

THE MEDICAL CARE PROGRAM FOR FARM SECURITY ADMINISTRATION BORROWERS

R. C. WILLIAMS*

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 has appeared as an incidental by-product of a depression-born program of farm loans which were made exclusively to families unable to obtain credit from any non-governmental source. It is designed to accommodate a very special economic group only. It is governmental only in that its organization is sponsored and its operations partly financed—through loans to its debtor families to enable participation—by a governmental credit agency which has loaned several hundred million dollars with little security except the character and productive ability of families receiving medical aid under the arrangements.

Its background explains 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. The depression brought economic chaos to an already unstable farm economy. Crops were selling at low prices, credit had vanished. It was a period of foreclosures and “penny” auctions. The wholesale migration of farm families from one farm area to another seeking an opportunity for livelihood became a common phenomenon. 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 continue planting their crops.

The Farm Security Administration makes these loans, repayable within 5 years at 3 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 can receive a loan he fulfills the following requirements:

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

* B.S., 1907, Alabama Polytechnic Institute; M.D., 1910, University of Alabama. Since 1936 Chief Medical Officer of the Farm Security Administration, on assignment from the U. S. Public Health Service. Three years in private practice. Field Director of Sanitation, Alabama State Health Department, 1913-1916. With U. S. Public Health Service since 1917 upon various assignments ranging from hospital duty, industrial hygiene, and public health administration to epidemic duty fighting bubonic plague in Mexico. For nine years editor, *Public Health Reports*, published by Public Health Service.

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 operations.
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. The purpose of loans and guidance is to make the families again self-supporting and self-reliant. The major factors given emphasis in undertaking to aid the rehabilitation of a family are: suitable land tenure, adequate equipment, adjustment of any over-burdening previous debts, sound planning of farm and home management, use of community and cooperative services to supplement family equipment, adequate financing at reasonable rates of interest, careful budgeting and record keeping. Farm Security Administration supervisors work with the farmer until the loan is repaid, helping him to plan his farm enterprise and advising him on more effective methods of raising crops or conserving the soil. Home management supervisors periodically visit the farm-wives and advise them on their problems of canning, raising garden produce, sewing and other work of the homemaker involving the success of the family enterprise.

II

It was through these county supervisors, who are constantly in touch with borrower families, that the first inklings of a serious gap in the program's early efforts were called to the attention of administrators. Difficulty in working with some of the families was traced to lack of medical attention—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.

A director of the rehabilitation program in a western state reported,

"As to need for medical assistance for our rehabilitation families, I believe I can safely state that 75% of our families on this program have been placed in their present position by some form of illness in the family and the resulting crippling effect of doctor and hospital bills. Practically every financial statement shows a liability of from \$100 to \$3,000 now owing to doctors, hospitals, or both. In my opinion, the 'missing link' in our rehabilitation program in this state is a satisfactory approach to this very vital question of health of our families and excessive medical costs."

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, some kind of medical care program was plainly indicated to the Farm Security Administration from a purely economic point of view, as a credit agency, by the findings of this survey.

The basis of the medical care program is a conviction 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 for its farmers could be found.

III

Once the need was recognized, the next step was to get medical aid to needy borrower families who could not obtain it through regular channels. There was no organized system of providing medical care for medically indigent rural families in most of the states. In a few states, the families had to be certified as paupers before any medical aid was given. In one state, a "Black List" of patients who had not paid their doctor bills prevented physicians from attending indigent cases on pain of expulsion from the local medical society. Nothing could be done for these families without the help and understanding of the medical profession. The gap between the families needing medical attention and the physicians who could render it was not simple to bridge.

Due to the cost and delay involved in making a loan, and the additional difficulties of auditing and individually justifying expenditures for medical care by borrowers, it was not feasible for the Farm Security Administration to make small supplemental loans to its borrowers to help them meet medical care bills as they were presented. A single loan to each family at the beginning of the year to cover medical care for the twelve months was indicated. Even this, however, was precarious. The incidence of disease among individuals is not exactly predictable; and it was certain that in some instances where serious illness developed, any probable sum set aside would be inadequate to cover costs for the family stricken; either the bill would go unpaid or the family would be bankrupted, the loan advanced by the Farm Security Administration defaulted, and the work of rehabilitation left to begin again. In other instances the sum loaned for medical care would be too much. In order to avoid the occasional family financial disasters and the defaulting of medical care bills which the loans were intended to forestall, it seemed necessary to persuade borrowers to pool the funds loaned to each for medical care at the beginning of the year, so as to give each family assurance of all needed care as well as to keep medical costs within their ability to pay. Finally it was necessary that physicians, assured that each of these near-relief families was paying according to its ability into the pool, should accept as payment for services that proportion of their regular fees which funds in the pool would cover.

When a medical care program was started in 1936 in Arkansas, North Dakota and South Dakota, however, the principle of prepayment for medical services had not yet been accepted by the medical profession. And while insurance for protection against loss of life, threat of fire or theft were old stories to the American public, the banding together of a group of people for mutual protection against the incidence of illness was new to the public and viewed with misgivings.

The families which had borrowed from Farm Security Administration had learned the rudimentary lessons of cooperation for their everyday needs by buying plows, livestock for breeding purposes, or canning equipment in groups for the use of all participants. This form of cooperation, however, showed immediate results in the use of the purchased article. Paying a flat sum for medical care was somewhat of a risk. You might be sick this year, and then again, you might not. It was a higher type of cooperation that these families would have to accept voluntarily.

On the other hand, two facts argued the feasibility of the plan: the fact that these farm families realized they had desperate need for such a service and wanted one, and the fact that 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 on hand.

The only feasible approach to the problem, at any rate, seemed to be the grouping of families under a plan, paying a flat fee per year for medical care, and the participation of physicians who would agree to treat these families at a uniform fee schedule which would take into account the families' low income.

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 that 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 started only in the spring of 1937—but already 26 state medical associations have approved medical care plans.

In some states, the medical association welcomed the opportunity of trying out an experiment which was obviously necessary and which they had long wondered about. Other state medical associations accepted the plan on sufferance with the understanding that it was purely on a trial basis. At a recent meeting of the House of Delegates of the American Medical Association, a resolution stating general approval of the action of the procedure of state associations cooperating in guiding the organization of such plans was passed without dissenting voice.¹

IV

A great variety of plans has been initiated, but, in general, they follow three patterns. In most of the plans, borrower families pool their funds and put them in charge of a trustee.² The trustee then pays all physicians' bills for the group as fully

¹ A publication from the Bureau of Medical Economics of the American Medical Association states, "Medical societies are warranted in studying these plans with the same sympathetic attitude that they have toward any other persons who need medical care. The actual operation of any specific Farm Security Administration plans will, of course, depend on acceptance by the practicing physicians in each community in which the program is proposed. These physicians may properly look to state and county medical societies for an expression of acceptance or rejection of the principles involved." *ORGANIZED PAYMENTS FOR MEDICAL SERVICES* (1939) 89.

² When a family borrowing from the Farm Security Administration lacks funds at the beginning of the year to make the payment into the fund, the Farm Security Administration will increase the amount

as funds will allow, on a monthly, *pro rata* basis. Under another plan which is gradually being discontinued, funds for each family are placed in the hands of 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.

The basic procedure in each case, however, is the same although state and county differences are apparent in most plans. Before any medical care plan is set up, county supervisors—the people who are directly in contact with the families—are asked if there is a need for a medical program revealed in the current farm and home plans of the family. If there is a need and the families desire to participate, representatives of the Farm Security Administration charged with the responsibility of carrying out the program draw up a tentative medical care plan. A common understanding of the benefits that should be included and a reasonable family fee, based on income indicated in the farm and home plans, is reached before the matter is laid before the state medical association by representatives of the Farm Security Administration.

A meeting with the economic committee or council of the state medical association usually follows at which a memorandum of understanding or a guide to be used as a basis for developing local Health Service Associations within the state is drawn up. These memoranda of understanding are prepared by the officials of the state medical associations, with the assistance of officials of the Farm Security Administration. The usual policy of the state association has been to refer the memorandum back to its house of delegates for final endorsement. In some states, simple resolutions were adopted by the house of delegates referring this matter back to the local medical societies to be worked out, without specific recommendations. Based on these memoranda or resolutions, agreements are then worked out with local medical societies.

The agreements with the county societies recognize the three basic principles of the medical program: (1) the participation fee for borrower families is based on their ability to pay as determined by their farm plans; (2) there is free choice of physicians who agree to participate; (3) funds are set aside in the hands of a bonded trustee at the *beginning* of the operating period.

The medical 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) emergency surgery necessary to save the life or limb of the individual as determined by the physician in charge of the case; (c) emergency hospitalization believed necessary and recommended by the attending physician; (d) obstetric care, including pre-natal, and post-natal, services; (e) ordinary drugs dispensed or prescribed by attending physician; (f) dentistry prescribed by the attending physician and believed necessary to relieve acute systemic diseases or relieve pain.

of the general loan for rehabilitation by the sum necessary to permit participation. No separate loan for medical purposes is made; participation in the medical care program is regarded as quite as necessary to sound farming as is adequate workstock, and no distinction between moneys for the two purposes is made in either the loaning or collection processes.

V

For these services the family under the most typical agreement usually pays from \$15 to \$30 a year. The amount paid varies according to benefits included under the plan, according to size of average farm incomes in the locality, and according to size of family. A typical payment schedule for physician's care in a low-income county might be an annual \$18 for a man and wife with an additional \$1 for each child up to eight with a maximum payment of \$26 per family. The money is pooled and a certain 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 for the period covered.

Physicians submit monthly statements based on a fixed fee schedule to the trustee for services rendered. These bills are 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 allotment. If the allotted funds for the month 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.

The pool plans vary as to organization. While under many of the county pool medical care plans the farmer-participants 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.

Benefits included under the medical care plans also vary according to the participation fee and local needs. The percentage of money set aside from the total funds for hospitalization, drugs and physicians' services are worked out with the local county medical societies. The majority of county pool plans cover emergency medical care, including obstetrics, and hospitalization. Forward looking counties have also added dental services, while a few plans provide only for emergency medical care. In one state, 40 counties have plans for dental care which are operated on a separate basis. For \$3.50 a year for each family and \$.50 in addition for each person in the family, the participating family obtains emergency treatment, simple fillings, extractions, prophylaxis and cleaning.

Drugs are sometimes a problem under the plans. Unless druggists cooperate³ with the program, it is found that an unusually high percentage of the funds—sometimes as much as 35%—must go to pay the standard price of drugs; from 7% to 12% is more nearly normal. In a number of the plans, however, physicians dispense the drugs they prescribe or have the prescriptions charged to themselves. The ideal solution, of course, would be to have the borrower families pay for the drugs they need independently of the plan. It was found, however, that because these families have such a low cash income, they were not in a position to pay for drugs and often the families could not have the physician's prescription filled.

³ By accepting pro-ration of bills along with physicians or giving a fixed reduction.

In all county pool plans, there is a set fee schedule for the physicians serving the families. The individual contract plan works on an entirely different basis. Funds for each family participating are set aside 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 they have paid, the physician continues his services free of charge during the remainder of the period.⁴

VI

Experiences with the two plans clearly indicate that for low-income families the first plan is preferable, that is, a plan providing for pooling of the individual fees into one general fund. In Ohio and Missouri, where the individual contract plan is in effect, results have not been wholly satisfactory and the plan may be dropped within a few months. The plan is hard on the physician when a protracted illness develops and too often, families will not see the physician in order to save the money they have set aside for medical purposes.⁵ 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. In Missouri, the Economics Committee of the State Medical Association has agreed to try out a medical care plan on a pool basis in a few counties to study its merits.

County or district plans for medical care are operating in 23 counties in Alabama, 68 in Arkansas, 2 in Colorado, 5 in Florida, 108 in Georgia, 5 in Indiana, 2 in Idaho, 5 in Iowa, 25 in Kansas, 7 in Louisiana, 41 in Mississippi, 12 in Missouri, 1 in New Jersey, 7 in New Mexico, 10 in North Carolina, 11 in Ohio, 12 in Oklahoma, 17 in South Carolina, 7 in Tennessee, 18 in Texas, 1 in Utah, and 8 in Virginia.⁶ The swift extension of the program during the last two years is indicated by the increase in the number of county plans operating in Georgia where there were 5 counties participating last year and 108 counties this year.

Agreements with the state medical associations prior to approaching county medical societies have been reached with Wisconsin, Wyoming, Kentucky, Pennsylvania, New Hampshire, West Virginia, Vermont, New York, and Washington.

VII

There is a somewhat different approach to the problem of medical care in home-stead 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

⁴ The Farm Security Administration through its local supervisors keeps in touch with the working of the plans where they are set up, but has no authority over them—loans are to the individuals to enable participation, not to the group or association organized to obtain medical aid.

⁵ A collateral function of the prepayment feature of the plans is that of encouraging acceptance of preventive medicine by the participants. Too often low-income families in the past have habitually waited until illness became serious to the point of debilitation of the patient before obtaining medical aid.

⁶ These figures were taken from a statement prepared as of June 30, 1939. Since that date, additional counties have been added to the program in several of these states.

homesteaders is often an acute one. In a few instances, they have employed a physician living nearby 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 30 projects, and programs are now being set up on eight other projects.

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

A few facts regarding a typical project program will illustrate how the medical care needs of the homesteaders are being met. Every one of the 141 families on this project became a member of the health association, 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%. Of the families in the association, 96% had one or more of their members receiving service during the year, and 47% of the families received service for which the charges exceeded the \$18 membership fee.

VIII

Distinct from the general program of medical care is the program set up in North and South Dakota and in California and Arizona. These four states had local problems necessitating 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 living in highly unsanitary conditions who 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. The family had the free choice of any physician 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 physicians and other professions concerned. Bills were paid monthly and prorated 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 that practitioners other than legally qualified doctors of medicine were seeking to participate in the plan.

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

At present, North Dakota has no medical care plan, but an outline of proposed action has been drawn up. It includes a payment of \$33 per family a year to include emergency medical and dental care as well as emergency hospitalization and prescribed drugs. A higher fee was set to avoid the past experience of having insufficient funds.

A further change proposed was that the medical care program be set up on a unit basis, utilizing one or more counties as local conditions seemed to indicate, and that funds paid into the plan by the families residing in a given area be kept separate for that area, thus leaving in the hands of the families and professional groups in the district virtual control of the plan. In effect, the proposal as it stands 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 the seven counties in that area. There is a potential case load in this area of approximately 2,500 families or 12,500 persons, with 13 physicians, 8 dentists, and 2 hospitals. Funds will be loaned to these families for participation on the basis of \$33 a year per family, which will provide emergency medical and dental care, hospitalization and prescribed drugs.

The unit was set up in order to test the legality of a ruling recently issued in South Dakota. At a recent session of the South Dakota legislature, a bill was enacted which purports to require that all practitioners of the healing art participate in any public health and medical care program that is conducted in South Dakota. The bill might compel the South Dakota Farmers' Aid Corporation to utilize the services of osteopaths, chiropractors, and other similar practitioners, and thus alienate the medical profession from the program. The Attorney General of South Dakota has given a written opinion to the effect that this act applies only to funds appropriated by the State of South Dakota. The matter cannot be finally decided until it is passed upon by the proper courts.

In order to pave the way for such action, the single medical care unit was set up at Pierre. Should the osteopaths and chiropractors wish to make a test case of the matter, they may seek an injunction and the matter will be finally determined by

the courts. No further units will be established in South Dakota until this legal question has been settled. The decision will affect approximately 22,000 families in South Dakota who are receiving aid from the Farm Security Administration.

IX

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 remain 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 agency has a representative on the Board of Directors of this non-profit corporation.

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 and surgical care, laboratory examinations, X-ray, dentistry, prescriptions, and required treatment.

Although the migrant-workers are obligated to repay the cost of service "if so requested," their economic status precludes any expectation of repayments 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 and 6 in Arizona.

X

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 over-

looked. No matter how perfect a plan is theoretically, when put into practice it must deal with actualities. There has been a certain amount of abuse of the program by both the physicians and the families. Physicians will sometimes present bills for previous services to these families, or for services to families not on the program, or charge a higher fee for rehabilitation borrowers than for other people on the same economic level. Families sometimes use a number of physicians during the month, will request service for chronic ailments, or request unnecessary services. These difficulties were to be expected and mechanisms have been set up to control them.

Each participating physician gets a list of participating Farm Security families in his county and each family on the program gets a list of cooperating physicians. The health participation agreement which the family signs sets forth the medical benefits to which they are entitled. Physicians keep individual records of each family visited. In some areas, participating families make monthly reports on health services they receive. In addition to this, 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 towards the medical care program is, on the whole, favorable. In an Arkansas county which has had a medical care plan operating for three years, families were asked whether they did not object to paying \$20 to \$30 into the medical fund when a doctor might not be called all year. The replies were invariably something like this: "I'm pleased about it. I hope I just go along paying that money and I hope no doctor ever crosses the step. Just knowing I can get a doctor when I need one suits me." Many of these families feel that the plan is like "burial insurance."

A physician serving these people stated that no country physician ever got more than 40% of his bills paid. At present, this physician is getting 100% payment on his bills. Not all physicians participating in the program manage to get such a high percentage of repayment, but a county supervisor reports, "The participating physicians are well pleased." Monthly payments to physicians have ranged from 40 to 100%. Payments under the plans average the country over, 65% of total bills presented. One physician remarked that he was glad to get that much of his collection, since in other cases he had not collected that much. From another county in a southern state comes the report, "The doctors would like a 100% payment, but they admit that 74% is better payment than they usually collect from their rural practice. Some doctors have admitted that they were opposed to the project until they served on reviewing committees or otherwise saw more of the aim of the program."

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. But, for the group of people for whom the program is giving new opportunities and aid in efforts to get back on their feet, the plan is a boon. Since it is impossible to isolate the results of the medical care program from concurrent Farm Security Administration programs of diet improvement, environmental sanitation, and better housing, it is impossible to state statistically the results of the program in terms of generally improved health.

In the final analysis, the fact that 99% 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.