"Widening the Road to Health" was the theme of the eighth National Conference on Rural Health sponsored by the Council on Rural Health of the American Medical Association. More than 700 medical, farm, and community leaders, representing several million rural area people, attended the conference at Roanoke, Va., February 27 and 28. Our report of the meeting begins with a review of conference activities since 1946 by Dr. Crockett, chairman of the Council on Rural Health. It includes in news-summary form reports of seven other papers and, in brief, a review of rural dental problems. Two additional briefs summarize the viewpoints on rural health councils of a physician and of a State public health director. These were given at a preconference meeting of State committees on rural health. The seventh National Conference on Rural Health was reported in Public Health Reports, May 1952, pp. 479–483.

Looking Back To Look Ahead in Rural Health

By F. S. CROCKETT, M.D.

A REVIEW of the past 8 years may help us in forecasting where we go from here. Let us, in part, recreate the atmosphere in which we lived in 1945. A great world war was ending. Nearly all civilian activities had suffered change and dislocation. This was especially true in health and medical care.. Some 60,000 physicians had entered the armed services, in many instances leaving communities without a physician or with an aging one.

Earlier, in the midthirties before World War II, the decreasing number of physicians in the small towns was impressive. This phenomenon had been slowly developing since the beginning of the century. The element of need seemed increasingly urgent. The big question was what could be done about it?

Dr. Crockett, Lafayette, Ind., is chairman of the American Medical Association's Council on Rural Health.

The American Medical Association formed a committee on rural health, predecessor of the present council, in response to an invitation from the American Farm Bureau Federation, an organization representing at that time about 1 million families from farms in practically every State. Individual physicians were fully aware of the rural health situation and were anxious to make available all the resources and information in their possession required for study and solution of the problems.

In the organizational plan for the medical profession eight areas of rural America having comparable rural health problems were recognized. A member of the committee living in each area was given responsibility for developing rural health activity suitable and acceptable to the people in the area. This intimate knowledge of sectional problems was augmented by advisory members. We first invited advisory members from the Farm Bureau, Grange, Cooperative Milk Producers Federation, Farmer's

Union, and Farm Foundation of Chicago. Later the Committee on Policy and Planning of the Land-Grant Colleges and the American Agricultural Editors Association gave us advisory members. We have received recognition and support from constituent State medical societies. Forty-three State rural health committees have stimulated interest in providing service for their rural areas. They have done much to organize State and local health councils, enlisting the support of a large segment of the citizens. The State committees have received major support from many sources, especially farm organizations, which have also organized State and local health committees.

Ground Rules

Into conferences such as this one flow the combined thinking and planning of the rural and professional leadership of the whole country. This combination of skill and experience justifies our claim that rural health promotion has become truly a citizenship responsibility—a duty resting upon each citizen to contribute, to the fullest extent of his knowledge and experience, the wisdom required to make any community effort succeed.

The first national rural health conference, held in Chicago in March 1946, had several unique features. For instance, it was not a meeting of physicians to solve a health problem. It was a meeting of physicians and laymen to discuss and solve their mutual health problems—tacit recognition that rural health is a job for the citizen and that it requires community cooperation. The conference was national in scope—some 3,500 invitations were extended to all groups thought interested in the problem. Nearly every State was represented.

The ground rules for the conference called for an open forum in which everyone was free to express his opinions. It was believed that through a multitude of ideas a more complete picture would evolve. The conference was exploratory with no preconceived ideas to be supported. Discussion from the floor was deemed important, equal to the prepared addresses.

The American Medical Association, while sponsoring the conference, claimed no privileged position. Constructive criticism was expected and desired. There were to be no decisions by majority vote. Truth cannot be established that way. Instead, areas of agreement were sought. Disputed problems have often found solution with the passage of time and more experience. These ground rules have not been changed. They apply with equal force to this eighth conference.

Three statements epitomize some of the thinking at the first conference.

The late Ransom Aldrich of Mississippi, first chairman of the Rural Health Committee of the Farm Bureau, pointed out, "The chief problem of medical care in rural America is cost. In my county, doctors charge a dollar per mile. The low income group in rural America simply does not get medical service from that kind of charge."

Dr. L. W. Larson, North Dakota, a member of our committee, remarked, "Rural health has always been a problem. While there has been considerable improvement, two phases remain unsolved—the availability and the cost of medical care. (*a*) Availability means bringing the doctor to the patient or the patient to the doctor. (*b*) The cost will be less if the patient can go to the doctor. The use of prepayment plans will spread the cost and reduce the cost to the individual."

Leland B. Tate, of the Farm Foundation, proposed that better medical care and health service, and health education should bring to the individual: (*a*) "Knowledge and understanding of what is desirable for maximum health, and (*b*) insight into ways and means of getting and paying for adequate health and medical services."

Three basic factors, that still concern us, were noted and emphasized at the first conference: medical services; the maintenance of health through education of the individual; and the economic situation that exists at the moment affecting various segments of rural people.

The Common Effort

These are, in part, the progressive steps by which we have built the National Council on Rural Health and mobilized existing related professional, educational, and civilian groups for a common effort on the national, State, and local levels. What then is this common effort?

Our objective in this common effort has been the benefit of the individual and his community. The technique to be employed was, we believed, important—as important as is the objective. This benefit was not to be had free, but was to be earned by the community and by the individual. By this technique, based on rugged individualism, on personal pride in one's ability to care for himself, on meeting common problems through group action, the objective was to be won.

This basic philosophy and the methods employed in its achievement reflect the thinking of the medical profession. I believe it is acceptable to our advisory groups. We have given much thought to this whole matter. Where does the local physician, of the county medical society, fit in? True, they are the experts in health matters, but no community problem can be solved by a minor segment of the population.

We have come to believe that this is not the physician's job; it is not a job for the medical profession; it is not a public health service job; it is not a layman's job. It is a job involving all citizens collectively and equally—one in which each contributes for the common good his knowledge and experience and in return shares in a better place in which to live and rear his family.

We believe we should take advantage of the strength accruing from group action. Citizens organizations lend themselves well to health promotion, and many have been formed on the county basis in many States.

The trading center, and its surrounding trade area, is the logical health council area. It has been observed that people get medical services where they go for other commodities and services. Since the county is a convenient area surrounding the trade center, or county seat, we have come to call these local organizations county health councils.

County health councils are truly local. This is the area where people live. This is where they can conduct their local and community affairs to suit themselves. This is the level where local self-determination permits the fullest expression of individual thinking. Schools, churches, highways, public health services, law enforcement—everything entering intimately into daily living—reflect the individual's attitude toward, and concept of, his responsibilities as a citizen.

A county health council should be organized whenever a large majority of the local leaders and local citizens are ready for it. In Indiana, for example, 34 counties out of a total of 92 have health councils. Some have been very active; others shade down through varying degrees of activity. What we need in Indiana is an overall State organization interested in stimulating well-directed activities originating locally in response to local needs. A number of States have such State health councils. They have followed no set pattern, but each has contributed richly to the fund of general experience.

Any organization able to accomplish what the people want done is a good and sufficient organization. It is a well-recognized principle, however, that the best public opinion exists where the greatest number think as we do. Any organizational plan that secures a favorable public opinion and wide popular support is to be preferred. This is the way our common effort can be, and has been, implemented. This is the highway we wish to broaden now.

Steps on the Road

A brief review of the succeeding national conferences will complete the picture of our progress.

The second conference studied methods of bringing and holding doctors in rural areas; building hospitals and diagnostic facilities; medical care for low income families; and prepayment plans for medical and hospital care.

The third conference considered the health problems of rural youth. We learned that the country was no better and no worse than the

city. Each to be a healthful place to live must utilize well-known health measures.

The fourth conference studied the rural and farm environment; the accident rate; animal diseases affecting man; soil depletion effects on nutritive crops; and use of newer chemicals in pestilence control and possible poisonous effects.

The fifth conference was the first to be highlighted with a theme. A courageous "Let's Do Something About It" dominated the program thinking in 1950. It was pointed out that the community health council, if properly organized with broad interests, wide support, and wise leadership, will supply the channel through which any community can solve its own health problems in its own way and to its own satisfaction.

"Why Wait—Let's Do It Ourselves" was the sixth conference theme calling us to further action. Success stories of State and county health council accomplishments cited examples of vision, leadership, and energy exhibited under the stimulus of good neighbor and good citizenship practices. It was a dramatic confirmation of previous years' studies and recommendations.

The theme at last year's seventh conference of "Help Yourself to Health" was an action slogan in the best rural tradition. Discussions of successful planning in a number of States, and recitals of "take home" ideas garnered from the program, afforded ample opportunity for thorough discussion from the floor.

Accomplishments

The national conferences have created a receptive climate for a number of developments. Several come readily to mind such as Blue Cross and Blue Shield and Farm Bureau and Grange sickness insurance; Hill-Burton aid to hospital construction; placement service for physicians in communities wanting physicians; nurse recruitment plans; organization of State and county health councils, and organization of rural health committees by State and county medical societies.

Health educators have been added to faculties of several land-grant colleges. At least two States have emphasized general practice training of medical students. Some State plans include graduate instruction which will bring the medical school to many rural physicians who cannot leave their patients without medical care while taking refresher courses.

Surveys of local health conditions by lay personnel in local health councils, under professional guidance, is a most revealing activity. We have survey reports from Columbiana County and Clinton County, Ohio; Parke County, Ind.; and Madison County, Idaho. No doubt there are other reports that have not reached us.

The compilation of much pertinent material by the Council on Rural Health, available on request to the council's secretary, should prove helpful to anyone developing a home program.

Another accomplishment of the council which has done much to strengthen and give common direction to many agencies interested in promotion of better health for rural America has been the addition of a field director to the staff. Members of the council are all working physicians who take time off from earning a living whenever they do anything to promote this cause. This limiting factor has been removed by having a full-time representative whose duty it is to go into every State and acquaint all interested persons and groups with the council and with each other. In obtaining a field director, or roving ambassador, the council's effectiveness has been enhanced manyfold. We like to refer to him as our catalytic agent, so many desirable reactions result when he is around that somehow never happened before.

A unity of purpose and performance by all of us engaged in stimulating rural people to attain a fuller and more healthful life is created by our knowing each other better and working together. This is one of our objectives.

In charting the direction we have traveled these last 8 years, we have been guided by a realization that we live in a real world; that each of us must live and act as a responsible person; that the world does not owe us anything except opportunity—opportunity to solve

our own problems in our own way and to our own satisfaction.

The Future Problem

Final solution of the three basic factors of medical care, health maintenance, and purchasing power uncovered at the first conference is our future problem.

Medical Care

Medical care is that service we require when we are sick. This we can not give to ourselves. We need well-trained doctors and nurses and well-equipped hospitals. Since 1946 this situation has improved. Many doctors have settled in the small towns. I doubt if there are now many prosperous communities, where desirable living conditions exist, without needed medical personnel. It is in communities in the lower income level that the greatest challenge exists—places where poor schools, churches, roads, homes, and farms go hand in hand with inadequate medical care.

Health Maintenance

Health is more than freedom from disease. It should have a positive quality, abundant and vital in character. We should think of health maintenance as consisting of all those things we learn to do for ourselves so that we can keep the good health we now have. This is our own responsibility. We owe it to ourselves. It is no other person's duty to maintain our health for us unless we become dangerous to the health of other people. The individual is capable of doing many things needed to maintain his health. Of course, there are some health problems that require community action. The local public health service was created for this purpose and needs and deserves the support of all citizens. It is an official body created and governed by law. A volunteer organization is more resilient. It can make and change its own rules to meet quickly any emergency. There is much that such a citizen's council can do to make everyone health conscious. This is not a new or untried idea. In many counties in a number of States such groups have done excellent jobs in cleaning up health hazards and teaching the simple rules of health.

Purchasing Power

The third basic factor involves purchasing power—the "take home pay" in rural areas. Price parity is equality of earning opportunity. Its realization would go far to solve the medical care problem and payment for the service. There are today few prosperous rural communities without needed medical coverage. However, they too will benefit from local organization. There is more to this problem than getting a physician and paying him for his skill. Public opinion can be mobilized in support of many improvements in hygiene, sanitation, and other health measures.

Sharing and spreading the costs of medical care through insurance is of interest to everyone, rich or poor. In the purchase of goods and services, a sliding price scale cannot be applied as it is in taxation. Great progress continues in the insurance coverage of rural people and we can entertain a reasonable hope of the eventual coverage of 60 percent or more of those who should have it. The greatest challenge is how to bring the benefits of prepayment to the 40 percent.

To these problems, there is no easy, simple answer. All the points I have made are debatable. There is an honest difference of opinion. But there is much evidence warranting the conclusion that the future trend is away from "statism", with a return to individual initiative, to voluntary organization on the local, State, and national level for the meeting of social needs. The promotion of local organization for this purpose by the past seven conferences seems timely and even prophetic as we view it now.

We must continue to encourage county or community organization. Continuing education is the best method for achieving our goal of individual and local self-help. It is the sure foundation for State and national solution of health and other social problems. There is no substitute for a well-informed citizenry.

In taking a long look ahead, physicians will do well to follow Dr. Louis H. Bauer, president

of the American Medical Association. Recently he urged the expansion of voluntary health insurance to cover the aged (those over 65 years of age) and those suffering from illness of long duration; promotion of volunteer organizations so that we can have a better distribution of physicians through establishing needed facilities; making good medical care for the indigent available everywhere; extension of public health coverage to areas lacking it; and protection of the public so that people may always obtain the services of a physician.

During the past 8 years we have been making progress in line with these suggestions and the potentials are much greater than anything that has been accomplished up to now. We are given an unprecedented opportunity for service to society. Our goal is the well-serviced, well-informed community. We must reach our goal by showing that the way along the ever widening highway to health is gained by patient and sturdy trudging. It is not a journey that can be made by thumbing our way.

Highlights of the Conference

Group Health Insurance Advised for Farm Families

Group health and accident insurance gives farm families an economical way of meeting medical care costs, Carll S. Mundy, M.D., Toledo, Ohio, vice chairman of the Council on Rural Health told the Eighth National Conference on Rural Health.

Dr. Mundy pointed out that group coverage with payroll deductions is the most economical form of insurance. This method, he said, has been adopted by many industrial and business concerns.

"Since payroll deduction is impossible for farm families, some other satisfactory and economical arrangement must be made to collect and forward premiums for the group," he added.

Farm organizations and church groups have served this purpose, he said. "Enrolling all the depositors in a rural bank and authorizing the bank to deduct premiums from the contract holder's account and to forward them to the insurance company is another method that is working well in many communities. The prime requisite in each instance seems to have been imagination and leadership."

Dr. Mundy stated a group must be not only qualitatively representative, but quantitatively it should include more than 50 percent of the farm families in a community or locality.

He also pointed out that the farmer would have a more economical and better coverage for his purpose if he took advantage of the deductible principle which eliminates the insurance of small, frequently recurring and unpredictable items.

"The greater the number of small items we permit to remain in this deductible category, the cheaper will be the insurance," he said.

According to Dr. Mundy, the hospital bill probably will be the largest item in the cost of a major illness. Surgical fees are usually the second largest item when surgery is performed.

"There are many sources of insurance available," he said. "Commerical carriers operate in most States. In many States there are companies sponsored by the Farm Bureau, the Grange, or both. These, together with Blue Cross and Blue Shield, offer a variety of contracts that should satisfy the needs of most groups."

Facts on Food Values Needed in Rural Areas

Farmers need to know more about food values, Janet L. Cameron, Blacksburg, Va., food and nutrition specialist for the Virginia Polytechnic Institute's agricultural extension service, told the conference.

Miss Cameron reported that a survey in Appomattox County, Va., a fairly typical rural area, showed that three groups of foods were seriously lacking in the diets of more than half of the families. These are tomatoes, citrus fruits, and other vitamin C foods; milk and milk products; and green and yellow vegetables.

"Even though farm families usually produce much of their vegetables and part of their fruit and meat, the largest part of their income goes for food," Miss Cameron said. "Therefore, a big responsibility in nutrition is to help them understand food values in order to get the most for their dollars.

"It may help our people to know that green cabbage is now much cheaper than lettuce, yet just as nutritious; that pork liver is far more nutritious than sausage or ham, yet the cost is much less. By the same token, beef liver or heart has more iron and vitamins than beef steak or roast, yet it costs far less. If the cost of fresh milk limits the amount a family can use, canned or dry milk is equally nutritious.

"Lack of income may limit or prevent some families from getting an adequate diet, but most farm families can have a garden and produce enough vegetables to give them two

groups of food which studies show they lack."

Focus on Youth

Miss Cameron said progress in nutrition since World War I has prevented or alleviated dietary deficiency diseases, such as scurvy, rickets, and simple goiter. Synthetic nutrients have made it practical to improve common foods as a means of preventing deficiency diseases in large populations, she added.

Studies show that the poorest fed member of the family is the adolescent, especially the girl, Miss Cameron pointed out, adding: "Somewhere along the line we have failed to establish in her the good eating habits of her childhood, or we have not helped her to see the importance of nutritious foods for her happiness and success in the years ahead."

New Hospital Achieved By Community Action

The record of a small town—with a population of less than 5,000 people—successfully passing three bond issues to build a 55-bed hospital was reported by Lilyan C. Zindell, Perryville, Mo., administrator of the Perry County Memorial Hospital.

Everyone seemed to want to participate in the project, Miss Zindell said. The Missouri Farm Bureau Federation gave a helping hand. Former residents of Perry County living in St. Louis also contributed.

The hospital has attracted four young physicians into the community. In less than 2 years, 800 babies have been delivered without a maternal death. Local businessmen and farmers serve on the board of trustees, she said.

Hospital Volunteers

Since the hospital was opened a group known as the "hospital volunteers" have sewed several thousand items needed by the hospital and have served as receptionists. Currently, they are working to create a student loan fund for use by young people in the community who go into schools representing the professions that, combined, make the hospital team.

Miss Zindell urged other communities to consider the financing of the medical education of qualified local youths as a means of assuring a supply of doctors for their areas.

Community Shows Way To Get Physician

Huddleston is a Blue Ridge mountain town in Bedford County, Va. Its population of about 250 is hardly enough to cause a physician to give it consideration as a place to practice.

But the people of Huddleston were of the opinion that they needed a physician, and they were determined to get one. Six months ago, they did. Now, they have a clinic which they helped erect and where a young physician serves from 250 to 300 patients a week. These patients come from a widespread area.

The story of community enterprise which changed the medical care picture of the small town and its surrounding country was told by Earl J. Shiflet, Richmond, Va., State deputy of the Virginia State Grange.

The story is this:

In the spring of 1951, the newly organized Otter Grange of Bedford County included in its community program plans for obtaining a physician.

Organizational Help

A request was made of the Bedford County Medical Society to ascertain whether there was need for a physician in Huddleston. Within 10 days, the society reported there was a need and expressed the opinion that a physician could develop a good practice.

The Virginia Council on Health and Medical Care gave the community a list of physicians seeking a place to practice, and Huddleston was placed on the council's list as desiring a physician. Among those contacted was a 29-year-old 1951 graduate of the Medical College of Virginia, who interned in the Norfolk General Hospital, and was seeking his first location.

The Otter Grange, in its planning, was joined by the Parent-Teacher Association and by other groups in the community. The young physician visited Huddleston and showed an interest. The community offered to make certain provisions in order that he might be able to start his practice without too great a financial burden upon himself.

Build Clinic

A trust company was formed to represent the community in an agreement with the physician. It was decided that the physician should have a clinic in which to practice and a desirable place in which to live. The physician was consulted on the type of clinic, and it was agreed to build a cinder block building consisting of a reception room, an X-ray room, doctor's office, examining room, and a laboratory. It was to be rent free the first year, after which $500 a year was to be paid. The physician was to receive first option on the purchase of the clinic within 10 years.

An old, used school building near the clinic was converted into a comfortable and attractive residence for the doctor and his family at a $70 monthly rental.

Mr. Shiflet paid tribute to the physician, saying:

"This was his first practice. He was setting up practice in a strange community. He was strictly on his own in a new kind of medical experience, with no one to fall back upon for advice. He had a family to provide for.

"First, and most important, he started off by giving good medical service to his patients. Residents of the community will testify to this.

"He has followed a strenuous schedule, sparing nothing to meet the medical needs of his people. He has purchased good equipment to in-

sure good medical attention. He has endeavored to make the clinic comfortable and attractive.

"Patients coming to the clinic are received by a charming receptionist. To complete the staff, the doctor has employed a trained nurse to work with those receiving medical attention. To make everything as convenient for the patient as possible, an X-ray machine has been installed and drugs are available at the clinic."

Small Town Practice Chosen Over Big City

Seven years ago, a 32-year-old physician in the Army Medical Corps figuratively tossed a coin. Should he, after being discharged from service, enter into general practice in a small town in the Ozark Mountains, or should he undertake further study to become a psychiatrist in a big city?

The Ozarks won. Today, Mountain Home, Ark., has a family physician who is happy in his surroundings although the road traveled was a rough one. This story was told by B. N. Saltzman, M. D., of Mountain Home, Ark.

A 1940 graduate of the University of Oregon Medical School, Portland, Dr. Saltzman, like many other young physicians, entered the Army after his internship. By 1946, he had accumulated sufficient discharge points to consider leaving the armed services. He was stationed in the Canal Zone at the time.

He heard that the town of Mountain Home, with a population of about 2,000 and located in the north central part of Arkansas, needed a physician and that the residents were willing to go to great lengths to make things suitable for a good medical practice.

Facilities Offered

There was no hospital, but he was informed that a modern office would be provided and equipped. A home would be made available to him and his family, and there would be a new car.

"I would, of course, have to pay for these things later, but all I had to do now was to start practicing," Dr. Saltzman said.

He went to Mountain Home, where he found there was no modern office available and no equipment; there was no home available in the town, and his query as to a new car was met with expressions of "great glee and wonderment."

But another physician in the town, who was retiring because of ill health, turned his small office over to Dr. Saltzman and acted as his sponsor. Dr. Saltzman's savings went for the purchase of a small house still under construction; his old car had to do for another year. Sleeping quarters were established in the back of the office. After 4 months, he was reunited with his family.

There was no lack of patients, however, Dr. Saltzman said. The difficulty was in finding time to care for them. "My obstetrical practice flourished, and soon I was delivering as many as four babies a day in the homes."

Home vs. Office

Dr. Saltzman stated that he had to overcome the prevailing idea that the doctor should come to the home rather than that the patient should come to the doctor's office. Eighty percent of the house calls were useless and costly to the patient because of time and distances involved, he added. After modernizing his office and installing a laboratory, he began to educate his patients to come to him. Soon thereafter, Dr. Saltzman stated, his practice grew so rapidly that help was needed. He acquired an associate.

Then, the need for a hospital became more and more apparent. However, the building of it was left to the doctor. A hospital was completed 3½ years ago. It has 12 small private rooms for patients. Home deliveries are now a thing of the past; house calls have been cut to a minimum. Dr. Saltzman and his associates are seeing more people than formerly, although their work has been cut in half.

The University of Arkansas Medical School has selected him as a preceptor—a teacher of young physicians who are given first hand experience in the problems and rewards of general practice in rural communities.

Dr. Saltzman gave suggestions for communities which are in need of a doctor: let the doctor be invited by organized action of community leaders willing to back up their promises—don't needlessly work the doctor to death; he's human; provide a small community-owned hospital, open to all reputable physicians in the area.

Helicopter Suggested To Transport Patients

The helicopter as a possible means of transporting patients from sparsely settled rural regions to hospitals where every facility is available was suggested by Louis H. Bauer, M. D., Hempstead, N. Y., president of the American Medical Association.

"In Korea," Dr. Bauer said, "patients are transferred by helicopters from the front lines in a very short time to hospitals where every facility is available. This is something to be considered by certain rural areas."

Dr. Bauer said that the Council on Rural Health is filling a long-felt want in acting as a liaison with other organizations to improve rural health conditions.

"Now all groups are cooperating in an effort to bring the highest standards of medical care to these areas," he said. "No one organization can do the job by itself. It requires a community effort."

Attracting Physicians

"One of the difficulties in the past has been the developing of some means to attract physicians to those regions lacking them. A physician

who has spent 8 to 13 years of his life in being trained to practice modern medicine is not willing to settle in an area where there are no facilities for practicing such a type of medicine. Increasing the number of physicians will not do it, as they would still tend to congregate in cities.

"In some States, the problem has been solved by the community providing medical facilities and then permitting the physician to rent those facilities or to buy them through gradual amortization. Where this has been done, physicians have been obtained."

He also pointed out that in these days of good roads and automobiles a physician can cover a wider territory than before and is able to take care of more people.

"Every community does not need a hospital so long as one is available within a reasonable distance and good roads lead to it," he added.

More GP's Needed

Dr. Bauer expressed the opinion that medical schools should train more general practitioners, and that general practice should be a prerequisite for specialization. The AMA House of Delegates, he said, has directed that a committee be appointed to study this matter.

"Our voluntary insurance plans must be made available to rural people," Dr. Bauer stated. "Public health facilities must be extended to cover all areas so that there will be universal protection against communicable disease; protection of food, milk, and water supplies; elimination of disease-bearing insects, and adequate environmental sanitation."

Auxiliary Interested

Mrs. Ralph Eusden, Long Beach, Calif., president of the Women's Auxiliary to the American Medical Association, reported that the auxiliary membership, composed of 60,000 physician's wives, is actively engaged in the promotion of rural, industrial, and school health; prepayment medical care plans; health education; civil defense; and promoting good legislation.

Joint Action Cited

At a meeting of State medical committees on rural health held on the day preceding the annual conference, Walter B. Martin, M.D., Norfolk, Va., a member of the American Medical Association's board of trustees, said that the cooperation being shown by physicians and representatives of the people they serve is a splendid example of how a democratic people accomplish their objectives. "The problems of rural health are being worked out not by compelling laws, but by joint action of physicians, the public health services, and the people of the community," Dr. Martin stated.

Medical Care Insurance Seen as a Responsibility

Medical care insurance is missing from many family budgets because some individuals fail to assume full responsibility for their own family health and welfare, declared Frank W. Peck, Chicago, managing director of the Farm Foundation.

A person who neglects to plan his affairs to meet unforeseen contingencies has himself alone to blame, according to Mr. Peck.

He excepted the indigent, the aged, and persons otherwise unable to provide for themselves. Government has a role in helping these people, he said. However, he added, there has developed a growing opinion during the last quarter of a century that "preparing for the proverbial rainy day is old fashioned."

Medical care provisions are missing from many budgets, Mr. Peck pointed out, because a family may have had little experience with serious illness; their income is already being "stretched to the limit," because, in some instances, of the lack of understanding between "needs" and "wants," or they may have a tendency to "cross the bridge when they come to it."

He placed farm families with respect to attitudes toward budgets into four groups: those who budget and who may or may not include expenses for medical and dental care; those who dislike budgets because they find difficulty in keeping within them, or because of the self-discipline involved; those who are "getting along all right" and are willing to let "well enough alone"; and those who believe they will be taken care of, and look to the community or government to do it.

Education Needed

Mr. Peck offered "education" as the solution, stating: "This education includes appeal to logic and reason. It represents the teaching of values and benefits. It represents facing the economic facts of life, particularly in a business that has extraordinary risks and uncertainties. It belongs in the extension system of adult education."

Reporting on the activities of his organization, he said: "The Farm Foundation directs its educational effort to a better understanding of all plans and processes. It holds that only as rural people and medical men study and plan together will rural health programs be developed which will result in rural people raising their health standards while preserving those freedoms that are cherished by both farmers and medical men.

"In a situation so complex, difficult and dynamic as that of rural health in the United States, satisfactory solutions to all the problems involved are not to be found quickly. These problems have been developing for generations. Their solutions will require time, thought, effort, skill, cooperation, understanding, good will and patience."

County Health Councils And Public Health

PHR brief

Recognition of the essential dignity of each individual has been my guiding principle both in the private practice of medicine, in which for years I earned my living, and in public health practice, my present activity.

I should think that this basic principle would dictate the decisions of other private or public health practitioners. In fact the more difficult the decision the more we ponder about what will best befit the dignity of the individual. This is a theme worth keeping as we go forward in bringing better health to this Nation.

Without question the interest of rural groups will help bring better health not only through securing physicians for rural areas, but also through greater emphasis on preventive medicine and public health. It is also true that the presence of a local health department helps attract private physicians to rural areas. They realize that private practice has lost nothing and gained much through sound local health department services.

Physicians have limits of physical endurance. They do their best work only after families are well informed and when the families carry out their obligations by maintaining personal hygiene, environmental sanitation, proper nutrition, immunization, and by consulting the physician early rather than after complications have arisen.

Traditional functions of a local health department are vital statistics, control and prevention of communicable diseases, environmental sanitation, laboratory services, protection of maternal and child health, and health education. Another field now coming into the scope of public health was described by Dr. Thomas P. Murdock, AMA trustee from Connecticut, in an address to the Association of State and Territorial Health Officers last December. He said, "The field now covers many of the long duration illnesses such as rheumatic fever, chronic arthritis, cancer, crippled children, syphilis, care of the blind, and diabetes."

By Franklin D. Yoder, M.D., M.P.H., director of the Wyoming State Department of Public Health, Cheyenne.

The Common Meeting Ground

Daily, in outpatient departments and wards of hospitals, physicians see patients in whom the neglect of health has produced minor problems of disease and patients in whom the neglect of disease has produced major problems of illness. By taking an interest in these minor illnesses at a time when the patient is ready to listen to advice, the physician has a golden opportunity for the practice of preventive medicine. We, in public health, probably need to close the gap between the level of health education and recent improvements in the training and tools with which physicians work. Patient education is an important part of public health education because sick persons are concerned primarily about their own health, and to be concerned is the first step in learning. Patients want to know what happened to them, why it occurred, and to what extent they are responsible for their illness. The best education is still transmitted from one person to another in a heart-to-heart talk.

The health council actually is a projection of the concept of preventive medicine from the State level down to the community. That is where the laity, physicians, and the public health team find a common meeting ground to begin the solution of their community health problems. These problems change with time. We all know that a different pattern exists now from the one of the early-day health officer, who was thought to be mostly occupied with tacking up varicolored signs appropriate for each communicable disease.

The Community Health Council can approach disease prevention through fact finding and interpretation of needs, resources, and problems. It can formulate standards and promote their acceptance. The council can mobilize the forces and interests in the community for sup-

port, extension, and improvement of necessary services and facilities. It can help integrate related services, eliminate duplication of services and those for which there is no longer a need, and modify established services in keeping with new knowledge and changing community needs. Through central planning, informational, and referral service, the council can help promote full coordination and cooperation.

The importance of the participation of practicing physicians in community health council work cannot be overemphasized. Participation keeps physicians in touch with community health problems and enables them to give intelligent guidance to their solution.

In Wyoming we find several factors which produce interest in organizing a health council. In communities that want a public health nurse, a health council can help explain the benefits of this type of service to the people. Other communities may want to obtain a physician, they may want to take community action in eliminating a stream pollution or air pollution nuisance, or they may find it advisable to work toward building a hospital through the Hill-Burton program. Community health councils have been effective in these projects. Other conditions may help crystallize a health council in the communities of other States.

Put Into Practice

Health education is one of our broadest and brightest avenues to better health. An illustration of how health knowledge was put into practice by a western Nebraska family was given at last year's rural health conference.

The mother had suffered a broken arm, and the children, ages 6 to 14, had taken over. They planned the meals, taking into consideration the basic food elements and good sanitation. They policed the medicine cabinet for dangerous medicine, and they were justly proud of their new plumbing system and the disposal unit, safely located. Flies were under control and rodent control was so well in hand that even the cat couldn't find a mouse. The cows had been tuberculin tested (brucellosis wasn't mentioned), and the children were figuring how to pasteurize the milk. They had studied the soil in relation to the trace minerals and the other elements and to human nutrition. The family had health insurance and were helping with the preparation of an office building for a physician who was coming to their community.

In health education, as in other respects, the community health council can help in the development of good health practices on the part of our rural residents.

The Place of the Physician In Rural Health Activities

PHR brief

The physician's place in rural health activities is out in front. If physicians do not accept leadership in these activities—if they abdicate the role of guidance and direction which falls to them by training and responsibility—they forfeit not only a share of their influence, but also the right to criticize and judge the efforts of laymen who do interest themselves in this important field.

The rural health picture is not a single, simple one. It is a montage of many pictures, one that will vary from region to region, and from State to State. The whole environment of any given area—the climate, the soil characteristics, the stage of social and educational development, the types of landholding, and the level of transportation and communication—all these, and others, make up the facets of the greater picture.

The medical problem is not the only one in the rural health picture, and medicine alone—either in personnel or facilities—does not necessarily present the principal solution to these problems.

To illustrate, the doctors of the rural South, not so long ago, spent endless time treating

By Charles Reid Henry, M.D., chairman, rural health committee, Arkansas Medical Society, Little Rock.

pellagra. But when the whole health team—the laboratory nutritionist, the research chemist, teachers and leaders in information work, agricultural researchers, and the skilled field workers of the extension service—joined in the prevention of pellagra, it disappeared as a medical problem and as a health and economic factor. A great health program was overcome, not by bedside care—but by teamwork under medical leadership.

Of first importance in health activities, not only locally but at every level, is the attitude of the physician toward all the people and agencies available as allies in rural health efforts. The intelligent physician will let it be known that he welcomes all helpers in the field. He will not resent them as "busybodies," or be contemptuous of the layman's approach.

The typical physician—and the country doctor always—complains that he is terribly overworked, and can usually back up this complaint with facts and figures. But how often does he assess the whole situation around him which engenders his complaint? How well does he marshall others who might well lighten his load by helping to improve the circumstances—the larger health situation in which he works? Generally, the physician's responsibilities in rural health activities are the same as those of any conscientious man interested in the welfare of his community, but the physician's responsibilities extend further. In the smallest or unorganized communities, he may have to add to some degree the duties of sanitary engineer, epidemiologist, dairy and meat inspector, and quarantine officer. In larger communities, he will act as a watchdog to see that such functions are carried out faithfully.

Leadership Assignment

The mental curiosity and perception necessary to the successful completion of a medical education should naturally lead the physician to an awareness of health problems in his particular setting. He should further implement this awareness by sincere and eager cooperation with all the groups and agencies concerned with education, information, and community improvement. He should equip himself with a knowledge of techniques used successfully in other areas to uncover and attack such problems.

In Arkansas we have proved at our rural health conferences that the Extension Service, the Home Demonstration Council, the Farm Bureau Federation, the dental association, the public school administrators, and the Woman's Auxiliary of the Medical Society are all waiting for the go-sign from the local physician. They are all willing to do the legwork, paperwork, and the doorbell ringing necessary to gather facts on community needs. They are almost unanimous in assigning the physician number one place in planning and directing such activities. They will do the work, but they feel lost without his leadership and advice.

If the physician feels unequipped to exercise such leadership and to advise soundly, it is his duty to get the information necessary to initiate such activity, either from his State society rural health committee, from the American Medical Association, Council on Rural Health, or from libraries.

Planning and advising are not enough. No one can take the physician's place to speak with authority on medical matters; he cannot assign decisions and interpretations on such matters to nonmedical personnel, no matter how willing.

The physician must assume his personal share of information and educational activities. These will involve, in most instances, talks before groups eager to get sound information on subjects affecting their health and medical needs. Careful preparation of talks will pay good dividends, both in effectiveness and in good will. Farm people of today, whether cattle producers, members of home demonstration units or Future Farmers of America, are accustomed to technical information such as they see regularly in extension bulletins, farm and health magazines, and their newspapers. A grunt and an anecdote are no substitute for a factual well-organized talk enthusiastically given.

The Broader Area

He must not overlook his influence in increasing attendance and participation at regional or State rural health conferences. Probably more

than anyone else in the community, he can draft leaders who will bring back from such meetings the enthusiasm and the stimulation so vital to the spread of interest in these activities. He is, in a measure, the adhesive agent which binds the various community forces together in health matters. I cannot emphasize too strongly the almost militant willingness to help if only the physician will lead the way. The cooperation is readymade and all that is needed is the spark of physician interest.

State medical society officials, and especially members of State rural health committees, must see that information about rural health problems is spread to every local society and to every physician. The problem is not just one for "country doctors"—it is the concern, or should be, of every doctor in the State. The specialist, who receives patients from rural areas, has just as big a stake in the whole picture as has the general practitioner. His attitudes, his efforts become a part of the whole feeling of the people in his State in their appraisal of medicine and medical care.

Of course, the first duty of a physician is to his individual patients but more than that, it is the responsibility of his profession to safeguard the whole health and medical care situation as well as professional knowledge can do it.

Dental Aspects of Rural Health in Oregon

EDITOR'S NOTE: Dean Noyes defined the major dimensions of rural dental problems and reviewed in some detail recent studies in Oregon. This "brief" excerpts from his paper a few of these significant findings and viewpoints which, as the author noted, may be of assistance to other areas.

PHR brief

Dental rural health problems do not differ greatly in quality or type from those that are found in the urban areas, although there is some difference in the distribution of specific oral diseases in the country as compared with the larger cities. Our greatest problem is presented by the relatively thin geographic distribution of people in rural areas, which makes it necessary to modify appraisement methods of rural dental health and the administration of treatment.

The techniques of recording the type or pathologic nature of dental disease among rural peoples are similar to that in the city, consisting of surveys using data collected by dentists, dental hygienists or trained lay persons; the records of dental practitioners; the clinical judgment of these practitioners.

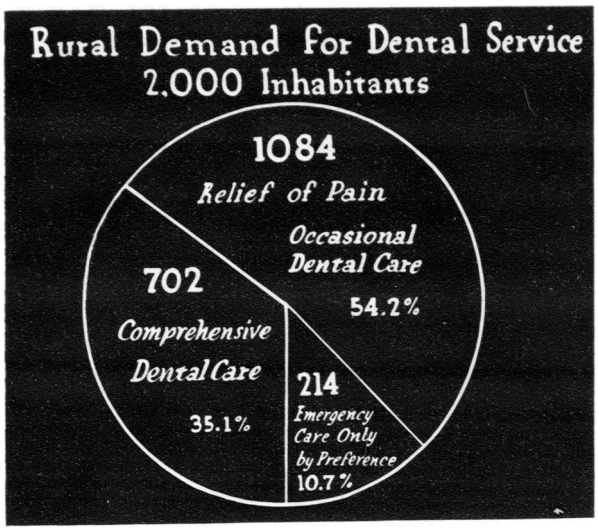
When we appraise our preventive measures, we find our armamentarium is comprised of the same therapeutic measures used with respect to those who reside in the city. These include education for adult and child; through education, the dietary control of oral disease of both the hard and soft tissues, and the promotion of good oral hygiene; through the topical application of sodium fluoride, particularly for young people, and the introduction of fluorine into the water supplies, with resulting benefits to children. In rural areas these benefits are limited rather largely to the school population and the extent to which an individual or household can take advantage of this proven preventive measure.

The advantage of fluorine in the water supply lies to a great extent in the early age at which it has effect. In other words, if we were limited to the topical application, even though we might be fortunate enough to make these applications to all the children of school age, fluorine in the home water supply provides the forming teeth of the child from birth to school age an advantage of even a greater degree of immunization.

I should like to mention, as well, the importance of early dental care. We may from time to time prevent serious problems if we take care of the little defects, and we can prevent serious and costly dental operations if we take care of the little things as the individual grows to attain maturity.

Now if we turn to the matter of treatment in rural areas, we find the same basic personnel as

By Harold J. Noyes, D.D.S., M.D., dean, University of Oregon Dental School.



in the cities except that here the personnel itself is spread over a wider area and the opportunity for choice of a dentist and the use of auxiliary personnel is far more limited. There are, of course, dentists who practice in small towns and the smaller metropolitan areas that are adjacent to farm and ranch country. In some cases, though far less than I would have expected, there is use of a dental trailer, which returns us to the itinerant dentists of the days of my grandfather, at which time it was not uncommon to have the dentist go around on horseback, or in a light wagon.

Dentists in metropolitan areas also have many rural patients, some of whom make it a business to come to the city periodically for dental care. Others combine dental attention with other business which they have in the city. This is difficult to arrange, particularly for young children, and it has other disadvantages. Auxiliary personnel—dental hygienists and dental assistants—likewise abound to a greater degree in the more heavily populated areas.

Rural Needs for Dental Care

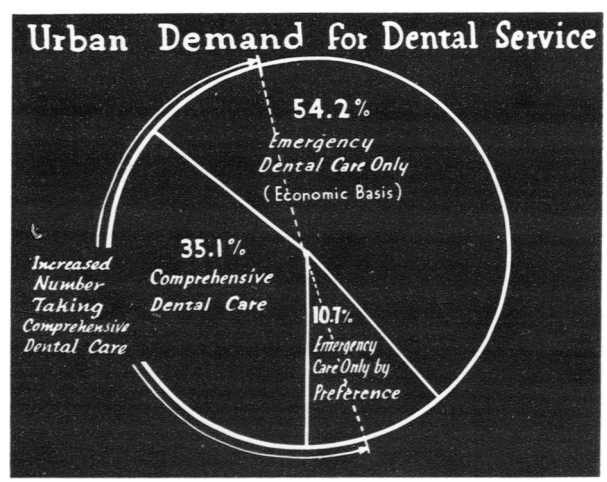
No clear line can be drawn between the rural and urban need for dental care. Nevertheless, people who live outside of corporate limits have a great handicap in access to dental personnel. Analysis of the dentist-to-population ratio in urban and rural counties of Oregon reveals a distinct difference.

Similarly, we must recognize the very real distinction between the needed amount of dental care and that demanded by a given community. Dental care must be considered in its proportional relation to general health, and the cost of complete dental care of the residents of Oregon would require the expenditure of approximately $73,178,475 for the accumulated dental defects which exist at the present time. The annual cost of complete care for each year's increment of dental ills will approach if not exceed $22,581,061. If there were dental personnel to provide these services, which there is not, the expenditure alone would be unwise if not impossible.

There exists a very real correlation between dental care purchased and the per capita income of the community. A similar relation, though less positive, exists between the educational level of a population and the willingness to procure dental services.

Effective Demand in Oregon

What, then is the effective demand in Oregon for dental care? The net income of 54.2 percent of the 61,188 farms in Oregon in 1945 is reported to be below $1,500 annually. Persons who receive half of the necessities of life from their produce may be expected to purchase little more than emergency dental care. Of the remaining 45.8 percent no less than 10.7 percent will refuse all but emergency care, leaving but 35.1 percent who will have the means and in-



clination to seek complete or nearly complete dental health service.

To deserve his consideration as a vocation among those open to young men and in order to make a livelihood which compensates him for educational expenditures a dentist must have approximately 700 patients that require his services for more than emergency care. Thus a dentist who is looking for a location in a rural community in the State of Oregon cannot consider any situation which does not offer approximately 2,000 inhabitants unless the average family income expectancy is above $3,000 annually. Under average conditions he can postulate that 1,084 persons will not be able or willing to utilize his services for more than the relief of pain or occasional dental care; 916 will be able to do so, but of that number 214 will be unwilling to go beyond the extent of the first group; and he will have to rely upon the remaining 702 for his stable living (see "rural demand" chart).

In November 1952, there were 992 dentists licensed and practicing in Oregon, which has 1,521,341 persons (1950 census). This represents a ratio of one dentist to each 1,534 people. There are now 27 dental hygienists practicing in Oregon. A statement of this sort must be interpreted in terms of the availability of service to the individual who wishes dental care. In the urban area of Multnomah County, for example, the ratio is 1 to 935, while in Polk County it is 1 to 5,137, and in Sherman and Wheeler Counties, there are no dentists reported by the State Board of Dental Examiners.

Moreover, this does not mean that each person in Multnomah County has 1/935 care of one dentist. It means only that the persons who are willing to purchase dental service have attracted dentists to this area in that proportion. Why can a dentist find it to his advantage to serve in a 1/935 ratio in Multnomah County, when he cannot afford to risk location in most rural areas where he will be one dentist to 2,000 people? Because the segments of the circle are altered and the percentages changed in the urban area of Portland (see "Urban demand" chart).

The 35.1 percent who have the resources and desire for dental care extend into the 10.7 percent that will not seek dental care. Moreover the 35.1 percent are sufficiently convinced of the value of this service that they will pay a higher premium for it. This means offering a greater bid for dentists than the same segment of rural population. Also, the 54.2 percent who feel that their circumstances justify only emergency care and limited service is transformed in part by dental health education and public social acceptances in such manner that they feel dental services deserve greater priority in their limited budget.

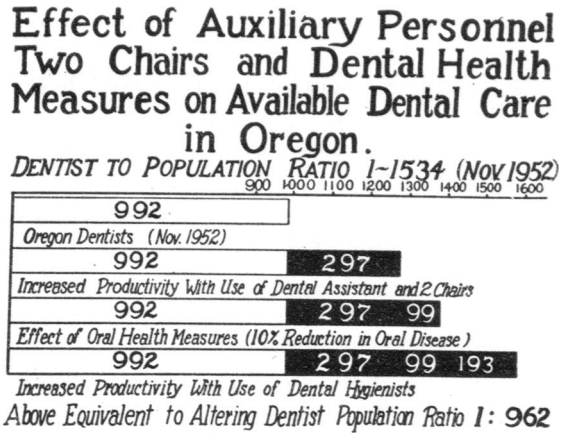
The Manpower Problem

Of the 992 practicing dentists in Oregon we can expect to lose 24 in 1953, if we accept the actuarial figure of O'Rourke (see chart). We may expect to lose, as well, 21 dentists who will leave Oregon to locate elsewhere. Anticipating that 75 percent of the Oregon residents whom we graduate in June of 1953 remain in the State of Oregon, we will increase our total by 35, and probably gain at least 5 Oregon graduates from out of State. We have the added opportunity for improving our ratio and compensating for such increase in population as may take place in the current year through the number of dental graduates from other dental schools who pass our State Board dental examinations and remain to practice in this State, estimated at 14. We could therefore expect to have 1,001 dentists in 1954, unless those taken by the Armed Forces are not replaced by veteran dentists who return to Oregon to practice.

Amplifying Service

There are additional ways in which the available volume of dental service may be amplified. The use of auxiliary personnel—dental hygienists, assistants, technicians—effectively increase the productivity of the dentist. Related is the use of two-chair offices and modern equipment, and of late very interesting studies have pointed to the increased hours of service they permit.

The data are irrefutable with respect to our ability, if we would utilize our present knowledge, to reduce materially the incidence of dental disease in children. It is possible where the



diet of a child can be controlled in an institution to practically prevent dental decay. Under present existing diets in the average home and with the almost insatiable desire which both children and adults have for sweets, this has not been practical in private homes. We should not, however, blame the dental profession for our inability to follow a dietary regimen which if implicitly pursued will make cavity formation negligible.

Likewise there is good reason to believe that the incidence of dental decay in children up to the age of 15 can be reduced approximately 40 percent by the topical application of sodium fluoride if the procedures advocated by the United States Public Health Service are pursued. However, the cost in the terms of a dentist's hours of time in applying sodium fluoride in his own office is about equivalent to that which would be required if he were to restore by fillings the cavities which he prevents. Here the use of a dental hygienist operating at a lesser hourly cost in the fabric of the public school system can perform a very important service.

We should not be misled, however, by thinking that a reduction in dental service required by children is a reduction in ultimate demand for care over the entire life span While it is certainly important from the standpoint of esthetics and function and the effect which the latter has upon health, we must recognize that the retention of teeth may increase the problems which come from disease of their supporting tissues in the later years of life. We cannot, therefore, look at preventive measures in childhood in any great degree as a reduction in the overall burden upon dental care.

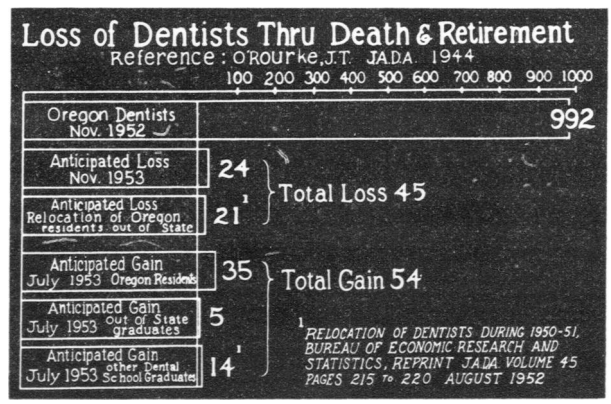
It is conservative to say that at least 10 percent of the need for dental care could be eliminated if the public would practice conscientiously and consistently the procedures which are presented in the literature and provided in the schools and follow the advice that is given in dental offices and in the programs which are promulgated by units of the dental profession and the State departments of public health.

To document this estimate: a 3-year dental health education program in Greenville, Tex., resulted in a rate of 9.9 missing permanent teeth per 100 children. In comparison, Jacksonville, Tex., where no dental health education was operating, there were 26.2 permanent teeth missing per 100 children.

If We Applied What We Know . . .

On the basis of national survey data, about half of the 992 Oregon dentists are now using two-chair offices, and about 64 percent employ dental assistants. The effect of full utilization of these resources would be to add 297 dentists to the total dental service rendered Oregon.

If we could develop effective measures in dental health education, it would relieve the burden on the dentists who are practicing in the State to an extent equivalent to adding 99 dentists to the overall total. Finally, if we were to save the operating time of 992 present practicing dentists by using dental hygienists



for the limited operations they are licensed to practice, we would in effect add 193.

In other words, applying tested procedures would change the effective impact of 992 dentists to a condition equivalent to having 1,581 and would reduce the present dentist population ratio from 1 to 1,534 to 1 to 962 (see chart).

To Increase Rural Care

There are several practical ways to increase rural dental services in Oregon. First, encourage local residents to study dentistry. There is a tendency to return to the area of residence for professional practice. This should be fostered, as should the challenge that dentistry offers in the field of human service.

Second, support the State department of public health, whose dental health officer can facilitate dental health education, stimulate dental health service programs, and implement local district dental societies.

Third, support the State dental school. If we are to meet our obligations and assist in the provision of increasing dental care in the rural and urban areas alike, we must continue our progress in increasing the number and the quality of dental school graduates. At the same time, it is essential that through the study of public health problems and energy directed in dental research that assistance be offered in the distribution of dental service and in the perfection of measures and technics which decrease the volume of dental ills.

Fourth, support local dentists. Earnest, conscientious professional men cannot exist nor can young men be encouraged to come to rural areas unless they can have the professional satisfaction of performing a comprehensive health service. They will be glad and willing, I am sure, to assist in the relief of pain, to perform extractions and emergency dental care and to construct full dentures, but if the rural areas are to compete with those of the larger cities in their bid for dentists it will be necessary to provide these men with the opportunity to administer dental service as a true health service and not on a basis of selling their wares over the counter upon the prescription of the patient, who is in no way qualified to make his own diagnosis or prescribe the expedient treatment.

Department of Health, Education, and Welfare Created

The Federal Security Agency became the U. S. Department of Health, Education, and Welfare on April 11, 1953. On the same day, Mrs. Oveta Culp Hobby was sworn in as the first Secretary of the newly created executive Department. Her nomination to the cabinet post was unanimously confirmed by the United States Senate on the previous day. Mrs. Hobby took office as Administrator of the Federal Security Agency on January 21, 1953.

As one of her first appointments, Mrs. Hobby named Park M. Banta of Arcadia, Mo., to the post of General Counsel. Mr. Banta replaces the former General Counsel of the Federal Security Agency, Mr. Alanson W. Willcox. After serving in the 80th Congress from the Eighth District of Missouri, Mr. Banta practiced law in Ironton, Mo. Prior to his election to Congress, he served as administrator of the Missouri State Social Security Commission from 1941 to 1945.

Also, Mrs. Hobby has appointed Mrs. Jane Morrow Spaulding of Charleston, W. Va., as Assistant to the Secretary of the new Department. Mrs. Spaulding's wide experience in social welfare work includes service as State director of Negro relief for the West Virginia Relief Administration and the founding of the only private child-caring institution for Negro children in West Virginia. Mrs. Spaulding succeeds Mrs. Anna Arnold Hedgeman, a former assistant to the Federal Security Administrator.