

STUDY AND PROVISION OF
MEDICAL CARE

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AMERICAN MEDICAL ASSOCIATION
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OUTLINE
OF
SUGGESTIONS

Bureau of Medical Economics, American Medical Association, Chicago

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OUTLINE FOR PROPOSED PLAN OF STUDY OF MEDICAL CARE

Prepared by the Bureau of Medical Economics

The Board of Trustees of the American Medical Association recently adopted resolutions designed to assist and encourage state and county medical societies to collect information concerning medical needs and to formulate preferable procedures to supply these needs in accordance with established policies and local conditions.

WHEREAS, A varying number of people may at times be insufficiently supplied with needed medical service for the maintenance of health and the prevention of disease; and

WHEREAS, The means of supplying medical service differ in various communities; be it

Resolved, That the American Medical Association stimulate the state and county medical societies to assume leadership, securing cooperation of state and local health agencies, hospital authorities, and dental, nursing and correlated professions, welfare agencies and community chests in determining for each county in the United States the prevailing need for medical and preventive medical service where such may be insufficient or unavailable; and that such state and county medical societies develop for each county the preferable procedure for supplying these several needs, utilizing to the fullest extent medical and health agencies now available, in accordance with the established policies of the American Medical Association. Be it further

Resolved, That the Board of Trustees of the American Medical Association establish a committee to cooperate with the Bureau of Medical Economics in outlining the necessary procedures for making further studies and reports of the prevailing need for medical and preventive medical services; and that the Secretary of the American Medical Association arrange to develop such activities through the secretaries of state and county

medical societies in each instance, urging the formation of special committees in each county and state where committees are not available for this purpose.

In order to utilize the experience of various localities, some uniformity of procedure in the collection of information is necessary. The following suggestions are offered to state and county medical societies:

I. OBJECTIVES

A. To determine the prevailing need for medical and preventive medical services.

B. Development of preferable procedure for supplying these needs.

1. Closer coordination of the local medical and preventive medical facilities to make the services more readily available and to eliminate duplication of effort, time, financial resources and personnel.

II. PROCEDURE

A. Responsibility.

1. The American Medical Association assumes the leadership in encouraging state and county medical societies to undertake studies to determine medical needs.

2. State and county medical societies are urged to assume leadership in their respective jurisdictions in determining medical needs.

3. The preferable procedure for supplying these needs is to be determined on the basis of the need. The medical and health facilities now available should be utilized to the fullest extent in accordance with the established policies of the American Medical Association.

4. State and county medical societies should seek information concerning medical and health needs from every source that may have data

pertaining to the subject. In some communities it may be necessary to request information and assistance from a considerable number of agencies interested in or actually providing medical care of special types or to special population groups. In other communities the number and variety of such agencies will be very small.

(It is impossible to enumerate the sources from which county medical societies should seek information; however, the agencies which are most likely to have data concerning medical needs and the utilization of medical and health facilities are physicians, dentists, nurses, health departments, hospitals, clinics, pharmacists, welfare and relief organizations, governmental offices—such as county commissioners, township trustees, commissioners of the poor, and other governmental agencies to be mentioned later—philanthropic organizations, community chests, churches, parent-teacher associations, Red Cross chapters, and other individuals, agencies and organizations which maintain an interest in or endeavor to supply medical relief.)

B. Special Committee.

The county medical society should appoint a special committee to direct the collection of information. This committee should be charged with the responsibility of securing information from those agencies which have exhibited official or voluntary interest in the medical needs of the community. Such information can best be secured by separate, individual contacts. Public mass meetings do not often yield dependable information.

1. **Personnel.** It will be necessary for county medical societies to consider well the number and qualifications of the persons who are to assemble the information desired. The number will depend on the size and details of the program undertaken and the resources available.

In many counties the work may be done satisfactorily by carefully selected volunteers. In

other counties where the size of the project will be fairly large, it may be necessary to provide part or full time employees. It is of the utmost importance that the persons who are charged with the collection and analysis of the information have an appreciation of the values and processes in the practice of medicine. Many of the errors found in some of the studies that have been made can be traced to the work and interpretations of nonmedical personnel who had no appreciation of the elements involved in the care of the sick.

III. SCOPE OF STUDY (DEMAND SIDE)

A. The demand for medical services.

1. In making a study, it is desirable that every item in medical service should be treated from both the demand and the supply side so that the completed report will, so to speak, strike a balance. This will prove a check against some of the factual errors and wrong conclusions that have been reported in other investigations.

- a. Preliminary survey. (Such a survey, if carefully conducted, may be all that is essential in some small towns and rural districts. It should involve a thorough and complete report from the administrators of each agency, followed, where thought necessary, with a study by outside observers. The records of most institutions will make it possible to determine the extent of the demand on them for medical services. The total of this demand divided into satisfied and unsatisfied demands will constitute one important element in determining the general demand for medical services in the

community. The following are some of the institutions that should be studied:)

(1) Private practice — physicians and dentists

- (a) Amount of free care given. (Investigation should be made as to whether such free care is confined principally to certain low-income groups or sections of the community and, if so, whether the burden of such free care is equally distributed among physicians and dentists in private practice.)

(2) Hospitals, outpatient departments and dispensaries—both public and private.

- (a) Bed occupancy. (Is there need of more hospital beds?)
- (b) The number of free beds and the amount of service given free. (To what extent does this supply the need? What, if any, type of sickness is not furnished hospitalization; e. g., tuberculous, chronic, convalescent? What, if any, provisions are made to pay for the hospitalization of indigent patients? Number of patients who applied for free hospital care but who were not or could not be accepted. Number of patients who applied for free dispensary or outpatient department service but who were not or could not be accepted.)

(3) Independent clinics (not connected with hospitals).

- (a) The location of clinics with reference to the patients who apply for service is important. (This will assist in determining the extent to which these agencies are in a position to meet the demand for service from those who should patronize clinics.)
- (b) The number and character of applicants for clinic service. (This should determine the economic class to which the applicants belong and form the base on which to decide the extent to which the indigent and low-income classes in the locality are reached by clinics. Furthermore, these data should show the

extent to which the facilities for the indigent or low-income groups are being utilized by persons who are able to pay.)

(4) Health departments.

- (a) Morbidity and mortality reports by income districts of the community (i. e., a comparison of the vital statistics from those sections of the community in which low-income people live with those sections in which the higher income groups live). Number of births and deaths unattended by physicians.
- (b) Information from health department officials as to actual lack of medical care. If there is a visiting nurse service, reports of any difficulty in obtaining medical service should be studied.

(5) Relief agencies and institutions.

(a) Private.

Councils of social agencies, community chests, family welfare agencies—Protestant, Catholic and Jewish—American Red Cross chapters, fraternal and benevolent societies, American Legion posts, service clubs, foundations, parent-teacher associations, Conference of Social Work local organizations, Young Men's and Young Women's Christian Associations, newspaper publishers, Salvation Army, and any agency supported by private or donated funds which deals with medical relief.

(b) Governmental.

County commissioners, courts having jurisdiction over medical relief, township trustees, city council or commissions, boards or commissioners for the poor, welfare and relief agencies—such as the Works Progress Administration, Farm Security Administration, and assistance for the aged, crippled, deaf, blind and dependent mothers and children—and other tax-supported agencies dealing with some form of medical relief.

The records of all relief agencies and institutions should be consulted to determine the demand for medical care as

indicated by the needs for and the efforts to obtain medical services.

(6) Educational institutions.

(a) Secondary school health services.

The number of pupils found by school health examinations to be in need of some medical service, the number who have received recommended medical services and the number who have been unable to obtain those services. (Determine in detail the reasons for inability to obtain recommended medical services.)

(b) College and university student health services.

What requests have come from institutions of higher education for assistance or cooperation in obtaining medical services for needy students?

IV. SCOPE OF STUDY (SUPPLY SIDE).

A. Supply of medical and health services.

1. Medical services are supplied in homes, offices, hospitals, industries, clinics, outpatient departments, dispensaries, and schools by physicians, dentists and nurses.

a. Preliminary survey. (To check with the demand for medical services, information should be obtained from the individuals, institutions and organizations which maintain facilities for furnishing medical service, such as the following:)

(1) Private practice — physicians and dentists.

(a) Number and location of physicians and dentists.

(b) Number and type of specialists. (Is the number of physicians and dentists in active private practice sufficient to assure prompt service when needed?)

(2) Hospitals, outpatient departments and dispensaries—both public and private.

(a) Beds and services available.

- (b) Number of inpatients receiving free hospital care and number of patient days of free hospital care for these patients.
- (c) Number of outpatients receiving free dispensary or outpatient service and number of visits to dispensary or outpatient department by these patients.
- (d) Total receipts to the hospital from patients for services in the dispensary or outpatient department and total cost to the hospital for these services.

(3) Independent clinics. (Not connected with hospitals.)

- (a) Number of patients receiving free clinic services and the number of visits to the clinic by these patients.
- (b) Total receipts from patients receiving free clinic services and total costs to the clinic for these services.

(4) Health departments.

- (a) Organization for services covering entire community:
Sanitation, food control, quarantine, vital statistics, and so on; laboratory services, biologicals and immunization; health education—in cooperation with other institutions for this purpose; extent of services to different economic classes, and relations with organized medicine and private practice. (Do private physicians and county medical societies cooperate? Is health department "practicing medicine"?)

(5) Educational institutions.

- (a) Secondary school health services.
Is health supervision of pupils provided at regular intervals? Is this service a function of the health department, the board of education or a voluntary organization?
- (b) College and university student health service.
What provision is made for supervision of the health of students? Are medical services provided by the institution or through the facilities in the community?

(6) Industrial medical services.**(a) Just what services are supplied?**

If services are confined to plant conditions and first aid, is there any complaint of lack of attendance by physicians in cases where workmen's compensation is not involved?

V. ORGANIZING DEMAND AND SUPPLY**A. Objective — to remove obstacles between patient and physician.**

1. The preferable procedures to accomplish this objective will depend on the information obtained from the study. Attention should be given to existing attempts to facilitate the meeting of physicians and patients for the rendering of medical services.

a. Economic obstacles.**(1) Classification of indigent and part-pay.**

(a) What individual or agency in the community is charged with the determination of indigence or the eligibility for free service?

(b) Is there a central admitting bureau for hospital and clinic patients or a medical-dental service bureau to determine eligibility for free or part-pay services?

(2) Method of payment for indigent care.

(a) Determine the resources for medical relief.
Cash—governmental and private relief agency funds.

Service—arrangements to distribute necessary gratuitous service so burden may be shared by all physicians.

(b) Determine function of hospitals, outpatient departments, clinics and dispensaries.

(3) Plans for low-income groups.

(a) Evaluate any existing organized method of providing or paying for medical services.

Medical-dental service bureaus, filter systems, industrial medical care plans, mutual benefit associations, "cooperatives" and group health associations, contract practice plans, "hospi-

tal" associations, group hospitalization plans, "list" hospital plans, all-inclusive rate plans, student health services, accident and health insurance policies, instalment payments and personal loans.

Do such plans afford a real opportunity for persons in the low-income group to receive medical services at less cost without interfering with the quality of the service?

b. Educational obstacles.

(1) Do the residents of the community fail to appreciate the value of medical services? Are they willing to support public health measures or to pay for needed services if it means a sacrifice of luxuries or nonessentials? Do they know of the proper agencies from which to obtain medical services for themselves or their dependents? What organizations or programs are sponsored to foster the development of health education and public information concerning medical services?

c. Deficiency obstacles.

(1) Are there definite deficiencies in the medical facilities or services available in the community? What steps can be taken to remove such deficiencies? Are these deficiencies supplied by facilities or services from other communities?

VI. GENERAL CONSIDERATIONS

- A. Throughout the study an attempt should be made to determine as completely as possible the percentage of the persons in low-income classes receiving care from public and private agencies; the percentage of total services given these agencies to the indigent and low-income groups; the extent to which tax-supported institutions accept patients who are able to pay full rates, and the num-

ber of individuals or families that have been denied medical services which they have sought. It is of equal importance to discover, if possible, the number of persons who presumably need medical services but have not attempted to obtain such services for the reason that they do not desire medical care. Furthermore, there may be still another group of persons who need and desire medical services but who, for reasons that should be discovered, fail to seek medical attention.

- B. It should not be concluded, from the foregoing suggestions, that the process of collecting information requires simply the recording of yes or no answers to some leading questions. Most of the desired data will require a search of records to obtain accurate and dependable information. In every phase of the study it is important that opinions and suggestions concerning the nature and extent of needs for medical services and the means to supply those needs include all phases of medical care for the indigent and low-income groups.

VII. REPORTS OF FINDINGS AND RECOMMENDATIONS

- A. The information from each individual, agency or organization contributing data to the study should be summarized or consolidated to present a complete statement of any community deficiencies in medical services to the indigent and low-income groups, together with the recommendations for the preferable procedures to remove these deficiencies. The work of consolidation and analysis of data from the several independent sources will be the duty of the special committee of the county medical society.

- B. The consolidated report of findings and recommendations should be made in triplicate—the original to be retained by the county medical society, one copy to be sent to the state medical society, and the other copy to be sent to the Bureau of Medical Economics, American Medical Association, 535 North Dearborn Street, Chicago, Illinois.

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Blanks to assist in assembling the desired information will be distributed at an early date to all state medical societies, and by them to the county medical societies.