposes. Nor does the plan distribute the cost over many families, so that the cost of severe illness to one family can be more nearly equalized.

County or district plans for medical care are operating in 21 counties in Alabama, 68 in Arkansas, 4 in Colorado, 5 in Florida, 108 in Georgia, 5 in Indiana, 1 in Idaho, 3 in Iowa, 35 in Kansas, 7 in Louisiana, 41 in Mississippi, 12 in Missouri, 6 in Nebraska, 1 in New Jersey, 12 in New Mexico, 11 in North Carolina, 11 in Ohio, 25 in Oklahoma, 17 in South Carolina, 7 in Tennessee, 43 in Texas, 1 in Utah, 14 in Vermont, 19 in Virginia, and 3 in Wyoming. The swift extension of the program during the last two years is indicated by the increase in Georgia from 5 counties having medical plans last year to 108 counties this year.

Agreements with the State Medical Associations prior to approaching county medical societies have been reached with Kentucky, New York, Pennsylvania, South Dakota, West Virginia, and Wisconsin.

The financial report of a typical county group health association will demonstrate how the program works. The association whose report is given below, was sponsored by the Farm Security Administration but is now conducted by borrower families. It is operating in a Southern county in which more than 300 farm families are Farm Security Administration borrowers; 307 families are members of the association, paying an average of approximately $27 a year. The financial report for 1938 follows:

Financial Report for the Year 1938

Membership fees: 307 members @ average fee - $27.15--$8,334.00

	Medical Fund $5,278.20 - 63.3% Monthly allotment $439.85			Hospital Fund $2,639.10 - 31.7% Monthly allotment $289.92		
	Bills Presented	Bills Paid	Percent Payment	Bills Presented	Bills Paid	Percent Payment
Jan.	$427.13	$427.13	100%	$ 10.00	$ 10.00	100%
Feb.	671.03	439.85	66%	251.00	219.92	88%
March	516.59	439.85	86%	79.00	79.00	100%
April	649.91	439.85	68%	296.00	219.92	74%
May	492.40	439.85	89%	188.50	188.50	100%
June	599.23	439.85	74%	327.50	219.92	67%
July	825.30	439.85	53%	192.50	192.50	100%
Aug.	612.97	439.85	72%	224.50	219.93	98%
Sept.	521.88	439.85	84%	200.00	200.00	100%
Oct.	617.40	439.85	71%	378.50	219.93	58%
Nov.	493.95	439.85	89%	190.00	190.00	100%
Dec.	827.49	439.85	53%	276.00	219.93	80%
ANNUAL DISTRIBUTION OF SURPLUS						
Accumulated balances		12.72			433.95	
Hospital fund s'plus		25.60				
Admin. surplus		76.07				
TOTALS	$7,255.28	$5,379.87	74%	$2,613.50	$2,613.50	100%

ADMINISTRATION

$416.70 - - 5%

Salaries	$172.50	Postage	$24.00
Supplies	73.13	Bond Premium	37.50
Equipment	33.50	To Medical Fund	76.07

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No. of family members- -	307
No. of persons -	1,653
No. of families having one or more persons receiving medical care -	291
No. of persons receiving medical care - - - - - - - - - - - - - - - - - -	913
Per cent of families having one or more persons receiving med. care	95
Per cent of persons receiving medical care - - - - - - - - - - - - - - -	55
No. of persons receiving hospitalization, or surgery, or both - - -	78
Home visits -	918
Office calls -	1,717
No. of physicians participating -	16

*Bills incurred	TOTAL- - - - - - - - - - - - - - - - - - - -	$9,868.78
	Medical Service - - - - - - - - - - - - - -	7,255.28
	Hospital Services - - - - - - - - - - - - -	2,613.50
	Aver. bill incurred per member family - -	32.16
	Aver. medical bill per person receiving medical care - - - - - - - - - - - - - -	7.95
	Aver. Hospital bill per person receiving hospitalization (and surgery) - - - - -	33.51

*Bills were presented for medical and hospital care and surgery on the basis of a fee schedule which was reduced 25% or more from regular fee rates.

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II.

There is a somewhat different approach to the problem of medical care in homestead projects established by the Farm Security Administration. In most of these communities, from 100 to 200 families have settled on adjoining farms. When these projects are located some distance from cities, the problem of medical care for the homesteaders is often an acute one. In a few instances, a neighboring physician has been employed on a part-time

basis. Occasionally, it has been necessary to attract a resident physician to the project, by setting up a program providing a basic guaranteed income. In most cases, however, the services of all nearby physicians are utilized. Medical care programs have been organized on 32 projects, and programs are now being set up on 10 other projects.

A wide variety of arrangements for medical care are in effect in these community projects. In several communities the homesteaders have themselves organized voluntary beneficial associations which have worked out special agreements with physicians and hospitals. On some projects, the families pay regular membership dues in cash, without help from the Farm Security Administration; on other projects the Farm Security Administration loans money to the homesteaders for this purpose, and these are later repaid when the crops are sold.

A few facts regarding a typical project program will illustrate how the medical needs of the homesteaders are being met. The 141 families on Ashwood Plantation, South Carolina, for example, became members of the health association by paying in advance $18 per family for general practitioner care for one year. All five physicians living nearby participated, agreeing upon a uniform fee schedule which represented a moderate reduction in their usual fees. An average of 83.5% payment was made on medical bills throughout the first year, the monthly payments ranging from 64.5 to 100 per cent.

Members of 96 percent of the families received service during the year, and 47 percent received service which exceeded the cost of the $18 membership fee.

At the beginning of the second year, the association added hospitalization for 21 days for each individual and specialist care for acute illness for an increased cost of $12 per family. A preliminary report indicated that in the first half of the second year 20 hospital cases were handled and that hospital and specialists' bills were paid 100 percent.

III.

Distinct and separate from the general program of medical care is the specialized program set up in North and South Dakota and in California and Arizona. These four states had local problems which made necessary a completely different type of plan. North and South Dakota had been seriously affected by the drought; California and Arizona experienced an influx of migrants whose highly unsanitary living conditions were a potential threat to the health of nearby communities.

North and South Dakota first tried a medical care program in 1936. In these two states alone, about 55,000 families were participating in a state-wide medical plan by November 1, 1938. By paying $2 a month per family for a minimum period of six months, families became members of the North Dakota Farmers' Mutual Aid Corporation or the South Dakota Farmers' Aid Corporation. Through these corporations they were entitled to emergency medical care, emergency dental care, emergency hospitalization, prescribed drugs and home nursing. Members had the free choice of any phisician licensed to practice medicine in the state. The charges made for medical service were based on a special schedule of fees agreed to by participating doctors and other professional men. Bills were paid monthly and pro-rated if funds did not cover the full amount of the bills.

With the advent of the more general program of medical care and the experience gained from it, certain flaws were noted in the Dakota plans. Both families and physicians seemed discontented -- the families maintaining that they did not receive enough services, the physicians stating that they did not receive adequate compensation for services rendered. In South Dakota, there was the additional factor of practitioners other than legally qualified doctors of medicine seeking to participate in the medical care plan.

The uncertainty of whether funds necessary to continue the program would be available caused additional uneasiness about the plans. The program in the Dakotas was declared inoperative as of July 1, 1939, pending reorganization.

At present, North Dakota has no medical care plan, although a tentative outline of proposed action has been submitted to the State Medical Association. This outline includes a higher fee of $33 per family a year to include emergency medical and dental care, emergency hospitalization and prescribed drugs.

The medical care program would be set up on a unit basis covering one or more counties, and funds would be kept separate for each area, thus leaving virtual control of the plan with the families and professional groups in the district. In effect, the proposal would put into operation in North Dakota local medical care plans similar to those existing in other states. The actual operation of the plan is pending its acceptance by the physicians of the state.

In South Dakota, a district plan is being set up on a trial basis at Pierre. This unit will provide medical care for Farm Security Administration families in several counties, having a potential case load of approximately 2,500 families or 12,500 persons. In this area, there are 13 physicians, 8 dentists, and 2 hospitals. Funds for participation will be loaned to these families on the basis of $33 a year per family to provide emergency medical and dental care, hospitalization and prescribed drugs.

No other units will be established in South Dakota until the unit at Pierre has proved effective.

In California and Arizona, a different type of medical care program was undertaken, to meet the needs of migratory agricultural workers who required medical attention, but rarely could afford to pay for such aid.

The influx of migrants into California and Arizona since 1935 has created a serious public health problem in these two states. Most of them have a low and uncertain income, live in roadside "jungles", patched tents or hastily-improvised shelters with no sanitary facilities.

The constant movement of migrants from one farming area to another, sometimes more than 300 miles away, contributed to the rapid spread of communicable diseases. Despite the vigilance of the California State Department of Health, outbreaks of smallpox or typhoid in widely separated counties remained a potential threat.

In May, 1938, the Farm Security Administration, with the cooperation of the California Medical Association, the State Department of Health and the State Relief Administration, formed the Agricultural Workers' Health and Medical Association, incorporated under state laws. Each of the agencies

has a representative on the Board of Directors of this non-profit association.

Migrants make applications for medical treatment at the association's district offices or camp treatment centers. A certificate of membership in the health association, which serves as an identification card, is issued to the applicant.

He then selects his physician from a list of participating physicians or is treated by the local part-time physician in charge of the treatment center. The Agricultural Workers' Health and Medical Association is billed for the medical services or hospital services rendered. In many treatment centers, local physicians work in the clinics at designated hours on alternate days. The personnel of the typical treatment centers consists of a part-time physician, a nurse, and a clerk. Services include ordinary medical care, surgery, laboratory, X-ray, dentistry, prescriptions, and diagnostic treatment.

Although the migrant-workers are obligated to repay the cost of services "if so requested" their economic status precludes any expectation of repayment in most cases. Some workers, however, have been able to repay a few dollars. In view of the savings effected in the health of the two states under this program, it seems probable that adequate financial support will continue. Similar conditions prevailed in Arizona, and similar measures were undertaken.

There are at present 13 medical care centers in California, at Fresno, Merced, San Joaquin, Tulare, Madera, Yuba, Yolo, Riverside, Santa Clara, Sonoma, Imperial, Kern and Calipatria, and 7 in Arizona - at Phoenix, Buckeye,

Avondale, Chandler, Yuma, Coolidge and Safford.

Appraisal of the medical care program is difficult. There are many pitfalls that have been avoided and yet, there are bound to be difficulties in a program which affects so many people in widely diverse areas. The human element cannot be overlooked. No matter how perfect a plan is theoretically, when put into practice it must deal with actualities. A reviewing committee, drawn from the physicians' ranks, is set up under each plan to go over bills. This committee can adjust bills when necessary. A strong reviewing committee limits abuses by the physicians. The county supervisor acts in a like capacity for the families, checking on the number of unusual demands for service made by families. Usually, if the family is abusing the program the matter can be adjusted satisfactorily, otherwise the family is dropped from the program.

The attitude of both the physicians and families toward the medical care program is, on the whole, favorable. Payments to physicians average, the country over, approximately 60 percent of total bills presented, which many physicians have reported is a higher percentage of payment than they receive from their ordinary practice in these areas.

The heart of the program lies in a clear understanding on the part of physicians and families as to what can be expected under the program and its limitations. It is essentially a special program for an under-privileged group of farm people. The program could not be transferred to any other segment of the population without some change. A more solvent group of people would demand an extended and fuller program of medical care.

Nevertheless, for the group of people whom the program is helping to

get back on their feet, the plan is a boon.

In the final analysis, the fact that 99 percent of the medical plans in operation last year are continuing to operate is a telling point, since the whole basis of the medical care plans is voluntary cooperation from families and physicians.

November 1, 1939
Figures as of September 30, 1939