EC1021 Do We Want Health?

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DO WE WANT HEALTH?

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Do We Want Health?

ELIN L. ANDERSON 1

I. THE PROBLEM AS NEBRASKANS SEE IT

HOW can we best look after the health of our families? What can we do to protect our children from the diseases that run through our neighborhood? How can we be sure that the milk they drink is free from diseases? What should we do to protect our families against tuberculosis and even venereal disease? Why cannot we, in the small towns, cities, and rural areas of Nebraska find some ways suitable to our communities by which we can all get the medical care we need within our means to pay for it?

These are questions which individuals and groups in Nebraska have been asking for years. Possible solutions, however, have seemed so remote that some people have felt that perhaps they must accept unmet health and medical needs as they must accept the weather. But now that ways of meeting these needs have been demonstrated in many parts of the country, hope rises again. To the list of individuals and groups, such as service clubs, women's groups, parent-teachers associations, and welfare organizations that have expressed interest in improving health services can be added the interest of 1,700 home demonstration clubs under the Agricultural Extension Service of the University. This year the requests from these clubs for advice in meeting rural family and community health needs exceeded in number all other requests for help.

Why is interest expressed now as never before? There are in Nebraska, doctors say, none of the bad health conditions of earlier days, no sweeping epidemics of typhoid or small pox, no high death rate among mothers and infants. "The trouble," explained one doctor, "is that the people ask too much nowadays. The pioneers were satisfied if they could have a doctor only at most critical illnesses." Is this the trouble—are people expecting too much or does the growing interest in health indicate a changing attitude toward medical services which should be encouraged?

Doctors have always said that one of the most effective solutions to health problems is the education of the people in caring for their health. Now that very education is beginning to bear fruit. There may be some people today who believe that health is a blessing from heaven and sickness a punishment for sins or the possession of devils, but the majority now know that sickness has natural causes and that much can be done to prevent disease and promote health. People know of the achievements of their own family doctor in curing disease; they read daily in the newspapers and magazines of the miracles specialists have wrought in the treatment of strange disorders; they hear of the amazing advances of medical science far beyond the limits of cure to the more distant horizons of pre-
vention and eradication of disease. People have, therefore, come to expect of medical service not merely care in time of acute or serious illness; they have come to expect that it will prevent disease, promote health, and enlarge life.

Yet what is the actual situation? Knowledge to cure and prevent many diseases exists in the medical sciences but the trouble is that this knowledge far outruns both the understanding of the people and the machinery by which it can be made available to those who need it. When such a situation exists, there tends to be between the doctor and the patient a loss of mutual understanding and confidence. The great challenge, therefore, facing both the medical profession and the general public today is, how can existing medical knowledge be made available to all the people? It is felt by many that were a solution to this found it would prove the greatest contribution to the battle against disease, misery, and want.

To this problem, however, there is no simple answer; it is tied up with our whole social and economic organization. But the way in which the people of Nebraska have raised questions about meeting their own family health and medical needs may point the way to the methods of solution. Their questions indicate that many people no longer look upon health as purely a personal concern; they see it also as a community responsibility. These people know that alone each family cannot protect itself from an unsanitary milk supply nor against a water supply that may carry typhoid; alone it cannot arrange that a doctor come to a community where there is none; alone few families can bear the financial burden of long and serious illness; alone few doctors can make available the most costly advances of medical science based on the most recent medical discoveries. To many people it is becoming clearer that the only way each family can assure for itself satisfactory health and medical services is through uniting with other members of the community in a cooperative effort with doctors, dentists, nurses, and all health agencies to plan a consistent and persistent drive against the forces of disease.

"But Nebraska is such a healthy state," some people explain. "We don't need to organize against disease. The state is favored by having a healthful climate, a sparse population which discourages the spread of communicable disease, and in certain parts of the state such a deep layer of sand that it acts as a natural filter to the water supply. Compared with national averages, the state has a low death rate from tuberculosis, little reported typhoid or diphtheria, and a lower than average rating for deaths of mothers and children."

"But that is just the trouble," others protest. "We don't have the sensational conditions of some southern states such as malaria or hook worm, and so we close our eyes to needs which are no less pressing, just because they don't make newspaper headlines. With such favorable natural conditions, Nebraska could well take the lead among states in the conquest of disease. Instead less favored areas are showing what organized community effort can do to lessen disease."

In the face of this difference of opinion it is important to determine what the situation actually is.
II. HOW HEALTHY ARE WE?

HOW healthy we are in Nebraska is difficult to know since there is in the state no systematic recording of how much sickness there is and what kinds of sickness are most common. Such recording is a first essential to planning a successful attack against disease, yet who does not know neighborhoods where the children have scarlet fever, measles, or whooping cough and where no one either calls a doctor or reports the disease? Who does not know families where there are other types of even more serious illness and no call is made on a doctor? In the absence of any systematic recording of sickness, we can only estimate the amount in the light of extensive studies which by wide samplings have shown up the defects and disease in our general population.

It was not until the first world war (1914-1918) that we gave much serious thought to the question of health needs among our people. When we learned that two out of every five men examined for the draft showed some physical defect or disease and that one out of every five was rejected as unfit for military duty, we became concerned. Since then, however, extensive studies made by house to house canvass in thousands of homes throughout the nation have revealed that just such conditions of defect and disease exist among our general population. Of some of these the individual is aware; of others he is ignorant. Dental needs are even more striking than medical ones. Many studies show that only 20 per cent of the people receive dental care except in occasional emergencies. The Farm Security Administration found in the region including Nebraska, that in 55 per cent of the families seeking loans, failure to succeed on their farms had been due to ill health.

A national health survey made in 1935-36 by a house to house canvass among 800,000 families including 2,800,000 persons in 83 cities and 23 rural areas in 19 states, revealed the startling amount of sickness that exists throughout our land. From the number of illnesses found on the day of the survey, it was estimated that 6,000,000 persons in the United States are unable to work, attend school or carry on their usual duties each day during the winter months on account of some illness or accident. Serious illnesses disabling a person for a week or longer struck one out of every six persons. These illnesses alone, which are disabling for a week or longer, if spread out among all the people of the United States would mean that every person would lose ten days from serious illness each year.

Among these longer disabling illnesses, respiratory diseases such as influenza, grippe, tonsillitis, ranked first; chronic diseases such as those of the heart, kidneys, rheumatism, and cancer take second place; infectious diseases ranked third; accidents fourth. The vast amount of disabling illnesses across the country can perhaps best be seen by the accompanying illustration (Fig. 1).

In Dawson county, Nebraska, a survey among 358 families of home demonstration club members showed that in 1939 sickness serious enough to disable a person for a week or longer struck one out of every seven persons in these families. It also showed that the order and ratio of dis-
abling diseases among these families were very similar to those for the nation except that accidents exceeded infectious diseases. Considering that Dawson county represents the more prosperous sections of Nebraska, there is little reason to believe that health conditions among the people of the state differ to any marked degree from the average for the general population of the United States. Once again war has called our attention to the state of the nation's health. Of those volunteering for military service in 1940 in New York State, 30 per cent, or nearly one out of every three men volunteering, have been refused as physically unfit. Many people, recognizing the necessity of physical fitness for war, are raising the question whether it is not equally important that people be physically fit for the increasingly arduous tasks of peace.

III. PREVENTABLE DISEASES

The toll of sickness and death caused by many diseases can be markedly lessened by applying existing medical knowledge in an organized manner. Let us, therefore, consider some of the diseases which communities in Nebraska through organized effort could lessen and even wipe out.

Mothers and Infants

A first concern of every community is the protection of our most important institution—the family. In every home the mother is considered the most important influence in molding the lives of future citizens. Communities build agencies like the school and the church to help the mother in her task. But where in Nebraska is there any similarly organized community effort to protect the mother's health as the prime essential to her carrying out her duties to her family? In family health matters the mother bears the first responsibility to diagnose sickness and determine what should be done. Yet, what community organized effort exists to help the mother, if necessary, in guarding the health of her family?

It is true that Nebraska can be proud of its low death rate of mothers and infants. Some doctors have done a splendid piece of work in educating the mothers who are their regular patients to come early in pregnancy and continue to come at regular intervals for a year after each child is born to assure the best protection of mother and child. But is there any assurance, based on organized community effort, that all mothers in Nebraska receive such help?

Few homes can afford to lose a mother and few wish to experience the sorrow of the loss of a child. Over a period of ten years, 1928-37, one out of every two hundred mothers in Nebraska died from complications of childbirth each year. During this same time, one out of every thirty-three births were still births, and one out of every twenty-two babies died within the first year. Perhaps statistics make this seem removed, but what if this happened in your family?
It has been estimated that, if adequate care were given, the deaths of women in childbirth could be reduced to one-half or two-thirds of the present rate. Through the United States Children's Bureau, appropriations have been made so that states wishing to can improve their community programs for the protection of the health of mothers and babies. Yet except for one county in Nebraska, there is no use made of the opportunity to develop such a program.

In so far as the well-being of any community depends upon the well-being of every family it would seem important to consider what a community health program might be which would put first emphasis on giving guidance in health measures directly to the mother in the home.

**School Children**

We become most concerned with children's health only when they have entered school. By law, school children are given physical examinations every year. These are usually given by teachers who are conscientious but ill-prepared to give these examinations. Each year a long list of handicaps is reported to the State Department of Health from every school district. Defects in teeth, throat, and eyes which might much more easily have been checked before the children ever entered school for the first time, yearly make the same long list. Occasionally a nurse or doctor makes the examination. When this happens the results may even be less satisfactory, for the danger is then that the community may sit back in the comfortable
belief that it has done its duty to its children. Such a community may forget that a mass inspection of school children by even a doctor or a nurse is not a physical examination and is inadequate except for gross defects, that such inspections are mere gestures unless there is a community-organized follow-up to convey to parents the importance of treatment, and to see that treatment is received when necessary. In a few communities in the state there are good school health programs. Although such communities should be highly praised for their efforts, it is hoped that they do not lose sight of the fact that the best results in terms of time, money, and constructive results can never be realized until the school health program is knitted into a broader community health program.

One defect found so frequently among children—that of the teeth—may be illustrated. A survey made by dentists in the state showed that conditions in Nebraska are much the same as elsewhere in the country, namely that approximately nine out of ten school children had decayed teeth or diseases of the mouth. The dental condition among children is even more serious than this would seem to indicate. A dental survey of 70,000 school children twelve years of age found that more than 90 per cent had either a decayed or filled permanent first molar or had lost one by extraction.

In our ignorance we have given little thought to the importance of condition of baby teeth, not only in the development of sound permanent teeth, but also in regard to general health. We have made little effort to build a preventive dental program for children—yet such a program would be much less costly than the expensive medical and dental treatments of later life that could thus be avoided to a marked degree.

Childhood diseases have become less acute, yet year after year epidemics of preventable infectious disease continue to break out and people take for granted that children must go through having measles, scarlet fever, whooping cough, and perhaps even diphtheria or small pox. Yet if we really wanted to apply existing knowledge regarding the prevention of most of these diseases, they could be wiped out. The most effective time to protect children through immunization and vaccination against diphtheria, small pox, and whooping cough is within the first year of life, but in how many families in Nebraska is this done? In the absence of any modern public health program vaccination and immunization tend to be given only during a "scare," and their importance is forgotten until the next "scare" occurs. In the absence of the eternal vigilance that a community-planned program entails, there have in recent years been recurrent epidemics of diphtheria and small pox, diseases which no longer need exist.

**Tuberculosis**

“There is a woman in our community who has TB,” explained a neighbor. “For several years now the doctor has told her that she should go to a sanitarium but she has her husband and four children to care for and the fifth one is coming, so she doesn’t see how they could get along without her in the home.”
9 OUT OF 10 SCHOOL CHILDREN HAVE DECAYED TEETH OR OTHER DISEASES OF THE MOUTH

FIGURE 2


The situation calls for immediate sympathy but it also calls for immediate action. For the failure to take care of the mother at this time only means that the community will have to pay later not only for care of that mother, but probably for the care of the husband and five children, as well as any number of other people with whom they have been in contact.

It is known that for every death from tuberculosis, over forty people have been affected and infected by this dread disease. Only a concerted campaign through nursing visits at the rate of twenty for every death can lead to the discovery of those infected. During the year 1939, 219 people in Nebraska died from tuberculosis, yet for every death an exceptionally small number of active cases has been reported. This can only mean that there are many people with this disease who are unknown and who may be infecting other people. Tuberculosis is highly infectious and treatment is very costly in terms of time and money to the individual, the family, and the community. It would seem, therefore, that the most economical thing that any community can do is to build a strong program for the detection and early diagnosis of this disease.

Tuberculosis is one disease against which there has been directed a long, consistent, organized community attack based on the principle of prevention. That such a program pays is shown by the reduction already made in the deaths by this ravaging and costly disease.

But tuberculosis remains a sinister menace, especially to people in the prime of life. In spite of the splendid efforts of the Nebraska Tuberculosis Association and other groups to track down the disease, only a broader community program can be successful in preventing this human and financial waste.
Venereal Disease

"Venereal disease?" asked a rural doctor. "Yes, we have it all right. Surprising in what so-called good families it's found, too. Do I treat it? Yes, sometimes. Last winter there was a man came to me with syphilis. He ran a restaurant in town. Believe me, I made it so uncomfortable for that man that he finally had to leave town."

Where the man went, or how widely he spread the infection after he left is not known. Whether he ever went to another doctor to continue his treatment after his experience with one who judged his morals before he treated his sickness, is uncertain. There is no assurance that he did not establish a restaurant in the next town in which he located. Can we afford to take such a limited view of our responsibility to wipe out this great plague?

It has been estimated that syphilis strikes one person out of ten in the nation, and that gonorrhea affects even more. Because syphilis is "the great imitator" many people with heart trouble, digestive disorders, and other serious illnesses do not always know that it is in that form that venereal disease has shown itself.

In 1939 there were 58 deaths recorded from venereal disease in the state. The actual extent of such disease, however, is not known, and only in the southeastern corner of the state are there two struggling clinics for treatment. The state health department receives through matched funds and outright grants, federal assistance to campaign against venereal disease. This year, however, it returned to the federal treasury $30,000 allocated to a venereal disease program. Meanwhile some neighboring states have made considerable progress in building an effective program against venereal disease.

Cancer

In 1939, 1,582 people in Nebraska died from cancer. For the state, as for the rest of the country, it is the second greatest cause of death. There is little help except through early diagnosis, but many people do not even know when they have cancer. It is estimated that one person out of every eight who reaches the age of 45 will ultimately die of the disease. On the other hand, it has been estimated that at least one-sixth of all deaths might be prevented if all cases received the benefits of medical treatment and additional deaths could be prevented by early diagnosis. Yet without an educational program through a public health department prevention is almost impossible.

Chronic Disease

Heart disease, kidney trouble, and other degenerative diseases are increasing in importance in the cause of death and disability in the older age group. If we were to become equally concerned with these serious conditions that develop slowly as we do about a sweeping epidemic, many of these diseases could be checked at an early stage and life prolonged.

To sum up—in spite of favorable natural conditions, there exist in
Nebraska many preventable diseases which only through better organized community effort can be greatly lessened. We give lip-service to the belief that "an ounce of prevention is worth a pound of cure," but our procedure to date would indicate that we prefer to enjoy our ailments rather than to build good health. It costs money to set up a program of prevention, but it costs a great deal less than to treat these preventable diseases after they have become far advanced. To date it would seem that rather than build the less costly program of prevention, we prefer to spend the greater sums involved in maintaining sickness and in caring for the tubercular patients, the mentally ill, the sick and crippled in hospitals and other institutions—institutions which stand as constant reminders to us of our failure to make use of existing knowledge in the campaign against preventable disease. Because of the very lean years through which Nebraska has been passing, it would seem that it could ill afford to do other than build a program to prevent disease in order to lessen the more costly burden of treatment which it now carries.

IV. COMMUNITY RESPONSIBILITY FOR THE PUBLIC'S HEALTH

That the health of the people is a community responsibility is recognized in that every unit of government sets up some agency to guard the public's health. The adequacy of this organization to meet modern health needs must, however, be tested by its use of existing medical knowledge to protect and promote the public's health. Can the present public health organization in each community meet this test?

County Health Organization

Every county in Nebraska has a local board of health and every city also has such a board. The county board of health is composed of the sheriff as the chairman, the county school superintendent as treasurer, and a medical adviser; the city board is composed of the mayor, chief of police, and a medical adviser. Unfortunately the members of these boards
are ordinarily so busy with their regular work that they can give but little time and thought to an *ex-officio* position or appointment. As a general thing two members of each board have had little if any training in matters of sanitation and the control of infectious diseases. The real work of each board is usually dependent, therefore, upon a single man, the medical adviser, and he usually serves only on call.

Every community can take some pride in the institutions which it has built to meet our modern needs. We can point to the school in which we educate our children or the church where religion and morals are taught; we can turn to the fire department to protect our houses from destruction or to the local police for protection against law breakers; we can look to the extension agent for advice about crops, and diseases of horses, cattle and fowl. But to what agency can we turn in a similar manner for advice on community conditions which may affect the family's health? Where can a family turn for advice about improvement in sanitation or disposal of excreta on the farm or in a small town? Where can a family get advice as to the most sanitary place to put a well? Where can a mother turn to make sure that even the pasteurized milk she may give her children is not from a very poor source? Where can a teacher get help with the health needs in her school? How can anyone be sure that the food he eats in any restaurant in Nebraska is not contaminated? How can any one be assured that his family is protected against tuberculosis or even venereal disease?

A few counties, six out of the ninety-three in the state, can point with pride to their county nurse. These nurses, however, have had no public health training and lack adequate medical direction. They tend to become investigators for the public assistance office, determining medical care needs among relief families in an effort to lessen the indigent medical bill in the several counties. Of the fourteen school nurses located in towns and cities other than Lincoln and Omaha, all but two lack training in public health and all lack the medical direction essential to giving most effective service. Communities, therefore, which have been interested enough in health matters to employ a nurse should study the advisability of developing a broader community health program. Careful study has shown that no matter how splendid a piece of work one nurse may do, the community cannot get the best returns from its investment until that nurse's work is integrated in a broader community health program and she can have the medical direction that only public health organization can make possible.

In many communities doctors and lay organizations have shown fine leadership in improving certain health conditions. Service clubs, women's clubs, parent-teacher associations, and other organizations have conducted projects for immunization of children, dental care, and tubercular testing. Without public health leadership, there is, however, no assurance that these projects will be carried on consistently year after year. Often willing groups say that before the bewildering number of health needs, they scarcely know where or how to begin, and wonder if what they do undertake is as constructive as it might be. They ask for leadership which
physicians, by the nature of private practice, cannot very well give. It is difficult to know from where that leadership can come except from a modern community agency concerned with guarding the people's health—in other words, a modern local public health department.

What is a Modern Local Health Department?

A modern local health department serves a county, or group of counties if the population is not large, under an advisory health council for the area to take the place of the many local boards of health now functioning. Such a public health unit consists of a director trained in public health to give leadership to community efforts for health improvement, a sanitary engineer concerned with milk, water, food supplies, and sewage disposal, and public health nurses to spread health education to each home and interpret family needs to the doctor and the doctor's order to the family.

The activities of such a department are along the following lines: (1) vital statistics—that is, the gathering of information about disease as basic information in the fight against sickness and death; (2) health education;
(3) maternal and infant care; (4) the school health program; (5) communicable disease control and prevention, including tuberculosis and venereal diseases; (6) sanitation; (7) laboratory service; (8) nutrition, public health dentistry, and other activities as the health consciousness of the community develops.

In all these activities, the major aim of the local public health unit is the health education of the people and the doctors to a better understanding of the forces that prevent disease and determine good health. Its success depends upon the extent to which it gives direction and coordinates the efforts of all groups concerned with the improving of the public's health, broadens the work of local doctors in disease prevention, and above all, strengthens the bond between every family and its family physician in his private practice.

What would a County Health Program Cost?

The United States Children's Bureau has estimated that a minimum county health unit serving a population of 20,000 would cost $10,000 a year, or 50 cents per person. In Nebraska, it has been estimated that a tax of one mill would give an average minimum of health unit activity, and a tax of two and one-half mills would give a maximum of health activity. The survey of public health activities in Nebraska in 1937 showed that 33 of the 93 counties in the state were spending nothing on preventive health measures; of the 60 counties which made some expenditures for public health 37 spent 3 cents or less per person. As long as there is no preventive health program every county will continue to bear a heavy burden of caring for indigents. This burden will consist not only of the cost of medical care for sickness that might have been prevented at much less cost, but also the cost of maintaining families who have become so broken in health before receiving needed medical treatment that they become permanent public charges. Considering this burden, it becomes evident that the initial investment for a program of health prevention is the best-paying investment that any community can make to improve the health of all the people and to lessen the present costly burden of caring for the sick and needy.

Several counties might unite to form a public health unit of from 50,000 to 70,000 population. The cost of the program would then be shared. When such a unit is established, any funds raised in the county for public health can be matched by federal funds if the state department of health so wishes. This would mean that counties that already raise some funds under public or private auspices for public-health purposes could make such a program at least doubly effective.

Are There Local Health Units in Nebraska?

For a short time a demonstration of a public health program was conducted in four different areas in the state covering nine counties. This demonstration was supervised by the Nebraska Department of Health but financed mainly by the U. S. Public Health Service and the Children's Bureau. When, however, the state legislature in 1938 cut the budget of
the public health department by almost one-half, it was possible to con-
tinue these demonstrations in only two areas, one of which includes Scotts
Bluff, Morrill, and Banner counties, and the other includes Lincoln and
Keith counties. Although the activities of the demonstration units are
restricted, they serve to show something of the contribution that can be
made by a public health program.

Today the situation is the same as in 1937 when a survey made by
the United States Public Health Service of public health activities in Ne-
braska pointed out that outside the city of Lincoln and except for the
demonstration units maintained by the U. S. Public Health Service, there
is no county in Nebraska which maintains a public health department.

This survey further pointed out that even if there are counties in
Nebraska which might be prepared to develop a public health program,
they would not be able to do so because there is no legislation enabling
them to do so. Until such enabling legislation is enacted, federal funds
available for local developments in public health under local leadership
must be returned yearly to the federal treasury. Until local public health
organizations are formed, the people who are asking for help in meeting
their family health needs, whether in regard to home care of the sick,
health habits in the home, sanitation, protection against tuberculosis
or venereal disease, or what to do when the first signs of heart trouble,
kidney trouble, or cancer appear, will go without much of the needed
health education, early diagnosis, and treatment.

State Health Department

Leadership in the promotion of health and prevention of disease on a
broad community basis rests primarily with the state department of health.
The major role of the state department should be that of an educational,
advisory, coordinating, and stabilizing agency giving direction and specialist
advice to local health departments. But in the absence of local health
units, the state department of health undertakes, with a limited budget
and limited staff, the enormous task of providing laboratory and statistical
facilities, public health engineering, making special investigations,
giving advice in regard to communicable diseases, maternity and infant
care, school health, preventive dentistry and other public health matters
over a state that extends 420 miles east and west and 210 miles north and
south.

Partly because of the lack of development of local health units, the
state is unable to use the funds allocated to it by the U. S. Public Health
Service and the Children's Bureau either on a matched basis or as outright
grants for furthering public health. For the fiscal year 1939-40, $71,155
of the funds allocated by the U. S. Public Health Service was returned
to the federal treasury in addition to $54,274 previously not utilized. For
the same fiscal year $107,362.22 of the funds available from the U. S.
Children's Bureau was unused.
Recommendations for Strengthening Our Public Health Organization

Thoughtful citizens who have tried to understand why Nebraska lags behind its neighboring states such as Kansas, Iowa, and South Dakota in the development of public health have decided that perhaps the first step to take is to strengthen the state department of health. It has been suggested that one need is to protect the department from political change. The state medical society suggests the appointment of an advisory health council to which the director of health would be responsible. It has been the hope of many people that such a council, if established, would comprise not only members of the medical profession, but also citizens with broad social understanding so that a comprehensive outlook on public health may be developed.

The survey of public health activities in Nebraska made by the United States Public Health Service during 1936-37 pointed out that one of the factors that hinders the development of public health service in Nebraska is misunderstanding about the meaning of public health. The report stated that "Physicians in some communities apparently confuse public health (preventive medicine) with the practice of medicine and oppose the establishment of health units on the ground that this is actually state medicine and will hurt their private practice. These doctors have not considered or do not realize the tremendous amount of aid a well-organized health unit can be to them and to their private practice. . . ." The survey, therefore, recommended that one of the greatest needs in Nebraska is the establishment of a division of health education in the state department of health so that a broader understanding might be developed among the medical profession, as well as the laity, as to their health needs and responsibilities.

Recognizing, however, that neither a program of health education nor disease prevention can be effective unless it is an integral part of every community's organized activity, the survey's strongest recommendation was that permissive legislation be enacted to enable counties or groups of counties to establish full health units, such legislation to include the permission to levy a tax for health purposes.

A number of other significant recommendations were made by this survey and individuals and groups interested in a health program in the state would do well to study these recommendations in the report available at the state department of health.

More than twenty years ago, Nebraska was on the road to building an effective health program for the state. A law passed in 1917 strengthened the state department of health so that it was ready to develop a good public health program. Then came the war to halt all such developments. Since then, however, little progress, if any, has been made in regaining the standard attained in 1917. The reasons for this lie deeper than the need for economy, for states poorer than Nebraska have developed more extensive public health programs. The reasons may lie in the answers to the following questions: Why is Nebraska today among
a group of eight states lowest in the use and application of both state and federal resources for public health services? Why were $30,000 for a campaign against venereal disease returned to the federal treasury this year when the two venereal disease clinics of the state are having such a struggle to survive and little else is being done to attack this disease? Why, in the light of the need for public health, is it not possible to use federal funds available for training physicians, sanitary engineers, and nurses in public health? Where does the major responsibility for leadership in public health lie?

As we drive along our splendid state highways, it might be well to recall that every mile of concrete highway has cost approximately $25,000. The state appropriation for the fiscal year 1939-40 for the health protection of its 1,313,468 citizens amounted to $26,780. Is the people's health worth so little more than a mile of concrete highway?

V. MEDICAL SERVICES

Public health organization to protect and promote the people's health is something to which we have given little thought. Health as such is something many people think little about until they lose it or become seriously ill. Then they turn to their doctor and expect him to patch them up. If they do not recover quickly, they may listen to their neighbors' advice about this or that cure and this or that distant hospital or clinic. Sometimes they may take a costly journey in search of treatment when perhaps satisfactory treatment could be received in their own community. The tendency to search for medical aid outside the home community, however, is an indication that people in time of serious illness want more than the personal relationship to their doctor; they want the help that modern medical science, ordinarily available only in well-equipped hospitals and clinics, can give. It is important to consider, therefore, the quality of medical services provided by our physicians, nurses, dentists, and hospitals, the availability of these services, and the extent to which they are used by those who need them.

Physicians

Nebraska can pride itself on having a medical profession whose standards rank high among the states. It has almost as many physicians in relation to the size of its population as the average for the United States; there is one physician for every 803 persons in Nebraska as against the national average of one physician for every 781 people. Measured against the desirable standard of one physician for every 700 people, Nebraska has almost a sufficient number of physicians. The distribution of these physicians, however, presents a less favorable picture. Whereas in Lancaster county there is one physician for every 469 people, in Loup county, which

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2 State appropriation for public health, 1939-1940, submitted by the Nebraska State Department of Health, to the United States Public Health Service.
3 The figures used throughout the report are based on the preliminary population figures for the state, 1940, U.S. Bureau of Census, except where noted otherwise.
has a population of 1,778, there is no physician. In five counties there is no physician. In some counties the amount of service rendered is limited by the great distances to be covered. In Cherry county for example, there are six physicians serving 9,627 people, or one physician for every 1,605 people distributed over an area of 6,000 square miles; Sioux county has one physician for its 4,257 population spread over an area of 2,055 square miles.

The problem of physicians in some rural areas of Nebraska is much the same as that which the studies of the Committee on the Costs of Medical Care showed for other rural sections in the United States. These studies showed that in many rural areas the physicians are older men who frequently have not been able to keep up with modern medical advances. Many are removed from the well equipped hospitals and laboratories which are so essential to the practice of modern medicine. Many are among that one-half of general practitioners in the United States, whose incomes, even in 1929, were under $2,500. Their office maintenance and transportation take up more than the 40 per cent of total earnings that is the average cost of office overhead for the general practitioner. They spend approximately one-half of their time waiting for patients because people seldom seek their services except in time of serious illness or accident. Under such limitations, many of these physicians have given a lifetime of great service to their communities. When they leave, however, few young physicians are willing to take their places; there is neither the security of income that they desire nor the hospital and other facilities so essential both to the practice and to the study of the ever expanding developments of modern medical science.

**Dentists**

The situation among dentists is similar to that among physicians. The state is fortunate not only in having a large number of well-qualified dentists but also in having a larger number in relation to the population than is true for the average of the United States. According to the State Board of Examiners there are approximately 1,035 dentists in the state in 1940. This means that there is one dentist for every 1,269 people in Nebraska as compared with one dentist for every 1,724 people in the United States. But again dentists, even more than physicians, are to be found in the larger centers of population and less in the rural areas. It has been estimated that if all the people in the United States received adequate dental care the number of dentists could be doubled without exceeding the true need.

**Nurses**

The supply of private nurses is probably sufficient to meet the present needs, but again few are to be found in the rural areas where need is greatest. Because of a complexity of reasons, nurses frequently remain at home waiting for a call while sick persons in the community need their services. There is a serious shortage of nurses trained in public health
WORK OF A VISITING NURSE

According to the directory of the American Medical Association in 1940, there are in Nebraska 89 general hospitals totaling 4,613 beds, an
In 1940 there were 1,635 physicians in Nebraska, or 150 less than in 1931. The location of physicians parallels rather closely the density of population in the state. (Source: Directory American Medical Association.)

average of one bed for every 285 of the population. This measures only fairly favorably against the professional standard of adequacy for general hospitals of one bed per 218 persons or 4.6 beds per 1,000 persons. In thirty-nine of the ninety-three counties, there are no registered general hospitals. This means that for some people the distance to a hospital is fifty miles or more. Then there are the contrasts such as between Douglas county where there is one hospital bed for every 139 persons and Custer county where there is one bed for every 896 persons. The situation may be studied more fully in Figure 7.

The problem is not only one of hospital beds but even more important, the use of those beds. In a recent study of a rural state, it was found that people were using the hospitals only half as much during these drought years as formerly. It is difficult to believe that their actual need for such service has lessened. According to the hospital survey made by the American Medical Association in 1939 between 50 and 60 per cent of the general hospital beds in Nebraska are occupied. This, according to a state authority, in turn results in a situation in which not a single hospital in Nebraska is paying its own way unless it has some support from public funds or private endowment. Thus a hopeless circle is formed while people go in need of hospital care.

The outstanding aspect of the situation is, in brief, that quite apart from the question of the extent to which medical facilities meet the need, those that do exist are not used to the fullest extent. Practitioners, well qualified and willing to serve, wait for patients, and hospitals remain half filled, while people go in need of medical care. Even young physicians establishing themselves in private practice have had little training in public health while people go in need of the knowledge of preventive health measures. Is there nothing we can do to improve this situation?
In 1940 there were 89 general hospitals in Nebraska including 4,613 beds. There were ten other hospitals for special diseases such as nervous and mental, tuberculosis, and orthopedic. (Source: Directory American Medical Association.)

VI. PAYING FOR SICKNESS

Upon each individual family rests the major responsibility of paying for medical services. Eighty per cent of the burden of sickness is borne by the patients themselves. For the entire population the bill for medical services each year amounts to over three billion dollars. Of this amount only one dollar goes to public health services for prevention of disease for every twenty-nine dollars that are spent in treatment. For a large part of our population at least, this negative approach to health can mean only worry, debts, unemployment, a reduced standard of living, more sickness and more debt.

Who does not know from the experience in his own family or the family of some neighbor what the meaning of sickness is in such terms? Any neighborhood can soon relate circumstances similar to the following reported casually from a small rural area in Nebraska:

A mother postponing medical care until too late because of her anxiety to get her children what they needed and not add one more worry to her husband's financial troubles during these long drouth years.

A young boy dying before he could get to the operating table because of the lengthy investigation needed by hospital and relief department before a poor but independent family could get assistance in this one emergency.

A prosperous young family set back for years by the heavy medical bills for a long and serious illness.

A family remaining on relief indefinitely because of the failure of relief officers to appreciate that the cost of an operation for hernia which would make the man physically fit would amount to a lot less than the
cost of keeping him indefinitely on relief because of a condition that could be treated.

Two children with tonsils and adenoids in condition serious enough that the children are becoming deaf, but not serious enough to warrant the "emergency" care possible through the Farm Security Administration's medical loan.

It is the cumulative force of just such situations that makes the statistics of sickness throughout our country roll into the hundreds of thousands.

**Can We Not Afford Good Medical Care?**

The actual amount of money spent by the average family for medical service is no more than it spends on candy, tobacco, and ice cream. In the nation-wide study conducted by the Committee on the Cost of Medical Care, appointed by President Hoover during 1928-31, it was found that families with incomes under $1,200 spent on the average $43 a year for medical care. Of this amount 18 per cent went for medicine, 48 per cent to doctors, 15 per cent to dentists, and 9 per cent for other purposes. An analysis made by the Extension Service of the University of Nebraska in 1938 of the total living value of 185 farm families showed that during that year, 66 families whose incomes (money and nonmoney) ranged from $1,000 to $1,500 spent on the average $48.00 for medical service; 85 families whose total living value ranged from $500 to $1,000 spent on the average $25.15 for medical services. A similar study of 369 families who were Farm Security borrowers showed that these families spent, of their own funds, on the average $15.32 for medical services. These studies illustrate one aspect of the problem, namely, that medical care is received in relation to ability to pay, rather than in relation to need for such services.

**Sickness Is Unpredictable**

Why does our present policy of paying for sickness rather than for the maintenance of good health present such a special problem? The trouble is that sickness is unpredictable both in terms of when it will strike and how much it will cost. In any given year about half the people have little sickness and very low sickness bills; about one-third have moderate sickness bills; while the remaining one-sixth have very high bills. No one is sure that he may not be among the unlucky one-sixth in any year. Then, too, as conditions now stand, the family with the greatest amount of sickness must carry the biggest burden, even though the very sickness makes the family less prepared to carry such an additional burden. How the burden of sickness is carried can best be seen in the illustration.

**The Burden Bearers**

Bearing the burden of sickness becomes more serious when we consider where sickness falls most often. The National Health Survey for 1935-36 verified the findings of earlier health surveys in showing that the people who can least afford to pay for sickness have the greatest amount of it. As incomes decrease, sickness not only increases in frequency but also in
Sickness costs fall unevenly. (Courtesy Public Affairs Committee.)

severity. For example, chronic disabling illnesses occurred among families on relief at a rate 57 per cent higher than among families of incomes of $3,000 or over. The illnesses that did occur lasted 63 per cent longer among relief families than among families in the higher income brackets. To a somewhat lesser degree this same condition was true of the families just above the relief level.

The problem is intensified by the fact that not only does sickness increase as incomes decrease, but also medical service received decreases as incomes decrease. In the case of disabling illnesses lasting a week or more, one out of four people receive no medical care whatsoever among 20 million people in the relief groups or among the 20 million people who can purchase it only at the risk of curtailing food, clothing, shelter, and other essentials of health and decency. The total situation may perhaps be best seen in Figure 9.

Thus families in the lower income brackets are caught in a vicious circle; they have the greatest amount of sickness; sickness leads to unemployment; unemployment leads to a reduced standard of living; a reduced standard of living leads to more sickness; more sickness leads finally to dependency; and then we provide free medical services. When the Technical Committee on Medical Care, appointed by President Roosevelt in 1936, made its report, it was forced to state the unhappy conclusion that in spite of all the brilliant advances of modern medicine the poor of our cities (and farms as well) experience sickness and mortality rates as high today as were the gross rates for the nation fifty years ago.

**How Many Are Medically Needy?**

The American Medical Association in its Factual Data on Medical Economics for 1940 shows by a chart and commentary that there are three groups in our population who present medical and economic problems: first, the indigent, who are a community responsibility; second, the group having incomes up to $1,500 a year, who have variable needs for
assistance when they have minor illnesses and who are the most important economic and medical problem when they have major illness; and third, the group having incomes between $1,500 and $3,000, who carry their own load of minor illness but sometimes need help for major illness. Both these income groups, however, present a serious problem more economic than medical in regard to chronic illnesses. How large these groups are for whom some planning is needed is important to consider.

In 1935 the National Health Survey found that in urban areas 15.6 per cent of the persons canvassed were in families who were on relief; 44.3 per cent were in families whose incomes were less than $1,000; 65 per cent were in families with incomes under $1,500. In rural areas the situation is more acute, 72 per cent of farm families having incomes under $1,500.

Even in our peak year of prosperity, 1929, a large proportion of our population was still in the lower income brackets. This may be seen in Figure 10.

It is not known how Nebraska compares with the average for the country as far as income levels are concerned, but there are many indications that it cannot be above the average. The percentage of the population on relief is similar to that for the nation as a whole. Upon careful analysis of all those in receipt of public assistance in January, 1940, the state assistance office estimates that 16 per cent of the population was on some form of relief at that time. Federal income tax returns are a rough measure of the percentage of the population who have an annual expendable income of $2,000 or more. In 1937, the percentage of people filing income tax returns in Nebraska was 3 in contrast to 4.9 per cent for the country as a whole. In Dawson county, 40 per cent of the home demonstration club women stated that their annual income, including value of home supplied products was under $800 in 1939; 16 per cent stated it was between $800 and $1,000; 24 per cent stated it was between $1,000 and $1,500. In other words, 80 per cent of the families represented in the project clubs had incomes under $1,500. Although nationally, 72 per cent of farmers have incomes under this amount, there is little reason to believe, considering the long drouth years, that 80 per cent for Nebraska is not a fairly accurate picture even for its more prosperous sections.

What are the Implications of This for Nebraska?

In the light of the fact that such a large number of families are in the income levels where sickness is most frequent, and considering the special problems of availability of medical services characteristic of rural areas, it would indicate that Nebraska is in very real need of improving its health services.

VII. INVESTING IN HEALTH

Developing a program of health is a complex task. What it involves is perhaps best summed up in a recent article by Dr. C. W. M. Poynter, Dean of the College of Medicine, University of Nebraska, in which he says:
"For the last five hundred years the medical profession has thought in terms of relief of disease. We now know enough to begin to work on an entirely different angle, namely, the maintenance of a buoyant and efficient health for our public. This will require for the education of the profession, in fact, a radical change in their thinking and a larger education of the public. It would not be as expensive a program as the one we now follow. If the individual solicitously attempted to maintain his health rather than let everything go by the board until he had collapsed and had to be taken to the hospital, the program would not be as expensive to maintain and the public would be receiving treatments of a minor character as preventive measures rather than the radical procedures which we see in all of our hospitals today. Even in this program there is a question of cost and the cost must be borne by the public since they are the only source of funds and the only society benefited. Our dilemma in medicine at the present time is to produce a sense of the value of health on the part of society and a willingness to organize ourselves and budget for this just as we budget at the present time for silk stockings, jewelry, clothes, homes, or food."

A satisfactory program of medical care and health services for Nebraska depends fundamentally on the character of the country and its people. Nebraska is essentially a sparsely settled great plains state, with a population of 1,313,468 spread over approximately 78,000 square miles. In 1930, 42 per cent of the people were on farms; 23 per cent were in towns...
of less than 2,500 population; 14 per cent were in cities of from 2,500 to 25,000; 21 per cent lived in Omaha and Lincoln, the two largest cities of the state. Hence it is evident that organization to meet health needs must be set up primarily to serve small towns and cities and sparsely settled rural areas.

**Essentials of a Health and Medical Care Program**

The Committee on the Cost of Medical Care and other groups of physicians and laymen have recommended certain essentials of a satisfactory health and medical program for small towns and rural areas. These groups consider that a satisfactory health program depends upon the close coordination of the three main channels through which health services are now provided. They are (1) practitioners—physicians, dentists, nurses; (2) hospitals; (3) the public health organization. They recommend further that the hospitals become to a much greater extent the center of health and medical facilities. A modern well-equipped hospital, they point out, offers the general practitioner the only real opportunity for the study, diagnosis, treatment, and prevention of disease through the use of X-ray, laboratory, and many modern facilities that no general practitioner can afford alone. The hospital also offers the physician the valued opportunity for consultation with his fellow physicians and specialists.

The Committee does not recommend that a hospital be located in every community but rather that a few well equipped hospitals serve a large area and that the smaller ones, or medical stations located more conveniently to the people, work in close collaboration with the larger hospitals. Instead of each small hospital or medical station trying to serve all cases, it would provide hospital beds for emergency cases, possibly for maternity care, and also for certain minor illnesses. Serious cases would be referred by agreement to the larger hospitals for thorough diagnosis and treatment. In every small hospital or medical station there would be a doctor, a dentist, nurses, and at times a visiting specialist. There would also be a small laboratory and other facilities necessary for carrying on the public health activities of the district. Through such organization the hospital, big or small, would be the center, not only for medical care but also for all the preventive measures and health education needed in the community. The hospital, in short, would be the health center of the community as the church is the religious center and the school is the educational one.

In many rural areas it will be necessary for one physician to continue to serve as formerly. Where the situation permits, however, a group of physicians working through a well equipped hospital will provide more adequate health services. In the light of the importance of the hospital as the center of health services, communities are encouraged to study their hospital needs in relation to their ability to support such service. The federal government has already taken steps by which rural areas may be assisted, through state and federal funds, to provide hospital services.

In building a comprehensive health program some people would put their major emphasis on a strong program of public health; others would
seek ways by which security against the financial risk of sickness could be developed. To many people both approaches are essential parts of a health program whose goal is to prevent disease, prolong life, and promote physical and mental efficiency through organized community effort. No goal short of this, say these people, is enough in the face of modern science.

A comprehensive program developed through the coordination of existing health agencies would make its advance against disease along the following fronts: (1) a community public health program that would put its major emphasis upon broad community measures for disease prevention and treatment of costly diseases; (2) a more satisfactory health program for dependent families; (3) an opportunity for independent families to provide, through group effort, more satisfactory health services.

**Paying for Health and Medical Services**

Whatever development in health and medical services takes place in Nebraska depends in the last analysis upon what the people are willing and able to afford. It is important, therefore, to consider some of the methods we now employ to pay for health services and changes that are being made to meet changing needs.

**For Indigents**

Community action to provide health and medical services has expressed itself in the form of taxation more than in any other way. Hospitals for
the tubercular, the crippled, and the mentally sick are supported from tax funds. The principle of public support through taxation has also been accepted for paying physicians for the medical care of families on relief. Because the large number of these families has made a heavy drain on public funds and taxpayers have been in a poor condition to bear additional burdens, the health and medical services provided have not always been adequate. Many counties are so poor that only cases of gravest emergency receive attention. Considering the various difficulties in this situation and the importance of a constructive health program to rehabilitate people, it is of utmost importance that a fresh analysis be made of the medical care program for indigents. In such a study help may be received from the American Public Welfare Association which has made a special study of the administration of medical care for relief families and has made some significant recommendations for its more effective administration.

For Farm Security Administration Clients

The method used by the Farm Security Administration to provide emergency medical care for families who have secured federal loans for carrying on their farms warrants study since it implies the principle of family budgeting for health services. The Farm Security Administration has made arrangements with the state and the county medical societies by which emergency medical care can be provided to their clients for the sum of $30 a year. Each family's medical loan is put into a common pot and divided into twelve equal parts against which the doctors monthly make their charges for services rendered. Twenty-six county medical societies have adopted this plan in Nebraska. It has meant that Farm Security Administration clients have been protected against the costs of “emergency” illnesses and the doctors have received more money than they would have from the collection of fees from this group. On the other hand, in some parts of the state, physicians have received a low percentage of their fees and clients have felt the need of many medical services not included in this emergency care. In spite of its difficulties the plan is proving a valuable experiment in determining ways of providing medical services for this group and in discovering the amount actually needed to provide medical care. In one section of the country experimentation is proceeding to include the care of the county indigent group in such a plan.

For Independent Families

The group which presents the most hopeful opportunity for providing a health plan rather than a sickness plan includes families whose incomes are above $1,000. It is especially important for the group whose income is under $1,500, which, the American Medical Association has pointed out, presents the most important medical and economic problem. Since any serious illness in these families may mean dependency, it would seem that no more constructive measure could be made to protect both family independence and the community pocketbook than that an opportunity be provided these families to make some regular provision for health services.
These families, some people contend, are getting as much medical care as they want but they are not interested in investing in their health; they prefer to spend their money on candy, tobacco, automobiles, and gasoline. Judgment, however, cannot be passed without more careful analysis of the situation. People buy chocolates and cigarettes according to the money they have in their pocketbook; automobiles are no longer a luxury but a necessity to farmers and many workmen. These and other costly items which a family needs can now be bought on the installment plan when they cannot be purchased by a cash payment. Every family knows in the beginning what the automobile or refrigerator is going to cost and what it can pay per month for it. No one knows when sickness will come or how much it will cost. Few people look with such gloom on life that they set aside a yearly amount for the sickness which they feel is sure to come; many might be much more ready to set aside a certain amount for the protection of their health if that could be arranged with their own family doctor whose services are strengthened by community facilities for modern diagnosis, treatment, and prevention. Until an opportunity for budgeting for health protection is provided, it is difficult to know how big an investment people are really willing to make for protection of their health.

The American College of Surgeons considers that the voluntary, periodic, prepayment plan for families of moderate means offers a reasonable expectation of more effective methods of securing medical service. It suggests that the payment for hospitalization be the first project to be undertaken. The American Hospital Association is ready to assist communities in developing such a project. Already in many parts of the country group hospitalization plans, costing from three to five cents a day, have met with marked success. They have had the happy result not only of providing hospitalization for families in time of sickness but providing the hospitals with revenue needed to make them going concerns.

More and more, however, programs are being conducted and plans considered to provide more complete medical care through prepayment plans. The California State Medical Society has endorsed the principle of insurance. Some county medical societies have established "service bureaus" through which people, willing to have their incomes investigated, can secure medical service in time of sickness at reduced rates and make arrangements for paying in installments. Other plans put emphasis on disease prevention and offer any independent families who wish it, an opportunity to provide for medical and hospital services at a yearly stipulated sum. These plans take various forms and range in cost from $30 to $60 a year per family.

The Ross-Loos Clinic in California is an example of how a group of physicians may provide health protection to a group of consumers. This clinic, manned by 71 physicians, provides medical services, including house calls, diagnosis, medical treatment, surgical treatment of all kinds, eye tests and hospitalization, at a cost of $2 per employed person per month. Family dependents may receive all professional services but are required to pay for hospitalization and for certain supplies and apparatus. People
at a long distance from the main clinic are served through several medical stations manned by three or more physicians and equipped with facilities for minor surgery, laboratory, etc. Recently members and their families numbered over 60,000 persons.

Rural areas have tried various methods to secure needed health services. In Canada, in the provinces of Saskatchewan and Manitoba, over seventy rural municipalities have applied the method of taxation to secure physicians' services. In the United States, some rural areas have offered a financial guarantee as an encouragement to a physician to serve the area. Other rural areas have turned to the principle of cooperatives through which to provide for themselves the services of a physician, hospital, visits of a specialist, and sometimes a dentist for a stated yearly sum. The outstanding rural medical cooperative is the Farmers Cooperative Community Hospital Association in Elk City, Oklahoma. Here, through the leadership of a physician, the farmers bought shares to build a community hospital and then worked out arrangements by which they could have the services of physicians, a dentist, and hospital care. A family of four pays $25 per year for medical services which include physical and laboratory examinations, surgical operations, obstetrical care, dental examinations, X-rays, and extractions. There are additional charges for hospitalization, ($2 per day), anesthetics, operating room supplies, home calls and some other special services. In the spring of 1939, 1,800 families were members of the association.

Many leaders among physicians and laymen consider that these voluntary agreements between a group of people and their physician, or preferably group of physicians, working through a well-equipped hospital, offer a hopeful opportunity for people to secure more adequate health services within their means to pay for them. That people welcome the opportunity to build for themselves some health security by prepayment plans is evidenced by the fact that hospital and medical care plans today include some 5,500,000 people in this country.

Experiments such as these are making a real contribution to discovering the ways by which the health needs of the people may be met. It is by the failure and success of such experiments that, in a democracy, ways will be found of providing health services that are satisfactory to those who serve and to those who are served. The successful plans are those which make possible the following conditions: (1) that the quality and availability of medical service is improved; (2) that the major emphasis is on the prevention of disease and the promotion of health rather than the treatment of sickness; (3) that the people are guided to a more intelligent choice of physician who becomes their consultant in health as well as in sickness.

When physicians and people can come to a common agreement by which the prevention of disease is part of each private practitioner's responsibility to each family, and satisfactory ways of paying for such services are found, the strongest foundation for a health program will be built.
In planning a health program it must not be forgotten that there is a group of independent people who live on such a subsistence level that budgeting is out of the question. Of the forty million people in the United States, almost one-third of the population, living in families with incomes less than $800, only half are on some form of relief; the other half are struggling to maintain their independence. In Nebraska, this group, willing as it is to meet its own medical needs and willing as physicians are to help, seeks neither physician’s charity nor government aid except in dire need. If the members of this group are to maintain their independence, their efforts to provide for themselves medical needs must be supplemented by some community aid. One suggestion has been a combination of taxation and insurance.

No one method of payment will provide medical services for all the people. Numerous methods may be developed such as taxation, insurance, cooperatives, and a combination of taxation with cooperatives or insurance, as well as our present individual paying for medical services. Whatever methods of payment we use, they must be such as to safeguard the best interest of the people and the physicians and provide modern medical and health services. Whatever methods of payment we use there must be only one health program. We cannot continue to have one health program for indigents, another for Farm Security borrowers, another for W.P.A. workers, another for maternal and child health, another for tuberculosis, and still another for crippled children. Whatever methods of payment we use there must be coordination of all these services into one unified health program for all the people.

**VIII. WHAT CAN WE DO?**

EVERYONE knows that health is determined by many factors other than medical services available. Economic and social conditions such as housing, working conditions, and diet, all have their influence directly or indirectly on the individual and community health and welfare. Everything that is being done to improve these economic conditions is in one aspect a health measure. On the other hand, economic and health conditions are so interdependent that while the betterment of economic conditions will improve health, improvement in the availability of medical services will be one of the biggest contributions to the conquest of disease and poverty. When people ask for health protection they have in mind essentially two things: (1) the protection of their family against diseases which the application of existing medical knowledge can prevent or greatly lessen, (2) security against the continuous financial hazards of illness.

There is no one answer to improving health services in any community. Different needs demand different solutions. The most important single step, therefore, that any group can take is to study their local needs and determine the best ways of meeting them. The American Medical Association has encouraged such study, pointing out that when local health needs are met there is little danger of state medicine. Every community, therefore, that forms a study group, health committee, or health council
to determine their needs and ways of meeting them, or launches upon any local project for sanitation, tubercular testing, and immunization of children is taking the first and most important step in building a health program for their community.

In undertaking any such specific program, help is available through consultation specialists in the state department of health. At the same time study of the broader aspects of the problem is essential. This pamphlet has been written as a guide for groups interested in studying their local health needs. Further help is available through health study outlines.

Health security is such a complex question that it may seem to the average citizen that he can do little about it. In reality there is a great deal he can do, for in the last analysis, it is he who determines what health services he is willing and able to support. He looks, however, to the physician for leadership. When the leaders among the people and the physicians in each community, as well as in the state, study the question together with mutual respect for their respective responsibilities, there is every hope that a health program will be built which is satisfactory both to those who serve and those who are served.

Nebraska’s political philosophy is based on the admirable principle of “pay as you go.” If the state is to maintain this policy, however, it cannot afford to continue its present costly program of maintaining sickness and disease. For economy’s sake alone, it can only afford a program of disease prevention. The investment in a health program would pay for itself many times, not only in the reduced burden of the cost of sickness, but also in the returns it would bring in a people physically and mentally strong to meet, with the spirit of the pioneers, the increasingly complex problems of this proud state of the great plains.

Do the people of Nebraska want to invest in health?