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"WE ARE ENTITLED TO, AND WE MUST HAVE, MEDICAL CARE": SAN JUAN
COUNTY'S FARM SECURITY ADMINISTRATION MEDICAL PLAN, 1938 – 1946

by

John Howard Brumbaugh Jr.

A thesis submitted in partial fulfillment
of the requirements for the degree

of

MASTER OF SCIENCE

in

History

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Logan, Utah

2015

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ABSTRACT

“We are Entitled to, and We must have, Medical Care.”: San Juan County’s Farm
Security Administration Medical Plan, 1938 - 1946

by

John H. Brumbaugh Jr., Master of Science

Utah State University, 2015

Major Professor: Dr. Victoria Grieve
Department: History

This thesis traces the efforts of rural county in Utah attempting to create a professional medical system and addresses the challenges community faced in this effort including divisions among local and national medical societies, women and gender issues, and opposition to religious hierarchy. Navigating these conflicts, the local leaders in San Juan County established a medical cooperative which enable the permanent residence of a physician and later the construction of a hospital. San Juan County provided these medical services for its residents at a time when many of counties in the United States failed to expand their health services. San Juan succeeded due to dynamic leadership, support of local medical association, and the slow expansion of the medical system.

(124 pages)

PUBLIC ABSTRACT

“We are Entitled to, and We must have, Medical Care.”: San Juan County’s Farm
Security Administration Medical Plan, 1938 – 1946

John Howard Brumbaugh Jr.

From the passage of the Patient Protection and Affordable Care Act, also known as Obamacare, in 2010, politicians and laypeople have been given much debate on national healthcare. With these circumstances, the study of Farm Security Administration’s health plans, one of the earliest attempts of government sponsored healthcare systems, is both timely and prudent. A study of the FSA becomes a usable past, which one medical historian believed would illustrate “some of the enduring themes that punctuate the debate over the proper role of government in health care.

The research project consisted of exploring primary and secondary documents related to the FSA’s work in Southeastern Utah. The project required resources from the San Bruno branch of the National Archives to understand the national and regional perspectives of the FSA. Furthermore the journals and interviews of original participants were located at Brigham Young University’s L. Tom Perry Special Collections at the Harold B. Lee Library. Finally, newspaper records of the proceedings were found in the San Juan Record using the Utah Digital Newspapers.

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I give special thanks to my friends and colleagues for their encouragement throughout the process of graduate school. Jon Alfred, Joe Foster, Andrew Simek, Sarah Fassman, and Donald Bradley, I value as true friends. I hope we meet again, but not in the graduate students office.

Finally, I would like to thank my wonderful family. They are the inspiration of my life. I cannot imagine my world without Sam, Jenni, Howie, and Libby. My wonderful companion, Liz, I love you with all of my heart. Thank you for your years of patience as I struggled to complete this project.

John H. Brumbaugh Jr.

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CHAPTER 1

INTRODUCTION AND HISTORIOGRAPHY

In his 1937 inaugural address, President Franklin Delano Roosevelt explained the need to continue New Deal programs. He stated many Americans were still “ill-housed, ill-clad, and ill-nourished.”¹ The Depression, with its widespread misery and suffering, coincided with a political climate for action, scientific advancement, and local willingness for change. This confluence of events enabled rural health care to make great strides.² In 1932, The newly elected president, Franklin D. Roosevelt advocated for “Social Consciousness,” or the public responsibility to care for the sick and poor. But Roosevelt was interested in addressing the root cause of problems, not just the symptoms.³

In viewing the ills affecting the United States of America, President Roosevelt directed one of the most dynamic public responses in the country’s history. The New Deal and the second New Deal attempted to bring relief to the country’s poor. Although some scholars debate the success of this government intervention in ending the economic downturn, Roosevelt’s efforts had a lasting impact on communities throughout the country. A program started by one of the New Deal’s organizations, the Farm Security Administration (FSA), would raise the level of healthcare in rural America from the

¹ Franklin Delano Roosevelt, “One Third of the Nation,” (second augural address, accessed September 24, 2010); available from <http://historymatters.gmu.edu/d/5105/>; Internet.

² Brenda Jeanette Taylor, “The Farm Security Administration: Meeting Rural Health Needs in the South, 1933 – 1946” (Ph.D. diss., Texas Christian University, 1994), 34.

³ Ibid, 37.

Depression through the beginning of the Cold War. Also, the FSA medical plans encouraged the spread of group health care.

This thesis will examine FSA medical plans in the state of Utah from 1938 to 1946. Embraced by citizens in the most rural counties, FSA medical cooperatives improved the nature and expectations of health care in Utah. Although these medical programs carried the promise of spreading equality and fundamental human rights to the lowest classes of society, power and control remained in the hands of both professional physicians and agribusiness. These powerful groups, combined with effects of WWII, ended the FSA medical cooperative experiment in 1946. The purpose of this thesis is to study the role of FSA medical programs in improving the health services in the rural communities of Utah by examining the farmers who supported the programs from the New Deal years to the Cold War era, and the forces that opposed cooperative health care when the Great Depression concluded, like the American Medical Association.

Background

As the Depression took hold of the nation, the ability of a citizen to access healthcare plummeted. Rural areas and farming communities were hit particularly hard. The historian and physician Michael Grey explained that one of the most pressing issues was physician distribution. Urban and wealthier states like New York had low doctor to

patient ratios--one doctor to 621 individuals---while rural and less affluent states had higher ratios--at times exceeding one doctor to twenty thousand individuals.⁴

Historian Brenda Taylor explained the public health crisis deepened before the Great Depression rocked America. The United States Public Health Service expanded throughout the 1920s, providing funding for local health departments. But in a surprising turn, Congress dramatically reduced its expenditures in 1933 to less than one-tenth of its needed operating costs.⁵ Federal agencies knew this reduction in funding posed a major problem. Alarming results began to funnel back to health agencies. One red flag that the Depression was causing a health crisis was that, for the first time in decades, infant mortality rates began to rise.⁶ The question was, in particular places, or nationally?

Funds flowing through the Federal Emergency Relief Administration addressed some of the health concerns of rural residents. In late 1933, federal relief money could be used to pay medical bills of families on relief, but not hospitalization bills. These payments were allowed only in extreme circumstances where patients suffered from acute pain or the patient's ability to work was hindered.⁷

With few other options, a number of US citizens during the Depression formed cooperative medical plans. Historians have struggled to define exact what a FSA cooperative was. Each rural community had its own variation on the FSA cooperative. But generally, FSA clients, working with the organization's Health Services Branch,

⁴ Michael R. Grey, *New Deal Medicine: The Rural Health Programs of the Farm Security Administration* (Baltimore: John Hopkins University Press, 1999), 25.

⁵ Taylor, "The Farm Security Administration," 42.

⁶ Grey, *New Deal Medicine*, 33

⁷ Taylor, "The Farm Security Administration," 43.

negotiated arrangements with local medical practitioners for general medicine services.⁸ The FSA clients paid physicians for services with single annual premium or at a reduced rate per service fee. Pooling resources enabled families and individuals to limit costs and protect against future disasters, protected the FSA from loan defaults, and ensured physicians received compensation for services rendered.

Early attempts at cooperative medical systems often met with coldness from the American Medical Association. When the organizers of Arthurdale, a workers community in West Virginia, solicited advice from the AMA on employing a physician on a contract basis, AMA secretary Olin West responded negatively. West explained that finding a good physician to work on a contract would prove difficult.⁹ Despite the resistance from organized medicine Farm Security Administration pushed forward collective medicine in an attempt to facilitate agriculture rehabilitation throughout the country.

Photographs hide the history of the FSA. The images captured by Dorothea Lange, Arthur Rothstein, Russell Lee, and Post Wolcott obscure the impact of the FSA on rural America. The FSA photographers were not purely preserving stories. Roy Stryker and others used the photographs to fashion a success story about poor farmers and the federal programs that saved them. The FSA has come to be known through its visual culture, but the FSA was really about agricultural remediation. Federal officials wanted to improve the productivity and financial stability of the nation's farms. The FSA

⁸ Grey, *New Deal Medicine*, 5.

⁹ *Ibid*, 48.

gave farmers short term loans at low rates to purchase needed resources from bulls to water rights.

Although the FSA's primary focus was short term loans, the organization branched out into many aspects of rehabilitation. One of the areas was healthcare. FSA field agents found many people in rural communities were plain ill, and that illness and poor health were major factors in loan default, therefore health care needed to be addressed by the loan provider. Secretary of Agriculture Henry Wallace explained in 1938, "Loans may be made by the Farm Security Administration for the purpose of financing...the purchase of necessary equipment, stock, supplies and subsistence needs of, and for soil and farm laborers, and for such other purposes as may be necessary in the administration of rural rehabilitation and relief for needy persons." The "other purposes" claimed in the memorandum gave the FSA latitude to construct any program, including collective health systems, for the betterment of agriculture in the United States.¹⁰ Without minimizing the importance of crops and land, this study attempts to analyze how the FSA affected the farmers and communities in Utah through the development of cooperative medical associations.

As one scholar explained, "A family in good health was a better credit risk than a family in bad health. So far as the government was concerned the program was simply a matter of good business."¹¹ The FSA wanted to extend the benefits of health care to as many disadvantaged families as possible. In 1937, Will Alexander, assistant director of

¹⁰ Ibid, 127.

¹¹ Grey, *New Deal Medicine*, 52.

the FSA, sent out a letter asking regional directors to “assemble” as much information as possible on the inadequate health care of FSA clients.¹² Addressing the problems of rural health, the FSA created pre-payment health plans, which allowed farmers to collectively purchase health insurance.

FSA Cooperatives offered Utah farmers a reasonable alternative to other New Deal programs like the Resettlement Administration (RA), predecessor of the FSA, which took farmers from sub-marginal farming communities and “resettled” them in more productive locations. The RA faced a number of problems implementing its agenda. The RA measured rural communities in terms of dollars and cents. Farmers had emotional and religious ties to the land. Regardless of income, some people simply did not want to leave their homes. Also, public disapproval of the program reached high levels. Americans were not ready for wholesale government-sponsored wealth redistribution.¹³

President Roosevelt’s Second New Deal created the FSA from the RA, as an attempt to help the poorest third of farmers. The term the FSA used to describe this process of assistance was “rural rehabilitation.” Thus the agency was attempting to raise farmers back to their pre-Great Depression wages. Assistance to farmers largely came in the form of federally subsidized loans with three percent interest rates. Farmers could organize cooperatives to purchase needed equipment, land, seed and stock or to market their agricultural products. Although the FSA did find some success in its assistance

¹²Ibid, 51.

¹³ Brian Quayle Cannon, “Remaking the Agrarian Dream: The New Deal’s Resettlement Program in the Intermountain West” (Master’s Thesis, Utah State University, 1986), 196.

programs, disease and sickness posed a major setback in the rehabilitation rural farming communities. The FSA discovered nearly half of all defaulted federally subsidized farm loans were the result of sickness. This major reason for default coupled with a desire to assist people in unimaginable circumstances led to the creation of a medical care program within the FSA.

FSA medical programs were similar to many voluntary private health insurance plans of the 1930's and 1940's. Farmers organized into cooperatives to negotiate price rates with local medical and dental practitioners. Excluding the small government subsidy, two other factors differentiated the FSA medical program from private plans: low income families and health education. Private insurance companies tended not to focus on low income families because they had few economic incentives to do so. The FSA depended on its ability to show that the FSA provided economic relief to the poorest third of rural farmers. If the farmers were sick, then they wouldn't be able to repay federal loans. Second, The FSA used a proactive approach to health care. It sponsored preventive health education throughout the areas it influenced.¹⁴ At the program's peak in 1942, more than 140,000 families in 41 states were enrolled in FSA medical plans. A study of the FSA medical cooperatives provides some insight into the lives of agricultural workers in the West as well as the poorest class of workers in rural communities, landless casual workers, and the indigent class. Unfortunately, much of the FSA's centralized health system in Utah was accessible only to people of property. Therefore it is recognized that this study of Utah must limit its conclusions about the

¹⁴ Grey, *New Deal Medicine*, 15.

impact of the FSA's medical cooperatives to only rural landed farmers and the communities with a majority of these workers. A larger study of the FSA would reveal the agency did attempt to address the needs of migrant agricultural laborers through a limited number of migratory labor camps in the most active agricultural regions in the West, particularly in California. But Utah did not have the agricultural output to justify the FSA creating a migratory worker camp in the state.

Utah's low agricultural output (in comparison with California) limited the number of workers to a group of residents largely better off than the migrant workers of California. The FSA divided the nation into ten regions. The FSA linked Utah, California, Arizona, and Nevada into one area called Region IX. California drew much of the attention. There regional director Jonathan Garst allowed a third party organization to direct the health care program. California's Agricultural Workers Health and Medical Association soon brought Nevada and Arizona under its influence. Only Utah's medical cooperatives remained under the direction of the FSA.

One of Utah's most rural areas, San Juan County, received benefits from the FSA's efforts. The Four Corners regions of Utah had varying levels of use for FSA's loan program, but San Juan County desperately needed healthcare. The region is known for its incredible rock formations and the last Native American uprising in Utah. Beginning with the Hole in the Rock expedition, Anglo settlers came to the region in 1879-80. The climate proved inhospitable to agriculture but some, like the Redd family, found great success running cattle and sheep. The Depression hit the region as a number of financial institutions closed permanently and credit dried up.

San Juan County's experience with FSA medical cooperatives highlight the conflict and interplay between rural and urban areas, national medical associations and state or local association, and the divisions with the Mormon Church. As urban areas experienced economic success, they were able to expand healthcare services. Rural communities, viewing these improvements, attempted to devise means to bring modern medicine to the country. Rural communities often used government agencies or programs to improve to the quality of healthcare in their towns. As the rural communities struggled to provide for their resident's healthcare needs, national health associations, like the American Medical Association, countered government intervention. These actions limited some of the health options rural communities had. In Utah, the Mormon Church added to the variety of local and national voices. Although the highest church leaders opposed most New Deal efforts, the local church leaders in San Juan County embraced the FSA medical cooperatives. The support provided by the local Mormon leaders proved critical to the longevity and distribution of health services in the county.

A late-1936 or early-1937 report on the FSA in San Juan County found the county was struggling with farm rehabilitation. Under the direction of Dave Evans, County Farm supervisor, and Mabel Sykes, home supervisor, the rehabilitation of the county consisted of lending money and creating detailed farm and home plans. Generally, the Resettlement Administration, forerunner of the FSA, only provided aid to families on relief rolls. But the FSA expanded original plans to included families in danger of having to go on relief. Federal officials met applications for loans with questions about the moral character of the applicant. These "moral character loans" ranged from a two to five year term with a five percent interest rate. By 1936 the FSA loaned out approximately \$42,000 to seventy

families in San Juan County.¹⁵ On July 1, 1936, the lending operations of the Resettlement Administration suspended in San Juan County, because all available funds were concentrated for severe drought areas of the middle-west. Utah was not a major agricultural region, so Utahns had to wait for more available funds to come from federal agencies.

In 1937, the Resettlement Administration returned as the Farm Security Administration. Within the FSA's portfolio of services for farmers was the ability to organize medical plans. San Juan County was the first to embrace a county-wide FSA cooperative medical association in Utah. In the county 3700 people were without the service of a resident full-time physician, making a medical cooperative financially practicable. Using the FSA's organization, county leaders cobbled together a health plan supported by state funds for child welfare work, medical service loans extended to clients of the Farm Security Administration, by the cooperation of county, church, women relief groups, various school boards, as well as by the annual contracts of local families.¹⁶ This health plan would prove highly successful in the county and eventually serve as a model for other Utah counties.

The San Juan County Medical Cooperative did have some critics. Federal intervention in the health care industry was deemed unacceptable by medicine's largest professional organization, the American Medical Association. But given the economic

¹⁵ "Activities of the Rehabilitation Division in San Juan County," Undated, Public Relations Newspaper & Magazine Articles & Press Releases June 1936 [2], Box 34, Record Group 96, National Archives and Records Administration, Pacific Region, San Bruno, CA.

¹⁶ "Blanding Chamber Commerce Active," *San Juan Record* (Monticello, Utah) April 14, 1938, 1.

trials of the Depression, physicians did make some allowances to accepting dollars from the federal government. The AMA claimed the right to receive government payment only as a temporary consequence of the financial crisis and “must be discontinued as rapidly as the stress on the profession is relieved.”¹⁷

Assessing the success of cooperative medical plans was the focus of the medical associations during the first years, 1938 to 1941. FSA leaders were careful to avoid the displeasure of the AMA and the state medical societies. The national director of the medical division of the FSA claimed, “The primary object of [FSA health plans] is to furnish medical care – not to raise the general level of medical practice in a given area.” This approach enabled a broad application of liberal ideals without stirring the universal wrath of the American Medical Association.¹⁸

Americans seeking health care during the 1930s faced some poignant problems. Of the over one hundred million citizens of the country, two and half million people were sick each day. Preventative care was an abstract idea, representing less than three percent of annual healthcare expenditures. Unnecessary illness and death cost the country an estimated ten billion dollars each year.¹⁹ In 1938, the Surgeon General Thomas Parran estimated that forty million citizens could not afford health care in emergency situations and the country needed at least three hundred thousand more hospital beds.²⁰

¹⁷Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York: Basic Books, 1982), 271.

¹⁸Grey, *New Deal Medicine*, 76 – 77.

¹⁹“America’s First Cooperative Hospital---Money-Mad Doctors,” *San Juan Record* (Monticello, UT) May 12, 1938, 1.

²⁰Joseph W. La Bine, “Beck Visit, Czech Border Tiff Point Probable Nazi Course,” *San Juan Record* January 19, 1939, 6.

Within the FSA client base, every failure of a FSA borrower was cause for concern. Poor health was the chief reason for failure. Will Alexander, Chief Medical Officer of the FSA, explained, “Only recently have we people in Washington begun to realize just how many of our borrower are handicapped by illnesses of one kind or another.”²¹ The FSA was largely successful in extending care to the rural populations of the country. Mott and Roemer estimated that in under ten years of service, the FSA assisted over one million citizens and developed one of the most extensive voluntary health systems in the United States. Ranging over nearly one third of the country, the FSA was by far the largest organization addressing medical care.²²

The Depression hit Utah particularly hard. With unemployment rates at record levels of 36 percent at one point, the state faced a number of major challenges. Per capita income declined to under \$300 in 1933. The value of the state’s mining products dropped from \$115 million in 1929 to \$23 million in 1933. Farm income dropped from \$69 million in 1929 to \$30 million in 1933.²³ As the worst part of the Depression passed and employment rates began to rise again, Utah residents began to contemplate improvement to their communities. In San Juan County, the primary focus was on the need of health professionals. The historian Robert S. McPherson explained as result of the Mormon dominance in the county, the sick were cared for “through community cooperation.”²⁴

²¹ Will Alexander, Administrator, “Dear Fellow-workers” August 8, 1939; Folder 160 [Public Relations] 49 [Jan to June 1940], Box 25, Record Group 96, National Archives and Records Administration, Pacific Region, San Bruno, CA.

²² Frederick D. Mott and Milton I. Roemer, *Rural Health and Medical Care* (McGraw-Hill Book Co., 1948) 394.

²³ Thomas G. Alexander, *Utah, The Right Place* (Layton, Utah: Gibbs Smith, Publisher, 2003), 311.

²⁴ Robert S. McPherson, *A History of San Juan County: In the Palm of Time* (Salt Lake City, Utah: Utah State Historical Society, 1995), 273.

One of the larger issues with the area was how to lure doctors to the isolated Four Corners region and to remain. McPherson noted that the first doctor in the region was a man named Harrison, who remained for less than a year. The next was Harry S. Bussey, again remaining less than a year. In 1929, the county guaranteed an income for a physician, and this time the county attracted Dr. C.R. Spearman.²⁵ By 1938, however, San Juan County had no doctor and only one nurse to care for over three thousand people. A.J. Redd explained that “Lots of babies were born at home and many broken arms and legs were not set properly... Many people died for lack of medical attention.”²⁶ Monticello’s mayor detailed the situation:

I feel that 75 percent of the people of the county and town have not had sufficient medical attention....The health of our younger generation has been impaired because of the lack of doctors to give periodical examinations....In the case of a serious accident, it has been necessary to move the patient sixty miles to a doctor, or else wait for the doctor to make the same trip, and this has been the cause of loss of lives. We have had no doctor to take care of maternity cases. This has been done by midwives without license or professional training.²⁷

Although San Juan County’s healthcare efforts have been largely ignored, overshadowed by larger projects in Arizona and California, the county’s attempts at collective medicine would impact the rest of the state for years to come.²⁸ Additionally, the experience of San Juan County illustrate show communities isolated from medical

²⁵ McPherson, *San Juan County*, 275.

²⁶ Ward Studt, Jerold G. Sorensen, and Beverly Burge, *Medicine in the Intermountain West: A History of Health Care in Rural Areas of the West* (Salt Lake City, Utah: Olympus Publishing Co, 1976), 109.

²⁷ “A Successful Medical Cooperative Association,” *Utah Farmer* 1939.

²⁸ Karl L. Schaupp, former Chairman of the Council of the California Medical Association, “Development of Health Service to Migrant Population in California and Arizona,” *Public Relations Newspapers and Magazines: Clippings [1935-1936]*, Box 34, Record Group 96, National Archives and Records Administration, Pacific Region, San Bruno, CA.

resources were able to use cooperative action to overcome barriers and expand access to health services.

There are some challenges in exploring the history of the FSA. According to a former chief of Community Programs of the Farmers Home Administration (the organization that replaced the FSA) Dennis Winter, most state level documentation was destroyed five years after the end of a corporation. FSA county level documents seemed to have had a similar end. Counties held those documents only until clients repaid the loans.²⁹

One of the most consistent resources in studying the era and region was the *San Juan Record*, published in Monticello, Utah. This newspaper claimed to be “‘Voice of America’s Last Frontier;’ Published in the Unique Scenic District of the World.” This weekly local newspaper began publication in 1915 and has continued to the present day.³⁰ *San Juan Record* was the only newspaper published in San Juan County and claimed to be “Independent and Progressive.” Marie M. Ogden purchased the newspaper from J.P. May of Duchesne in May 1934. Ogden was the director of the Home of Truth religious society. From January 1938 forward, C.S. Wilkinson acted as the editor-manager.³¹ The newspaper took a keen interest in the health cooperative movement. Both C.S. Wilkinson and Marie M. Ogden viewed the cooperative movement as a necessity for San Juan County. They held a negative view of doctors, believing that few were honest. The *Record* published articles blasting physicians for making a “living by deception,” like

²⁹ Studt, Sorensen, and Burge, *Intermountain Healthcare*, 92.

³⁰ See <http://www.sjrnews.com/> and <http://digitalnewspapers.org/newspaper/?paper=San+Juan+Record>

³¹ “Monticello, San Juan County,” *San Juan Record* September 1, 1938, 4.

prescribing unnecessary operations for wealthy patients or sugar pellets for patients who thought they needed medicine.³²

Although Marie Ogden had unique beliefs, including leading the spiritual group Home of Truth in which her typewriter acted as a vehicle to receive divine directives, her ownership of the *San Juan Record* did not seem to hurt the newspaper in the eyes of the locals.³³ In 1938, San Juan County agreed to subsidize the *Record*, which received over \$500 for “Publications and supplies” each year during the Depression and World War II.³⁴ If the leaders of the county had worries about the owner of the *San Juan Record*, it would be unlikely that they would continue the distribution of tax dollars to the newspaper.

Unfortunately, not all aspects of San Juan County can be addressed in this study. The largest omission is the Navajo and Ute tribes that call the San Juan region home. Given the size and scale of the thesis, this study did not have the resources or the time to address the issues surrounding health among Native groups. Native health care issues were the province of a different federal bureaucracy, the Bureau of Indian Affairs, and not the FSA, so it sat outside the purview of this study.

There are some new resources addressed in the study not considered in other scholarly work. Limited in past studies was the discussion of the role of nurses and women in the cooperative movement. Additionally, the San Juan County experience demonstrated how doctors and nurses collaborated in a successful community health

³² “Living By Deception,” *San Juan Record* May 26, 1938, 4.

³³ Wallace Stegner, *Mormon Country* (Lincoln: University of Nebraska Press, 2003), 331 – 343.. Marie Ogden relocated to the San Juan County as part of her Home of Truth religious movement.

³⁴ “Annual Financial Report of San Juan County for 1938,” *San Juan Record* February 2, 1939, 4.

plan. Additionally, no study considers Utah or how a prominent religion would lead to the success or failures of a medical cooperative.

Given the present debate on national health care, the study of FSA health plans is both timely and prudent. A study of the FSA becomes a usable past, which one medical historian believed would illustrate “some of the enduring themes that punctuate the debate over the proper role of government in health care.”³⁵

Historiography

San Juan County’s FSA health plan fits into a number of historiographies. Typically the FSA has been examined by scholars interested in the photographs captured by the FSA’s Historical division, under the direction of Roy Stryker. Works like James Curtis’ *Mind’s Eye, Mind’s Truth: FSA Photography Reconsidered* and Roy Stryker and Nancy Wood’s *In This Proud Land: America 1935 – 1943 As Seen in The FSA Photographs* provide important discussion of the visual culture surrounding the images and their legacy. Although the photographs provide an unmatched visual documentation of the Depression, it is critical to remember that the photographs were not the objective of the FSA bureaucracy. The FSA intended the photographs to sell the American people on the necessity and value of the FSA agenda of rural rehabilitation. The FSA programs had a much larger impact on the people of the Great Depression than the photographs did.

³⁵ Grey, *New Deal Medicine*, ix.

The historiography of the Great Depression has vacillated between favorable and unfavorable reviews of government intervention during the era. From the far left, critics claimed FDR's New Deal missed a golden opportunity to push through major social changes. In a sense, the New Deal did not do enough to push the country toward government control of means of production. From the Right, historical critics have argued that federal relief programs stepped outside the bounds of the Constitution. This thesis will avoid judging the overall success or failures of the New Deal. Instead, following a model similar to Roger Biles in *A New Deal for the American People*, the thesis will analyze the impact of a New Deal program on a specific group: the impact of FSA medical programs on the residents of Utah and the actions of those who opposed them.

Two works are the primary focus of any discussion of FSA medical cooperative. Frederick Dodge Mott and Milton Irwin Roemer's *Rural Health and Medical Care* and Michael R. Grey's *New Deal Medicine: the Rural Health Programs of the Farm Security Administration*. These works are central to the historiography. Mott and Roemer explored the trends throughout all the rural communities in the United States and is easily the most comprehensive examination of health care during the Depression era. Written shortly after the demise of the FSA, *Rural Health and Medical Care* reads more like a primary source. The authors were deeply entrenched in the FSA medical plans during the bureaucracy's years of operation. Michael Grey likewise noted that this work is more of a primary document than a secondary source. Grey's historical monograph is the only book

length treatment of the health plans. Approaching the topic from a national vantage point, he misses the regional variation that defined the FSA medical programs.³⁶

Paul Mertz, like Grey, placed a greater emphasis on the health care program. He claimed that of all the FSA cooperatives, the health care cooperative had the greatest impact. Although this conclusion maybe correct, this study only explored the American South, making a broader study of FSA medical plans needed to confirm his analysis. A study that shares Mertz's conclusion is Brenda Taylor's 1983 Texas Christian University dissertation. Taylor's analysis of FSA medical cooperatives provided no new insights, but simply applied Mertz's conclusion to the state of Texas.³⁷

The works of Mott, Grey, Mertz, and Taylor are the starting points in the discussion of historiography. How important were the health cooperatives to the overall agenda of the FSA? The classic work on the FSA, Sidney Baldwin's *Poverty and Politics: the Rise and Decline of the Farm Security Administration*, provides the most comprehensive institutional history of the FSA. It traces the internal and external dynamics that affected the agency. But Baldwin addressed the medical care programs in two scant paragraphs in the four hundred page text. Baldwin argues that the FSA grew out of a legacy of poverty politics, local, state, and federal legislation meant to ease the suffering of the poorest members of society. The author found that the cooperatives were met with unexpected cooperation from the physicians and regional medical societies. In

³⁶ Frederick D. Mott and Milton I. Roemer, *Rural Health and Medical Care* (McGraw-Hill Book Co., 1948) and Michael R. Grey, *New Deal Medicine: The Rural Health Programs of the Farm Security Administration* (Baltimore: John Hopkins University Press, 1999)

³⁷ Paul Mertz, *New Deal Policy and Southern Rural Poverty* (Baton Rouge: Louisiana State University Press, 1978) and Brenda Jeanette Taylor, "The Farm Security Administration: Meeting Rural Health Needs in the South, 1933 – 1946" (Ph.D. diss., Texas Christian University, 1994).

general, the plans were an integral part of the overall mission for rural rehabilitation program of the FSA.³⁸

Health care initiatives by the FSA have an interesting place within the discussion of national health care. Why wasn't compulsory health insurance a part of the New Deal? Daniel Hirshfield claimed that Americans were not yet ready to abandon individualism in favor of the collective ideals.³⁹ In his 1982 work Paul Starr disagreed with Hirshfield's conclusion. Starr contended that a majority of Americans approved of compulsory health insurance, but there was not a public consensus about how such an insurance plan would be created.⁴⁰

In 1946, Congress disbanded the FSA, replacing the agency with the Farmers Home Administration. Why was the FSA destroyed? John L. Shover in his work, *First Majority – Last Minority: the Transforming of Rural Life in America*, concluded that the dismantling of FSA was the result of anti-communism sentiments at the beginning of the Cold War and a lack of concern for small farmers by agribusinesses which controlled the Farm Bureau Federation.⁴¹

Paul Mertz and Brenda Taylor both approached the FSA's medical plans through the South. They questioned the role of the bureaucracy by examining how it functioned in the South. Only Grey explored the FSA's impact on the West and here only

³⁸ Sidney Baldwin, *Poverty and Politics: The Rise and Decline of the Farm Security Administration* (Chapel Hill: University of North Carolina Press, 1968), 208-209.

³⁹ Daniel Hirshfield, *The Lost Reform: the Campaign for Compulsory Health Insurance in the United States from 1932 - 1943* (Cambridge, MA: Harvard University Press, 1970),

⁴⁰ Starr, *American Medicine*, 279.

⁴¹ John L. Shover, *First Majority – Last Minority: The Transforming of Rural Life in America* (DeKalb: Northern Illinois University Press, 1976), 237.

intermittently. Taos, New Mexico's experimental health plan, examined in *New Deal Medicine*, provided the only extensive study of a FSA medical cooperative in the West.⁴² Even Mott and Roemer's extensive study of rural health care only lightly touches the West.

A study of FSA health plans in Utah adds to scholarship by explaining how medical care cooperatives spread from county to county. Furthermore, no study has attempted to explain how a unique population influenced the implementation of a medical cooperative. This Utah-based study discusses some of the connections between collective action and Mormon ideology.

Very little research has analyzed the integration of health professionals within the FSA. Mott and Roemer addressed the role of nurses and dentists in general rural health. As with all of their research, national in scope, their analysis of national trends has been unmatched.⁴³ Yet there are some limitations. Mott and Roemer did not attempt to discuss the role of nurses in establishing health practices in rural communities. Additionally, no authors have discussed the interworking of nurses from multiple agencies, government and non-profit sectors. Portia Kernodle in her history of Red Cross nursing addressed the conflict between government and non-profit nursing, yet the collaboration of the organizations was outside of the scope of her study.⁴⁴

This thesis aims to improve on the existing historiography in three ways. First, all the works on the FSA, with the exception of Brenda Taylor's dissertation, have focused

⁴² Grey, *New Deal Medicine*, 114 - 118

⁴³ Mott and Roemer, *Rural Health Care*, 186 – 196.

⁴⁴ Portia B. Kernodle, *The Red Cross Nurse in Action* (Harper & Bros., 1949).

on national themes within politics and health care. The numerous local variations of FSA organizations have been excluded from these narratives. The success of the FSA's medical plans through 1942 was in part due to regional adaptations. Communities and medical societies could negotiate the terms and components of the health plans. With all stakeholders represented in discussions, communities were more likely to create lasting institutions.

Secondly, very few studies have included any analysis of FSA medical plans in the West. A superficial review of the FSA literature could give a reader the impression that the FSA was only concerned with the South. Although the FSA work in the South was certainly transformative, the FSA operated throughout the United States. San Juan County was the earliest adopter of a FSA medical plan in Utah. By examining a single county, this study will be able to explore how an early adopter influenced the actions of neighboring regions and the state of Utah.

Finally, exploring San Juan County will expand our understanding of how the FSA transformed the medical practices of a community. Numerous scholars have chalked up the FSA medical plans' legacy to the possibilities of national health care or proving the viability of group health insurance, but San Juan County demonstrates how a county could embrace collectivism and provide vital services for all of its residents. San Juan County's health system grew from only one state-sponsored nurse in 1938 to a county operated hospital in 1948. The efforts of a FSA medical plan made possible the transition.

Thesis Organization

The FSA spans over three major periods in United States history: the Great Depression, World War II, and the Cold War. Attempting to capture the dynamism of the changing periods, this thesis will follow a generally chronological order, tracing the FSA's impact in Utah as the administration transitions from the Resettlement Administration to the Farm Security Administration to the Farmers Home Administration.⁴⁵

The first chapter will focus on the need for improved health care in rural communities. San Juan County mirrored previous attempts to establish a permanent physician to provide both urgent and preventative care. By drawing a physician to San Juan County, residents would not depend on other counties for medical services. Reaching this lofty goal of extended health care to the county required all community leaders, including religious leaders, to embrace the health plan. Once local leaders gathered public support for the cooperative, the larger task of organizing physicians, hospitals, and prepayment plans became the order of the day. The decentralized nature of FSA medical cooperatives facilitated their success.

Chapter Two explores the continued growth of the San Juan County Health Association. Little information from the era, beyond the simple statistical data, suggests anything revolutionary was occurring in the agricultural communities throughout the country. Only the medical societies seemed to be paying attention to the work of the

⁴⁵ James Marsh and Johan Olsen, "The New Institutionalism: Organizational Factors in Political Life," *American Political Science Review* vol. 78 num. 3 (Sep., 1984) 734-49.

FSA. During this time of quiet but exceptional growth, San Juan County would confront the pains associated with the expansion and efforts to maintain growth over time. After the initial surge of patient care with the founding of the cooperative, San Juan County would fall into the routine of public health concerns. Questions would arise about workload expectations for physicians employed by the cooperatives. While the male-dominated profession of doctors became the focus of the FSA medical cooperatives, women served an equally important, yet understudied, role in the health programs throughout the organization's history. Finally, patients' coverage questions would lead to the expansion of care into dental and comprehensive care.

Chapter Three addresses the impact on San Juan County's health association, opposition from the American Medical Association, and the ways the San Juan County health experiment influenced the rest of state of Utah. The five years between 1938 and 1942 were years of spectacular growth of the FSA medical plans, but from 1942 to 1946 the agency's national importance would greatly erode. Stripped of most of its power, the FSA was transferred into the Farmer's Home Administration in late 1946. Through this decline, San Juan County continued to be successful in providing medical care for its residents. Although WWII and the actions of medical associations would limit the number and scale of FSA medical associations, San Juan County's successes after 1938, its institutional advocacy, and its position within Utah enabled this health association to endure beyond the original FSA efforts.

CHAPTER 2

PROMOTING THE VISION AND ORGANIZING THE COOPERATIVE

The *San Juan Record* had a bold vision of the county-proposed medical cooperative. The newspaper envisioned a transformation in health care spreading over the land, with physicians offering medical, surgical, and dental care for those who urgently needed it.¹ Mirroring previous attempts to establish a permanent physician,² local civic leaders unanimously supported the proposed health regardless of political party.³ The focus of the health plan was urgent and preventative care. By drawing a physician to San Juan County, residents avoided emergency travel to Moab. With the inclusion of nurses and home health classes, preventative care became a key aspect of the health plan.

Reaching this lofty goal of extended health care to the county would require a paradigm shift in religious understanding as Mormons came to use government planning to improve their lives. Mormon leaders use their positions of trust as a platform to advocate for the advancement of a county health plan. Although this action by Mormon leaders like Joseph Harris was somewhat political, they believed they were simply advancing the community. Once local leaders gathered public support for the cooperative, the larger task of organizing physicians, hospitals, and prepayment plans became the order of the day. The decentralized nature of FSA medical cooperatives

¹ “Cooperation Triumphs Once More in New Field,” *San Juan Record* (Monticello, Utah) July 7, 1938, 1.

² San Juan County leaders contracted with a Dr. Spearman in 1929 by guaranteeing a minimum monthly income. The primitive health care facilities in San Juan County caused Spearman to leave within a year. See Robert S. McPherson, *History of San Juan County: In the Palm of Time* (Salt Lake City: Utah State Historical Society, 1995) 275 – 276.

³ John Rogers, February 22, 1973, p. 56, Southeastern Utah Oral History Project, Charles Redd Center for Western Studies, L. Tom Perry Special Collections, Harold B. Lee Library, Brigham Young University, Provo, Utah. Within San Juan County, few distractors have been located. It appears that all civic and religious leaders fully supported the cooperative.

allowed San Juan County leaders like John Rogers, Mormon leaders Joseph Harris, county officials, and community members broad license for improving the health care in the region.

The residents of San Juan County represented a mixed political group. In the watershed election of 1932, the county elected Democratic Party candidates in most local races. But the national races proved to be the outliers. San Juan County residents supported the Republican candidates, Herbert Hoover for president, Reed Smoot for U.S. Senate, and Don B. Colton for House of Representatives.⁴ John Rogers, a Republican county commissioner from Blanding, explained that within San Juan County it was more important to have balanced representation-- one person from Monticello and one from Blanding-- than to have a "party man." Regardless of the party, Rogers concluded, all San Juan County politicians favored the FSA medical plan.⁵ This section examines the social structures challenged by establishing a medical cooperative. The primary manifestations of the social tensions are shown in the forms of local San Juan County leaders breaking with Mormon hierarchy and local medical providers challenging national medical associations.

⁴ "San Juan County Divides Honors Between Parties," *San Juan Record* November 10, 1932, 1.

⁵ John Rogers, February 22, 1973, p. 57, Southeastern Utah Oral History Project, Charles Redd Center for Western Studies, L. Tom Perry Special Collections, Harold B. Lee Library, Brigham Young University, Provo, Utah.

Promotion

From idea to operation, San Juan leaders faced major challenges in improving the county's health care systems. The innovators pushing for a medical cooperative needed support from local leaders, approval from state medical associations, and substantial support from the community to finance the proposal. All these tasks represented major obstacles that had derailed past attempts to improve the county's health system.

Contracting with the Utah State Medical Association (USMA) was among the more important tasks Dave Evans of San Juan County and other FSA officials completed in 1938, which would open the door for all the medical cooperatives that would eventually dot the state. Throughout the United States, local health associations were the guardians of private medical care. Without the USMA's approval, no cooperative would ever be able to function. San Juan County received tentative approval from the USM in early 1938.⁶ Approval in hand, the San Juan County officials could approach local physicians. Typically regional or district FSA Medical Services staff, in San Juan County Dave Evans, attended the meetings of county medical societies, presented FSA plans and solicited physicians' support.⁷ Because San Juan County had no physicians, approval

⁶ San Juan County did not have any problem gaining the support of the USMA for two reasons. First the region's most prominent physician, Dr. I.W. Allen supported the cooperative. Dr. Allen served in Moab at the Grand County Hospital. Secondly, there were no doctors in San Juan County. Under the supervision of Dr. Allen, the medical cooperative would expand the number of physicians in the state and improve the healthcare an underserved area.

⁷ Michael R. Grey, *New Deal Medicine: The Rural Health Programs of the Farm Security Administration* (Baltimore: John Hopkins University Press, 1999), 54 and Ward Studt, Jerold G. Sorensen, and Beverly Burge, *Medicine in the Intermountain West: A History of Health Care in Rural Areas of the West* (Salt Lake City, Utah: Olympus Publishing Co, 1976), 93.

from the USMA was all local leaders needed to start the process to create a medical cooperative. Following their approval for San Juan County, the USMA adopted statewide FSA approval in December of 1938. Medical societies required counties to adopt principles of prepayment and physician choice.⁸ These principles ensured sound financial basis of cooperatives and voluntary participation by patients and health professionals.

With USMA approval, San Juan County civic, religious, and municipal leaders collaborated to bring the medical cooperative to fruition. Although the Farm Security Administration had a critical role in the development of the cooperative, without broad community support, especially the endorsement of local leaders of the Mormon Church, the cooperative never would have taken root.

Opposition to the medical cooperative started even before the first countywide meeting in March of 1938. Those who opposed the cooperative claimed it would benefit only the poorest citizens of the county: those who could not afford health care.⁹ Also the naysayers pointed out that a healthy individual had little use for health insurance. Individuals could go years without any benefit to membership in the cooperative. *San Juan Record* editor C.S. Wilkinson attempted to persuade the opposition by explaining how the program would benefit the wealthiest and poorest citizens equally, providing everyone ready access to quality health care. A person could go a long time without using

⁸ "Farm Security News," *Vernal Express* (Vernal, Utah) December 22, 1938, 3.

⁹ It has proven difficult to identify who exactly opposed the plan. The *San Juan Record* does not mention any names of the opposition. Oral histories conducted in the 1970s only note positive aspects of the medical association.

the benefits of the cooperative, but membership in the organization would prevent a bankruptcy and the loss of a farm.¹⁰

On March 28, 1938, more than thirty religious and civic leaders convened at the county court house to discuss the prospect of expanding the health care systems of San Juan County. Attending the meeting from Blanding was Mormon Stake President Joseph Harris, Mayor Marvin Lyman, W. Ervin Palmer of the County Welfare Department, and Mrs. Dorothy L. Bayles, county nurse. From Monticello, Ralph Bailey of the county Board of Commissioners (elected chairman of the meeting), Dave Evans of the Farm Security Administration, A.J. Redd (a member of the stake presidency), and H. Lloyd Hansen of the San Juan education department. All present at the meeting enthusiastically endorsed the movement and were “willing to do everything possible to promote and support the undertaking.”¹¹ With this broad support, it seemed likely the county would be able to improve its medical systems.

Eleven of the sixteen members of the original San Juan County Medical Cooperative Committee were religious leaders of the Mormon Church, including two members of the stake presidency, Harris and Redd. These leaders used church time to explain the benefits of the cooperative and to promote enrollment.¹² Due to the demographics of Utah in 1930, it is difficult to understate the role Mormon Church

¹⁰ “A Case of Benefiting Everybody,” *San Juan Record* March 14, 1938, 4.

¹¹ “Civic, Religious Leaders Endorse Health Program,” *San Juan Record* March 31, 1938, 1.

¹² “San Juan Medical Co-op Organized; Plans Active Membership Drive Soon,” *San Juan Record* June 6, 1938, 13. In the Church of Jesus Christ of Latter-day Saints (also called Mormons), the stake is an organizational entity usually containing five or six local congregations of “wards.”

support meant for the success of the cooperative. Week after week, Mormon leaders proclaimed the benefits of a cooperative health plan to their congregations.

The involvement of local and regional Mormon leaders promoting the medical cooperative complicates the scholarship outlining the role of Church of Jesus Christ of Latter-day Saints (LDS Church) opposition to the New Deal. LDS Church historian, Leonard J. Arrington and Davis Bitton explained that most Mormons held a negative view of government programs during the Great Depression, feeling that the programs were “inadequate” and “late in coming.” Furthermore Mormons believed it was their religious obligations to care for their own and reduce any dependence on outside aid.¹³

Aware of this legacy, the *San Juan Record* pushed Mormons towards the cooperative movement. The *Record's* editor, C.S. Wilkenson, printed thinly veiled attacks on prominent church leaders, like Heber J. Grant, president of the LDS Church. Grant completely opposed government programs, especially aid agencies. Wilkenson explained that early Mormon apostles, like Heber C. Kimball, condemned the inequality of wealth and identified the unequal possession of wealth as a curse of the earth.¹⁴

Although Mormonism of the 1930s was still reeling from the agricultural downturn of the 1920s, President Heber J. Grant attempted to combat the Depression by individual means. But never did the membership's financial resources match the challenge of the Depression.¹⁵ Give the opposition of LDS leaders in Salt Lake City, it seemed surprising that San Juan County's Mormon leaders would so whole-heartedly embrace the medical

¹³ Leonard J. Arrington and David Bitton, *The Mormon Experience: A History of the Latter-day Saints* (Urbana: University of Illinois Press, 1992) 272.

¹⁴ “Inequality, The Curse of Riches,” *San Juan Record* May 26, 1938, 4.

¹⁵ Arrington and Bitton, *Mormon Experience*, p. 272 – 273.

cooperative. John Rogers, bishop of the Blanding Ward, explained that local leaders attempted to support the national church leaders, but local bishops “couldn’t get after a person...if he took government aid. If he got sick and could not make it we would help them.”¹⁶ It seemed that local emergencies, especially health crises, overrode national direction from Mormon hierarchy or top LDS Church leadership struggled to connect an ideological agenda with local realities.

Not all Mormons opposed federal programs in the 1930s. Historian, Wayne Hinton, posited that Mormonism was not unique in opposing federal intervention, sharing animosity towards Washington DC along with a number of western and southern states. The real dilemma for Utahns was how to “minimize federal control and at the same time take advantage of federal dollars.”¹⁷ A FSA medical cooperative provided just these principles. Joseph B. Harris, the LDS stake president over all of San Juan County, promoted the FSA medical association publicly, calling it an “outstanding success and a great boon to San Juan County.” Continuing he explained that “no county or community would make a mistake by following San County’s example in this direction.”¹⁸ Throughout the course of the association, Harris constantly urged the support of the cooperative medicine.¹⁹

Local leaders understood the connections to socialized medicine from the inception of the cooperative movement. The *San Juan Record* introduced the idea of a

¹⁶ John Rogers, February 22, 1973, p. 56, Southeastern Utah Oral History Project, Charles Redd Center for Western Studies, L. Tom Perry Special Collections, Harold B. Lee Library, Brigham Young University, Provo, Utah.

¹⁷ Wayne K. Hinton “The Economics of Ambivalence: Utah’s Depression Experience” *Utah Historical Quarterly* 54, no. 3 (Summer 1986): 268 – 269.

¹⁸ “Quarterly Stake Conference at Moab Attracts Crowds,” *San Juan Record* May 18, 1939, 1.

¹⁹ “Successful Year of Cooperative Medical Program,” *San Juan Record* July 6, 1939, 1.

health cooperative by noting the connections between cooperatives and European medical examples. In a March article, the local newspaper explained the proposed system was similar to health systems of the “old world countries,” a clear connection to socialist movements in Europe. These systems used state and federal governments as the primary means of funding public health programs. The *San Juan Record* argued that this departure into socialized medicine would be in the “best interests of all parties concerned” and was the “only tenable answer to the local situation.”²⁰ In 1973, one San Juan County resident was quick to point out their efforts to establish a medical cooperative were not socialist. “We [residents of San Juan County] paid so much a year and could take our families to the doctor and he would take care of us.”²¹ Similarly, Blanding did have a socialist firewood cooperative; the town’s residents simply collectively gathered the firewood, built a storage facility in the middle of town, and allowed all residents to access the heating fuel.²² Group action was common throughout the Intermountain West, the traditional homeland of Mormonism. Although Mormons might not like the term socialism, due to their 20th century push to become the models of American citizenship, Mormonism embraced a communal principle: if not from its theology, then from its environment. The eminent Utah and Mormon historian Thomas G. Alexander argued the cooperatives of Utah had as much to do with the geography of

²⁰ “A Sane Departure,” *San Juan Record* March 24, 1938, 1.

²¹ Dorothy Adams, August 4, 1973, p. 7, Southeastern Utah Oral History Project, Charles Redd Center for Western Studies, L. Tom Perry Special Collections, Harold B. Lee Library, Brigham Young University, Provo, Utah.

²² John Rogers, February 22, 1973, p. 57, Southeastern Utah Oral History Project, Charles Redd Center for Western Studies, L. Tom Perry Special Collections, Harold B. Lee Library, Brigham Young University, Provo, Utah.

Utah as it did the people. The combination of diverse geography and isolated resources meant that a “relatively high degree of cooperation” was necessary to bring “independent by geographically separated resources together.” Alexander argued that the development of Utah “reads like a chronicle of cooperation.”²³

Despite connections to socialism, the FSA medical cooperatives provided San Juan County the expansion of health care and while simultaneously limiting federal control. These factors gave local leaders of the Mormon church in San Juan County enough motivation to urge their respective congregations (“wards”) to support the county medical cooperative. One of the first, Bishop L. Frank Redd of Monticello, called on the members of his congregation to enroll in the health system during a Sunday evening meeting shortly before the cooperative was to take effect. Although many people are prone to procrastinate, Redd explained, no one is immune from sickness. Without membership in the cooperative, a serious sickness could become a financial disaster.²⁴

With the public support of local leaders, county residents supplied substantial support through enrolling in the local cooperative health plan. When the cooperative opened for service on July 1, 1938, approximately 125 families contracted with the cooperative, and leaders hoped for another 200 families by the end of August.²⁵ By February of 1939, approximately 250 of just over 500 families had enrolled in the medical cooperative.²⁶

²³ Thomas G. Alexander, “Toward a Synthetic Interpretation of the Mountain West: Diversity, Isolation, and Cooperation” *Utah Historical Quarterly* 39, no. 3 (Summer 1971): 204.

²⁴ “Participation in Health Benefits Urged by Redd,” *San Juan Record* June 30, 1938, 16.

²⁵ “Cooperation Triumphs Once More in New Field,” *San Juan Record* July 7, 1938, 1.

²⁶ *Ibid.*, and “Moab Lions Club Sponsors Grand Co. Medical Unit,” *San Juan Record* February 23, 1939, 5.

Even as the community leaders advocated for the cooperative, major questions remained unanswered. Paramount was the question of who would be the physician in the county. With no history of a private health practitioner in the region, San Juan County faced a number of obstacles in their dream of improved health care.

Contracting a Cooperative Doctor

In the normal process of establishing a FSA medical cooperative, community members would solicit doctors in the area to participate in the cooperative. Any and all doctors in the region would be able to participate. Then the cooperative gave patients the choice of physicians to seek medical care. Both the physicians and patients were given choice in the cooperative.²⁷ San Juan County faced a unique situation that both strengthened and created incredible vulnerabilities for its cooperative. Because San Juan County had no physicians in the region, the situation necessitated the relocation of a doctor. The closest physician, Dr. Allen, resided in Moab, over sixty miles away for Monticello residents. The cooperative could not start until a Dr. Allen located a physician, and if the physician became incapacitated or disenchanted or drafted into the war effort, the cooperative would end with years of effort all for naught.

Despite some optimism, San Juan County harbored no illusions that employing a doctor would be an easy task. In addition to graduating from a reputable medical college and becoming licensed to practice in the state of Utah, requirements set by the America

²⁷ Studt, *Intermountain Medicine*, 93.

Medical Association (AMA) and USMA, the physician needed to be willing to relocate to southeastern Utah; begin a new practice in a vast, sparsely populated county; be willing to make his home in a rural district that lacked the conveniences and pleasures of urban living; be prepared to face the privations and handicaps common to isolated communities; have a few years of experience and be well up on obstetrics; embrace a cooperative principle largely condemned by the medical community; and be of good character, temperate, and honest.²⁸ Although the job description might have scared away some physicians, the AMA loomed as the biggest worry for San Juan County.

The AMA took an active role opposing the cooperative movement on a national level, as it had various health initiatives since the nineteenth century. Directors of the AMA felt that government had no place in the physician-patient relationship and the organization did not hesitate to voice its opinion. On the state and local levels, however, the AMA toned down its rhetoric and allowed for varying approaches. In effect, the AMA kept its opposition to the cooperatives while maintaining its supervision over any medical care system the FSA created. As some historians have noted, FSA enabled cooperatives to be governed according to the standards set by local and state medical societies. This concession by the FSA aimed to placate the AMA, while allowing the AMA to maintain its larger ideological opposition to government intervention.²⁹

AMA opposition to FSA cooperative movements was extensive and will be discussed in a later chapter, but for this section only a part of the opposition and its

²⁸ "Wanted – a Doctor," *San Juan Record* May 12, 1938, 4.

²⁹ Brenda Jeanette Taylor, "The Farm Security Administration: Meeting Rural Health Needs in the South, 1933 – 1946" (Ph.D. diss., Texas Christian University, 1994), 56.

aftermath will be considered. The Depression hit the health profession hard across the United States. Nationally, doctors saw a significant decline. To raise the income of doctors, state and local branches of the AMA looked to broaden the base of clients and increase collection rates. To reach these goals, some rural doctors turned to cooperatives.

Distrusting the cloaked intentions of the AMA, residents of San Juan County believed attracting a physician posed a major problem. The county leadership felt that contracting with a cooperative required a bold physician to break from the nation's governing health organization.³⁰ To compensate, county planners aimed to offer the new physician a salary above the national average. Although San Juan County was correct about the pay scale, the increased salary likely had more to do with the location of the job rather than AMA rhetoric.

Mott and Roemer explained the number of people per physician in rural areas declined from near 100 physicians per 100,000 residents in 1923 to 60 physicians per 100,000 rural residents in 1940. Declining numbers of rural doctors, Mott and Roemer argued, was the result of concentrations of wealth in cities. Physicians, having services to sell, chose urban markets with the largest purchasing power.³¹ Furthermore, Mott and Roemer identified unique FSA financing as a key to rural communities being able to attract physicians to extremely isolated areas.

The professional response to the Depression, the AMA licensing requirements for new doctors, and the excitement of a new phase of health care persuaded some physicians to accept employment with cooperatives. The physician and historian Michael R. Grey

³⁰ "America's First Cooperative Hospital --- Money-Mad Doctors," *San Juan Record* May 19, 1938, 1.

³¹ Mott and Roemer, *Rural Health*, 165 and 401.

explained that the FSA gained much support because rural doctors disagreed with the AMA's responses to the Depression. Physicians were "dissatisfied with the apparent unwillingness of organized medicine's national leaders to address the social, economic, and health consequences of the Depression."³² The AMA had to tread lightly on the topic of emergency relief measures, because the organization ran the real possibility of alienating a percentage of its membership.

Additionally, rural Depression-era doctors faced a crisis in collection rates. In some areas of the country, physicians collected for as little as twenty percent of the services they provided.³³ Private practitioners' income had dropped by 47 percent from 1929 to 1933. Compounding this issue were delinquency rates of 66.6 percent in 1933. The historian Paul Starr explained, "Not only were patients seeing doctors less often: they were paying their doctors' bills last."³⁴ With a return to normalcy, physicians faced lasting hardships. Medical cooperatives, with their pre-payment foundations and access to the low income levels, provided physicians with guaranteed revenue streams from income groups that, in the past, had been most likely to default on bills. For rural practitioners, linking with a cooperative seemed like a positive alternative to the status quo option.

The lack of hospital facilities and financial compensation posed larger problems, than AMA rhetoric, for San Juan County as they tried to attract a qualified physician. Dr. Israel M. Cohn, a dentist in Blanding, recognized the unique problem faced by San Juan

³² Grey, *New Deal Medicine*, 66.

³³ Taylor, "The Farm Security Administration," 56.

³⁴ Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York: Basic Book, 1982), 270.

County. Cohn presumed that attracting a qualified physician would be the greatest challenge. The dentist based his claim on shifts in American medical practice. By the 1930s, few doctors made home visits. Cohn explained in a 1938 editorial that two-thirds of doctors in the United States were associated with hospitals. In order to attract qualified talent, San Juan County would need a hospital.³⁵ Though Cohn's opinions had some merit, the response to early publication of San Juan County's cooperative doctor search suggests that like the AMA rhetoric, the need for a hospital was exaggerated.

The greatest factor in locating a qualified physician was monetary. FSA cooperatives paid physicians in four basic ways. Most common were the fee-for-service plans and capitation fee methods. The fee-for-service plans negotiated prices for professional services in advance, then the FSA disbursed monthly payments to physicians based on services provided. Capitation or per capita funding provided the financial structure to pay participating physicians a flat fee regardless of services provided based on the number of families or patients under the doctor's care. Some cooperatives gave doctors an annual salary, while a few cooperatives accepted in-kind transfers.³⁶

San Juan County had to overcome the misconceptions many doctors had about the salary of a cooperative doctor. Frederick Dodge Mott outlined one issue those in the health profession had with the cooperatives. Some doctors were "disturbed by the prospect of having physicians, in effect, contract to look after families for a definite, limited sum of money." This claim was not that physician were money mad as some felt,

³⁵ "Dr. Cohn Endorses San Juan County Health Program," *San Juan Record* March 31, 1938, 4.

³⁶ Studt, *Intermountain Medicine*, 93.

since occasionally physicians agreed to provide medical care based on the patient's ability to pay. But by accepting a salaried position, the physicians could do little to earn more.³⁷

Even with concerns about hospital facilities, income limitations, and AMA rhetoric, the San Juan County Medical Cooperative attracted the attention of some physicians. In April of 1938, Monticello received a visit from the first interested doctor, Dr. J. Eldon Dorman. Hailing from Carbon County, Dr. Dorman had experience in rural health care and a salaried income. Dorman's medical experience centered on work in the mining camps of the coal exporting county, a position much like the cooperative doctor San Juan County was looking for. However Dorman's visit was a little premature as community leaders had not yet made a decision on the fate of the cooperative. Therefore, San Juan County was not able to open the position, resulting in Dr. Dorman opting to remain in Carbon County.³⁸

With newfound confidence that they could obtain a physician, the Medical Cooperative shifted strategies, in a presumed cost cutting move, and outsourced the doctor search to Dr. I.W. Allen of Moab. The closest physician to San Juan County, Dr. Allen was to map out a health program for San Juan County, lead the search for a suitable doctor, and act as a mentor for the new doctor. Acting as the representative of the USMA, Allen carried substantial influence on all cooperative decisions. Additionally, Dr. Allen would service San Juan County until a permanent doctor could be located. Cost saving for the cooperative with Dr. Allen's involvement would come from hiring a recent

³⁷ Grey, *New Deal Medicine*, 70.

³⁸ "Dr. Dorman of Price Looks Over Field," *San Juan Record* April 28, 1938, 13.

medical school graduate. Reducing the salary seemed to be a factor in hiring a new doctor, but another benefit would be that young doctors might be more sympathetic to cooperative principles.³⁹

The *San Juan Record* lauded Allen for his spirit of cooperation, love of the medical profession, and desire to alleviate human suffering. Certainly, Dr. Allen seemed like an ideal fit for San Juan County. Close friends commented that Allen loved his profession and was never happier than when he was alleviating pain and suffering. But Allen was also a businessman. He commented that he was content in the county only so long as he had no financial worries. Additionally, his commitment to cooperative principles was questionable.⁴⁰ With the low collection rates by physicians throughout the country and challenges establishing a new practice in an urban area by a newly certified doctor, Dr. Allen likely chose San Juan County due to the guaranteed income rather than the innovative approach to healthcare. Despite a few reservations, many in the San Juan County felt lucky to have Dr. Allen as the medical director of the Health Cooperative.⁴¹

Regardless of his motivations, Dr. Allen had little difficulty finding an assistant. In June of 1938, Dr. Allen's located an intern at LDS Hospital in Salt Lake City, Dr. Harold Austin.⁴² Dr. Austin came highly recommended from a former resident of San Juan County, Mary McKeegan. The director of the County Infirmary for Aged People in Salt Lake City, Mrs. McKeegan supervised Dr. Austin for over a year at the infirmary.

³⁹ "County Health Committee Takes Unanimous Action," *San Juan Record* May 26, 1938, 1.

⁴⁰ "Cooperation Triumphs Once More in New Field," *San Juan Record* July 7, 1938, 1.

⁴¹ *Ibid.*

⁴² "Local News," *San Juan Record* June 23, 1938, 16.

Keegan wrote to the *San Juan Record* that Allen was an extremely capable and understanding physician.⁴³ Joining with the medical cooperative, the medical committee guaranteed Dr. Austin at least four thousand dollars for the first year by the medical committee.⁴⁴

Both Allen and Austin commented that they felt like they were part of an innovative turn in health care. Dr. Austin pointed out that the association marked a new departure in the field of medicine. Dr. Allen noted that the San Juan program was leading in the field of medical cooperatives and that the San Juan experiment was being closely observed by the American Medical Association and other groups throughout the state. The results would influence future developments in the field.⁴⁵

Contracting with Dr. Austin, San Juan County made a key step in the improvement of its health systems. But in doing so the community leaders did break with some counsel from the FSA. National policy makers wanted FSA medical cooperatives to contract with as many physicians as possible. In Arkansas and Mississippi, Chief Medical Officer for the FSA, R.C. Williams, heaped praise on cooperatives that contracted with multiple doctors. One such cooperative gave patients the choice between twenty-two different physicians. Conversely, Williams criticized cooperatives, like San Juan County, that limited patient choice to only one physician.⁴⁶ Although patient choice of physicians would be a selling point of many FSA cooperatives, convincing just one doctor to locate

⁴³ "Dr. Harold Austin Comes To San Juan Highly Recommended," *San Juan Record* June 30, 1938, 13.

⁴⁴ "San Juan Medical Co-op Organized; Plans Active Membership Drive Soon," *San Juan Record* June 16, 1938, 1.

⁴⁵ "Successful Year of Cooperative Medical Program," *San Juan Record* July 6, 1939, 1.

⁴⁶ Taylor, "The Farm Security Administration," 121.

in San Juan County was cause for a major celebration. Perhaps the most important aspect of the health cooperative in southern Utah was not that it greatly improved the quality of care in the region, but it opened care for Utah residents, moving the number of physicians from zero to one.

Establishing a Fortress against Disease

With a physician on his way to San Juan County, the last major question in the medical cooperative was that of hospitalization. Calling a hospital a “Fortresses against disease and premature death,” San Juan County residents wanted a hospital to provide the services necessary for health lifestyles.⁴⁷ Blanding dentist Dr. I.M. Cohn, once again chimed in on this subject, explaining that San Juan County “desperately needs a hospital right now, even if it starts with a modest building... as a most convenient location for saving lives, preventing accident complications, and most essentially for the health and welfare of the people.”⁴⁸ Years before the FSA started discussions about cooperatives, Cohn championed the cause to build a hospital in San Juan County. Cohn noted that a hospital represented the most “important project ever undertaken for the health and welfare of the citizens” of the county.⁴⁹ Advising prudence, the Blanding dentist recommended careful consideration of financing the hospital without overburdening any

⁴⁷ “America’s First Cooperative Hospital --- Money-Mad Doctors,” *San Juan Record* May 19, 1938, 1.

⁴⁸ “Blanding Dentist Approves Record Cooperation Stand,” *San Juan Record* July 21, 1938, 4.

⁴⁹ “Dr. Cohn of Blanding Expresses Strong Approval of Hospital Plan,” *San Juan Record* December 10, 1936, 1.

group. But he concluded that the benefits to the community would reach beyond health care to elevating the status of the community, advancing civic consciousness, and uniting the county.⁵⁰

San Juan County leaders faced something of a dilemma as they discussed the question of hospitalization. First, they debated whether to build a hospital in the county or establish a contract with a hospital in an adjacent county. In 1938, the hospital closest to and most frequented by San Juan County residents was in Moab, sixty miles north of San Juan County. Unlike the question of a practicing physician, medical cooperative leaders did not believe they were in desperate need of a hospital in the county. While having one doctor covering two counties was unacceptable, continuing the practice of San Juan County residents traveling to Grand County for hospital care did not seem unpractical. This fifty to eighty mile trip for hospital care was a reality that most of residents of San Juan County grew up with and planned for; therefore, it could prove hard for citizens to understand how a hospital could improve the health of the community. Furthermore, in the early stages of planning the cooperative, San Juan County leaders did not have complete confidence their health forays would prove successful. Turning away a physician after a year of service would be much easier than restoring capital costs of financing a hospital. In the final negotiations, San Juan leaders adopted the more affordable approach and contracted with Grand County Hospital, home to the cooperative's Medical Director, Dr. Allen.

⁵⁰ "Dr. Cohn Endorses San Juan County Health Program," *San Juan Record* March 31, 1938, 4.

Although this choice was more disappointing than controversial at first, the outpouring of success in early enrollment drives and fundraising ultimately turned some community members against the deal struck with the Grand County Hospital. After the cooperative raised over \$7,000 and opened for service, the health committee advised against rashly jumping from the Grand County agreement and establishing their own hospital. The cooperative board explained the financial success of the cooperative in the first year did not guarantee future outcomes. Prudence, they believed, marked the only path for long-term hospital building plans. The terms of service described in the cooperative contract limited the agreement between the cooperative and Grand County to one year, after which either party could renegotiate the terms.⁵¹

Financing a medical center in 1938 seemed out of reach for the cooperative leaders, but supporters explored ways to make their dream a reality. The ideas ranged from Dr. Cohn's modest hospital proposal to a cooperative hospital. The *San Juan Record* ran a series of articles about the idea of a cooperative hospital. In practice the facility would operate like a standard hospital, but the patients would own it. Cooperative hospitals had proven successful among the farming communities of the Midwest.⁵² The hospital in Elk City in western Oklahoma was approved by the residents of the community. Operating since 1932, the Elk City cooperative hospital proved to be an overwhelming success providing surgical, dental, and pharmaceutical services. To open a similar hospital, Dr. Michael Shadid, director of the Elk City Hospital, explained that communities needed \$100,000 for construction costs and medical materials. In the six

⁵¹ "Medical Committee in Disapproval," *San Juan Record* July 28, 1938, 4.

⁵² "America's First Cooperative Hospital --- Money-Mad Doctors," *San Juan Record* May 19, 1938, 1.

years from its opening, Elk City Hospital had over two thousand cooperative member families paying annual dues amounting to \$28 dollars each.

Although they embraced the cooperative principles, San Juan County's leaders knew the \$100,000 price tag was beyond their limited means. Also the idea that San Juan County could reach two thousand cooperative families in 1938 was a dream since there were not that many families in the entire county. Achieving the goal of two hundred families was obtainable, and so Grand County Hospital in Moab proved to be a workable option that benefited both counties.

Grand County hospital was anxious to share accommodations with the San Juan County residents to reap the economic benefits of expanded service. The Depression had affected hospitals in much the same way it had hurt physicians. Facilities were under-utilized as the sick avoided all health care for everything but absolutely critical services. Therefore, hospital beds remained empty. For the patients who were hospitalized, few had the resources to pay for services, and bills went unpaid. And further complicating the Depression's impact on hospitals, fund-raising efforts—a key component to hospital income structures—dried up.

In 1938, the Grand County Hospital contained faculties adequate to house sick from both counties. With the San Juan County Medical Cooperative contract signed, Grand County immediately applied for a \$60,000 Works Progress Administration grant to add forty rooms to the hospital. The expansion was based largely on the projected resources needed for San Juan County residents. San Juan County residents greeted the news of the grant application with disbelief. Leaders of the San Juan County explained that the expansion proposition seemed like a “risky” venture if financial success was

based on the “continued participation” of San Juan County. At any time the leaders continued, San Juan County could decide their cooperative was big enough and strong enough to establish its own facilities.⁵³ Knowing the mood of county, the *San Juan Record*—always an advocate of the county’s own health care facilities—explained if Grand County could expand its hospital with the support of San Juan County, then a two hospital system would be all the more practical. Residents of San Juan County could erect their own hospital and save the journey of sixty miles when they needed extra care.⁵⁴ But perhaps the most insightful analysis of the hospital situation came from Blanding dentist Dr. I.M. Cohn. He worried that any and all money sent out of San Juan County slowed progress rather than aiding in the development of the region.⁵⁵ Cohn’s claims were based on fact: allowing health care dollars to go to Grand County could only limit San Juan County’s ability to finance its own health care goals. Yet the temporary expedience of using the Grand County Hospital would turn into the cooperative’s only option for the next ten years.

A few other Utah counties faced similar dilemmas with health care expansion in the latter part of the 1930s. The addition of a hospital seemed the logical next step after expanding health care through FSA cooperatives. Following the San Juan County hospital discussion, Dr. Alfred Sorenson of Castle Dale believed the construction of a hospital in Emery County would reduce travel distance for medical care and limit the risk

⁵³ “Medical Committee in Disapproval,” *San Juan Record* July 28, 1938, 4.

⁵⁴ “San Juan’s “Place in the Sun’,” and “New Hospital Building For Moab Proposed,” *San Juan Record* June 14, 1938, 4.

⁵⁵ “Blanding Dentist Approves Record Cooperation Stand,” *San Juan Record* June 21, 1938, 4.

of possible transport accidents. Sorenson volunteered to remodel and equip his current office if the county could guarantee a sufficient number of cooperative medical and hospital contracts.⁵⁶ Emery County declined, but the movement for hospitals and their extra financial benefits was very much alive in Utah.

Despite the disagreements about creating a hospital in San Juan County and the statewide push to expand hospitals, San Juan county leaders opted for an approach which allowed for the greatest variation year in and year out, and the option which had the least financial risk. By contracting with the Grand County Hospital, the San Juan County Medical Cooperative ensured quality health care and low cost hospitalization.

Organization

After gathering support from the community, locating a doctor, and contracting with a hospital, the directors of the County Medical Cooperative only needed to package the health care plan for community residents. Building on early FSA models, San Juan County would create an affordable health care plan which would serve as the bedrock of local medical care for years to come.

The first medical cooperatives setup by the FSA in 1936 allowed for voluntary membership, freedom of choice of physician, and prepayment. Built from the foundation laid by the Resettlement Administration, the FSA cooperatives had very few lockstep

⁵⁶ "Emery County Now Studies Plans for Health Cooperative," *San Juan Record* October 13, 1938, 1.

principles mandated to all participants. Instead, FSA leaders like R.C. Williams and Frederick Dodge Mott geared efforts on group prepayment and voluntary participation. The FSA used two means to provide medical care to its clients: cooperatives and corporations. The latter form of health care was primarily limited to two major initiatives in North and South Dakota. A precipitous decline in health care in the northern Great Plains caused state medical providers, officials from a variety of New Deal organizations, and the Surgeon General to convene emergency meetings to solve the problem. The North Dakota Medical Association grew out of their efforts. This public-private program extended health care to all farmers that were on relief. Six months after the North Dakota launch, South Dakota had its own corporation.⁵⁷ The logistics of administering health care to such a large population proved difficult. Additionally, at times cooperatives overworked physicians and received too little income for their efforts. These factors doomed the Dakota corporations.

Cooperatives were easier to administer. Consequently, most FSA medical plans were cooperatives. San Juan County and all the counties establishing FSA medical systems in the state of Utah embraced this model. Within cooperatives, two forms existed. Simple trusteeships provided care outside of a defined group and a trustee administrated funds. The other form was an association in which local participants elected a board of directors to govern the plan.⁵⁸ San Juan County adopted the latter.

⁵⁷ Grey, *New Deal Medicine*, 43.

⁵⁸ Taylor, "The Farm Security Administration," 62.

Regardless of the type of cooperative, nearly all were based on a prepayment principle.⁵⁹ But there was the question of how often fees were due. Some cooperatives in the South allowed clients to pay monthly rather than the more traditional approach of an annual fee. The monthly fee was more cumbersome to manage, but it allowed clients more flexibility. Most cooperatives opted for annual dues, a choice which stabilized balance sheets.⁶⁰

Adopting the annual dues approach, the San Juan County Medical Cooperative needed to gauge the cost of health care for average residents. From a survey of residents, Mayor Lyman found that the average family devoted \$35 in 1936 for partial and inadequate medical services and \$57 dollars in 1937. Using a prepayment approach, the cooperative committee estimated that annual fees would be much smaller.⁶¹ The total dues for the San Juan system would amount to \$35 and provide coverage for an entire family, although the exact definition of family would be questioned in future years.

Early funding goals pushed for two hundred families to contract with the cooperative; later goals would be for over three hundred families. Dues would be the primary funding mechanism for the health plan, but the annual dues would only represent a part of the financial structure. Financing the doctor fees would be a combination of individual and family health contracts, the San Juan County School District, the

⁵⁹ Grey, *New Deal Medicine*, 169.

⁶⁰ Taylor, "The Farm Security Administration," 121.

⁶¹ "Blanding Chamber Commerce Active," *San Juan Record* April 14, 1938, 1.

incorporated cities of Blanding and Monticello, and funds from the State Board of Health.⁶²

With a funding structure in place, the San Juan County Medical Cooperative opened on July 1, 1938. The cooperative provided members two health care options. For an annual premium of \$25 per family, residents would receive a host of medical services, including surgical operations, maternity cases, laboratory work, examinations, vaccinations, and medical advice. Additionally, members of the cooperative had the option of purchasing hospital insurance. The hospitalization option totaled \$10. At \$35, the San Juan County cooperative was about the same price as other FSA cooperatives around the country. According to Brenda Taylor, plans in the South typically ranged between thirty and forty dollars.⁶³ In the Intermountain region, health plans had a wider range from twelve to seventy-two dollars.⁶⁴

Setting aside the benefits of the cooperative, the health plans did have a number of limitations. One of first requests of the health plans was to include dental services. The initial health plans failed to include a dental work clause. Additionally, Dr. Allen suggested that mental health and any diseases due to alcohol, drugs or criminal abortion be excluded from the cooperative. The policy excluded eye care and any type of appliance to correct the challenges of disabilities.⁶⁵ But in a surprising twist, the cooperative contract included treatment for pre-existing conditions. Excluding pre-

⁶² “San Juan Medical Co-op Organized: Plans Active Membership Drive Soon,” *San Juan Record* June 16, 1938, 1.

⁶³ Taylor, “The Farm Security Administration,” 114 – 117.

⁶⁴ Studt, *Intermountain Medicine*, 93.

⁶⁵ “San Juan Medical Co-op Organized; Plans Active Membership Drive Soon,” *San Juan Record* June 16, 1938, 1.

existing conditions would not occur in insurance policies until after World War II with the expansion of Blue Cross/Blue Shield plans.

As noted above, hospitalization was a separate part of the cooperative's health insurance policy. The cooperative's hospital option could be purchased for a ten dollar annual premium. The hospital rider enabled contracting families to receive a discounted day rate of one dollar per day. Services included nursing care, bed, meals, and laundry. The doctor held the sole judgment on the length of the stay.⁶⁶

At a total price of \$35, the cost of membership did present some challenges. First, low income farmers often could not afford membership. The relation between good health and loan repayment being well-known to the FSA, national guidelines enabled clients to borrow cooperative dues. If a farmer could not afford the annual payment, the fee was rolled into their farm loan.⁶⁷ Secondly, only a few members of the cooperative could expect to reap a full \$35 of services from the cooperative. As Grey noted "the FSA expected that higher-income families would be healthier and require less medical care." Cooperative principles would only work if families saw the purchase of insurance as a critical safety structure to assure good health.

The FSA medical cooperatives were successful in improving health for FSA client families, but FSA restrictions limited the improvement of health care for large segments of rural communities. Under FSA guidelines only FSA clients were eligible for membership in their health cooperatives. The medical cooperatives excluded high-income farmers without FSA loans and non-farmers from access to the medical cooperatives.

⁶⁶ Ibid.

⁶⁷ Studt, *Intermountain Medicine*, p. 93.

This situation provided a problem for San Juan County. Financially the county could not gather the monetary resources needed to relocate a physician to Utah without opening the health cooperative to the entire county. The FSA's understanding with the AMA was that medical cooperatives would be limited to the poorest and most destitute rural families. Continued federal influence in health care would damage the family-doctor relationship in the AMA's opinion. The FSA conceded this point and limited medical cooperative participation to only FSA clients. Undeterred by this guideline, San Juan County extended cooperative participation to the entire county. In 1941, when called before Congress to testify about the FSA medical plans, Chief Medical Officer Williams disavowed any responsibility for the cooperatives outside the FSA guiding principles. Williams argued that cooperatives like San Juan County strayed beyond the FSA clients—only policy at the behest of local doctors and some non-FSA participants were former clients who had repaid their loans.⁶⁸

San Juan County occupied a unique position because it offered FSA health care benefits to non-FSA clients. Geographically, only three western states had cooperatives with such inclusions: Nebraska, Montana, and Utah. Additionally these benefits were extremely limited in total participants with only 1,111 non-FSA families.⁶⁹ The group represented less than 0.5 percent of the entire FSA medical cooperative membership in 1941.

In July of 1938, Dr. Austin setup his office in San Juan County, splitting time between offices in Blanding and Monticello. The accommodations were humble to start.

⁶⁸ Taylor, "The Farm Security Administration," 123.

⁶⁹ Ibid.

The San Juan Health Cooperative located the offices at the Redd apartments in Monticello and in the home of Wayne H. Redd in Blanding. Dr. Austin alternated work between the communities: Monday, Wednesday, and Friday in Monticello and Tuesday, Thursday, and Saturday in Blanding.⁷⁰ With the opening of the health cooperative on July 1, soliciting membership ended. Following the membership drives, joining the cooperative required applying with Ralph Bailey at the L.H. Redd Store or with members of the committee of sixteen.⁷¹ The county medical commission announced that no new medical contacts for 1939 could be entered into after December 31, 1938.⁷²

Conclusion

With the establishment of the San Juan County Medical Cooperative, the local leaders who had promoted the idea, relocated a physician, negotiated with a hospital, and organized health care plan had little left to do. Local supervisors for the FSA had a key role in organizing the cooperative, but once the organization was functioning San Juan County's FSA supervisor Dave Evans had a much reduced job description. While he still provided loans for some FSA clients, his role in health care was to generally promote "harmony within the medical cooperative." What this phrase meant was up for interpretation, but nationally the FSA advised supervisors to avoid diagnosing any medical condition or even suggesting a particular doctor within the cooperative. Instead,

⁷⁰ "Be Reasonable," *San Juan Record* July 7, 1938, 5.

⁷¹ "Cooperation Triumphs Once More in New Field," *San Juan Record* July 7, 1938, 1.

⁷² "Notice," *San Juan Record* September 29, 1938, 16.

supervisors were to encourage the public health concerns of window screens, clean homes, clean water access, and food preservation.⁷³

⁷³ Taylor, "The Farm Security Administration," 125.

CHAPTER 3

WORKLOAD, NURSES, PUBLIC HEALTH, AND CHANGE

From the establishment of the San Juan County Medical Cooperative in July of 1938 to the start of World War II, Utah and FSA administrators/leaders wrestled with the responsibilities of a community medical program. Growth characterized FSA medical plans during this time period. From relatively few programs, like San Juan County's plan, "By 1942, there were medical care cooperatives in a third of the rural counties in the United States."¹

Yet this growth was quiet. Little information from the era, beyond the simple statistical data, suggests anything revolutionary was occurring in the agricultural communities throughout the country. Only state and national medical societies seemed to be paying attention to the work of the FSA. National officials of the FSA made a concerted effort to keep publicity at a low level. The FSA allowed the regional information specialists, the major mouthpieces for the administration, to be kept in the dark about subject of medical plans and openly discouraged from publishing about the successes of the health cooperatives. Although not encouraged to promote the medical care programs, regional information specialists were to publicize any environmental sanitation work, a major aspect of the FSA's public health initiative. But even in this

¹ Michael R. Grey, *New Deal Medicine: The Rural Health Programs of the Farm Security Administration* (Baltimore: John Hopkins University Press, 1999), 49.

health topic, national FSA officials advised giving ample credit to state and local health departments.²

During this period of quiet but exceptional growth, San Juan County would confront the pains associated with expansion and efforts to maintain growth over time. After the initial surge of patient care with the founding of the cooperative, San Juan County leaders and physicians fell into the routine of public health concerns. Questions would arise about workload expectations for physicians employed by the cooperatives. While the male-dominated profession of doctors became the focus of the FSA medical cooperatives, women served an equally important, yet understudied, role in the health programs throughout the organization's history. Finally, patient coverage questions would lead to the expansion of services into dental and comprehensive care. This chapter explores the demands placed on a new doctor in a rural community, the role of women within the healthcare system, and the tensions between the local and national medical associations as the San Juan County Medical Cooperative confronted change in its first years.

Doctor Workload

Dr. Austin was at the heart of the San Juan County Medical Cooperative. Drawing a physician to the county represented a major victory for Joseph Harris and county

² R.C. Williams, Chief Medical Officer, to L.I. Hewes, Jr., Regional Director, December 9, 1940, 163-01 Public Relations Newspapers and Magazines 7-1-40 to 12-31-40 [1], Box 32, Record Group 96, National Archives and Records Administration, Pacific Region, San Bruno, CA.

leaders. But the honeymoon period proved short. New members of the cooperative swamped Dr. Austin through most of the first year, leading to job burnout and some disenchantment with the system. A FSA home supervisor, Freda Davis of Uintah County, succinctly summarized the frustrations experienced by some physicians within the cooperatives: “The doctors gave too much service for what they got.” The FSA sold the idea of cooperatives to doctors by claiming that fees were paid upfront and many of the clients would be from income levels that normally would default on bills. The trouble was that all cooperative members wanted to get their entire premium’s value in health care. Eventually doctors became disenchanted with the workload and “wouldn’t join up and honor the program anymore.”³

During the first month of the program, patients with serious medical conditions jumped at the opportunity for health services. Within the first week, Austin sent six members of the San Juan cooperative to Moab for hospital services. Continuing with its usual pattern, the *San Juan Record* championed the success of the program, highlighting patient success stories like that of Mrs. Leon Adams. Adams gave birth to a baby girl by Caesarian and also had a diseased appendix and ovaries removed, all of which the cooperative covered the entire cost for her one-time enrollment fee of \$35. The normal price for these procedures would range from \$500 to \$1000. At the low end price of \$500, these operations represent one tenth of the principal held by the county cooperative. One patient using a tenth of the annual budget in a single incident would

³ Ward Studt, Jerold G. Sorensen, and Beverly Burge, *Medicine in the Intermountain West: A History of Health Care in Rural Areas of the West* (Salt Lake City, Utah: Olympus Publishing Co, 1976), 98.

prove to be a problem for the financial sustainability of the association.⁴ Of course patients cheered this medical plan, but health providers had mixed reviews. Dr. Austin and the Moab Hospital received less than one tenth of their normal billing rates. This issue caused the state medical society to question the financial standing of the San Juan County Medical Cooperative. Furthermore, the concerns of health professionals would lead to future changes within the county health plan.

Beyond the issue of compensation, workload was a major issue for coop physicians. As the centerpiece of the cooperative, Dr. Austin's attitude towards collective health was paramount to the success of the organization. Unfortunately almost immediately after arriving in San Juan County, Dr. Austin complained that he was getting the "run-around" during the first month of the cooperative. Members of the association from every end of the county requested home visits. Such travel in a country the size of San Juan represented a major challenge of time and resources.

Ideally, physicians would see most patients in the medical office, not in the home. Nationwide in 1943, the ratio of office visits to home visits was 4.7 to 1. In rural communities of five thousand people or less, the ratio was two office visits to one home visit. Mott and Roemer argued this data means that despite the removal of financial barriers, cooperative members "rarely abused the privilege of calling a physician out to the farm."⁵ Although Mott and Roemer felt the ratio did not represent abuse, home visits presented a major obstacle for improving rural access to health care. In a country like San

⁴ "County Health Program Functions," *San Juan Record* (Monticello, Utah) July 7, 1938, 4.

⁵ Frederick D. Mott and Milton I. Roemer, *Rural Health and Medical Care* (McGraw-Hill Book Co., 1948) 398-399.

Juan, even an unlimited number of doctors was useless if they devoted most of their time to travel. Improving the health of the community required providing opportunities for cooperative members to meet centrally with a physician. Increasing individual doctor to patient time had to be a priority, but home visits added to the stress of physicians, reducing the time they could dedicate to healing and compounding the workload when returning to the office.

The historical record does not provide an exact account of the number of home visits Dr. Austin made in his first year, but the situation forced the advisory committee to issue a statement to subscribing members to be reasonable with their demands. With emergencies as the exception, members of the cooperative were to visit the doctor at his office in Blanding or Monticello during normal business hours.⁶ Mott and Roemer noted that the concept of emergency was “broadly interpreted.”⁷ The *San Juan Record* explained that Dr. Austin had to go “days and nights” at a time without any sleep. Then turning the situation positive, the *Record* concluded “but he always wears a smile.”⁸ Nine months later the situation had changed for Dr. Austin. Rather than home visits, most patients were making office visits. The *San Juan Record* reported, “There seems to be an almost constant stream of patients [at Austin’s office] seeking his advice and services.”⁹

Dr. Austin did not openly criticize the workload in San Juan County, and there were very few complaints about the quality of his care and professional experience. Perhaps the *Record*’s picture of Dr. Austin was correct. Then often times the patient’s

⁶ “Be Reasonable,” *San Juan Record* July 7, 1938, 5.

⁷ Mott and Roemer, *Rural Health*, 395.

⁸ “County Correspondence,” *San Juan Record* August 25, 1938, 8.

⁹ “Dr. Austin is Busy Man,” *San Juan Record* April 27, 1939, 16.

perception of quality care could be based on the price of the medical bill. Arvilla Warren, a resident of Monticello, joined the Coop shortly after getting married. Warren would go on to have a baby while on the program. “The care was very personal,” she commented. “Dr. Allen went with me to the hospital and was with me the whole time.”¹⁰

With such a positive endorsement, the San Juan cooperative was destined for lasting success. Establishing the infrastructure for the San Juan County Medical Cooperative, doctors and nurses facilitated the health care, but it was happy patients that built the program through positive feedback to neighbors.

Nurses and Public Health

The role of women as healers has been a time honored tradition. Thus far in the discussion of the San Juan County Medical Cooperative, little has been said of women’s roles in the expansion of health care in the region. No studies of FSA medical cooperatives include an examination of gender roles with the health system. This unfortunate situation was largely the result of the male-dominated leadership of the county hiring a professional from a male-dominated profession of trained physicians. Within FSA medical history and in San Juan County, women residents and healthcare providers played a vital role in the transformation of the rural medical care of Utah.

¹⁰ Studt, *Intermountain Healthcare*, 110.

Female nurses provided professional training and needed assistance to the FSA medical cooperative in San Juan County.¹¹

Two organizations provided San Juan County with nurses during the 1930s: the Red Cross and the Utah State Health Department. The first Red Cross nurse came to the county in April of 1930.¹² The Red Cross historian, Portia Kernodle explained that through the 1920s and early 1930s, Red Cross nurses and nurses supported by government agencies often struggled to define the spheres of influence and services each party would be responsible for providing.¹³ In San Juan County, that struggle for turf never seemed to materialize.

Across rural America, countless public health nurses lessened the strain of physicians' workloads. San Juan County had the services of nurse Dorothy Bayles before the start of their FSA health cooperative. Bayles oversaw the transition from midwives to modern medicine. At the founding of the San Juan County health department, she was the only medically trained professional of any level in the county. With the shortage of medical personnel, she had to fill the role of health instructor and provide many of the services doctors performed.¹⁴ As Mott and Roemer explained, "Public health workers of all kinds...will follow the establishment of a full-time local health department."¹⁵ Thus, the work of the local health department and their nurse laid the foundation for establishment of the FSA's medical cooperative in San Juan County. But after the

¹¹ For the development of the nursing profession, See John Duffy, *The Healers: A History of American Medicine* (Urbana: University of Illinois Press, 1979), 279-283.

¹² "Red Cross Nurse will arrive about April 1," *San Juan Record* February 20, 1930, 1.

¹³ Portia B. Kernodle, *The Red Cross Nurse in Action* (Harper & Bros., 1949), 275.

¹⁴ Mott and Roemer, *Rural Health*, 345

¹⁵ Mott and Roemer, *Rural Health*, 521.

opening of the cooperative, Nurse Bayles took an ancillary role in the health plan. Working with Dr. Austin in the Monticello office, Bayles conducted preschool children examinations and directed tonsil clinics.¹⁶

While the county health department and Nurse Bayles laid the foundation for the medical cooperative, the founding of the cooperative enabled San Juan County to hire a second nurse. In 1930, the Red Cross placed a solitary nurse in San Juan County.¹⁷ An additional nurse allowed the cooperative to have a health professional permanently located at Blanding and Monticello, while the doctor could rotate between the towns. After the four month stay of the nurse, over nine years would pass before the agency stationed another nurse in the county. The gap between Red Cross nurses was likely caused by the absence of a doctor. The distribution of nurses has been known to follow that of doctors according to Mott and Roemer.¹⁸ On February 2, 1939, the *San Juan Record* reported that Miss Helen Peters, a representative of the Red Cross Nursing Service, was investigating the feasibility of placing a nurse in the county.¹⁹ Red Cross approval for an itinerant nurse would come shortly afterwards. Although the National American Red Cross was the primary sponsor of the new nurse, the other sponsor was the San Juan County Medical Cooperative. When the county established a Nursing Activity Committee, members included FSA San Juan County Supervisor David Evans and Dr.

¹⁶ "County Correspondence," *San Juan Record* August 25, 1938, 8.

¹⁷ Portia Kernodle explained that following the Great War, the Red Cross shifted its nurses to public health nursing efforts. This expansion of service was a fight against the "continuous disaster of preventable disease." Additionally, this era, 1930 – 1940, represents a prolonged period of decline for the American Red Cross. See Kernodle, *Red Cross Nursing*, 275.

¹⁸ Mott and Roemer, *Rural Health*, 521.

¹⁹ "Local News," *San Juan Record* February 2, 1939, 16.

Austin of the medical cooperative. The complete integration of FSA officials and the Red Cross nursing efforts point to the fundamental role the cooperative played in bringing more health care professionals to the county.²⁰

Red Cross nurses attempted to be as inclusive as all other public health workers. The nurses conducted clinics, health stations, school visits, and home visits in an effort to present information on a variety of topics including prenatal care, maternity care, infant and child welfare, care of crippled children, school nursing, tuberculosis work, communicable disease control, sanitation, and bedside nursing. Historian Portia Kernodle noted that the task facing rural Red Cross nurses was staggering: transportation infrastructure was poor, the hours of work long, living conditions rough, and social life bleak.²¹

Trained nurses were in high demand in the 1930s, and served to reduce the workload for overextended individual doctors. In April of 1939, the American Red Cross and the San Juan County Medical Cooperative collaborated to bring Anne Fields Anderson, an itinerant Red Cross nurse, to San Juan County. Anderson worked under the direction of Dr. Austin, with much of her plan of action in the county developed by a Nurse Activity Committee lead by Lovina Redd, a member of the Monticello Relief Society. The itinerant Red Cross nurse worked in the office of Dr. Austin, made home

²⁰“Itinerant Nurse to Begin Duties Soon,” *San Juan Record* March 30, 1939, 13.

²¹ Kernodle, *Red Cross Nursing*, 265.

delivery calls, and assisted in surgery.²² Anderson's service for four months in San Juan County was a standard duration for an itinerant Red Cross nurse.²³

The FSA attempted to use a multi-faceted approach to health care which incorporated nurses, dentists, health educators, sanitarians, and home management supervisors.²⁴ These professionals served a preventative purpose in the medical plans, whereas the doctors filled the treatment aspect. In general, the preventative services fell into the broad category of public health.²⁵

1934 saw the creation of the Public Health Service. Charles - Edward Amory Winslow defined public health as the "science and art of preventing disease...through organized community efforts for the sanitation of the environment, the control of community infection, the education of the individual in principles of personal hygiene, the organization of medical and nursing services for early diagnosis and preventative treatment, and the development of the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health."²⁶ Historically, health departments began to develop after the Civil War. The AMA viewed the public health movement cautiously. Historian Paul Starr noted that "while they favored public health activities that were complementary to private practice, they opposed those that were competitive."²⁷ By the 1930s, the functions of public health

²² "Red Cross Nursing Schedule Announced," *San Juan Record*, April 20, 1939, 13.

²³ "Itinerant Nurse to Begin Duties Soon," *San Juan Record*, March 30, 1939, 13.

²⁴ Grey, *New Deal Medicine*, 170.

²⁵ Mott and Roemer, *Rural Health*, 334.

²⁶ Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York: Basic Books, 1982), 180.

²⁷ Starr, *Social Transformation*, 185.

departments were becoming more fixed and routine, as well as less prestigious than clinical medicine.²⁸ Public health activities promoted by the FSA supported the efforts of the private practice of local physicians.

The connections between public health and the medical profession provided some understanding of why the medical associations carefully guarded their industry. It would seem that doctors and public health officials would be natural allies in protecting communities against disease. As public health expanded its efforts to counter social ills, physicians began to worry about the impact of public health programs on their personal income. In the end, medical associations would create barriers to protect private physicians, by relegating public health to the areas of education and sanitation.²⁹

In San Juan County, nurses filled the need for public health officials. Often one of the first steps in a public health movement would be to hire a nurse to find and refer patients to physicians, treat minor injuries, teach self-care, and do follow up work.³⁰ This was the case in San Juan County with the initial hiring of Dorothy Bayles in 1934 by the state.

The effectiveness of public health nurses has been the subject of some debate. Although historian Paul Starr claimed that public health efforts often barely reached the stage of sanitary reform in the South and the West, the FSA work in Utah reached past sanitation to public health classes and response to disease outbreaks.³¹ The Red Cross

²⁸ Starr, *Social Transformation*, 197.

²⁹ Brenda Jeanette Taylor, "The Farm Security Administration: Meeting Rural Health Needs in the South, 1933 – 1946" (Ph.D. diss., Texas Christian University, 1994), 178.

³⁰ Starr, *Social Transformation*, 188.

³¹ Starr, *Social Transformation*, 185.

nurse Anne Fields Anderson conducted a general public health program, including classes in Home Hygiene and Care of the Sick.³² Her classes represented a step in the direction of preventative care. In San Juan County, Anderson conducted these classes in the Women's Relief Society meetings of the LDS Church each Monday night. The goal of the courses was to help women become better homemakers and more capable of keeping their families healthy by showing them basic nursing skills. Students in the free courses learned how to make beds for patients, give bed baths, take temperatures, check pulse and respiration, change and apply sterile dressings, care for babies, feed and train children, and keep themselves in good health.³³ Anderson led National Child Health Day, first aid training, and home nursing classes as well.

In terms of preventative care, the San Juan County Medical Cooperative provided defensive measures against the most serious contagious illnesses. Dr. Austin provided community alerts through the *San Juan Record* when particularly dangerous maladies appeared in the region. Unfortunately many of the highly communicable diseases had a much higher prevalence in rural communities due to the lack of medical knowledge,³⁴ so having trained health professionals in the region reduced their risks. After Dr. Austin diagnosed two cases of scarlet fever in November 1938, he warned parents and teachers to watch for suspicious cases of sore throat and fever.³⁵ This public service represented a vital protection against highly communicable diseases. In December of 1938, he rushed

³² "Red Cross Nurses Enter Rural Service," *San Juan Record* June 15, 1939, 5.

³³ "Red Cross Nurse to Make Headquarters in San Juan County," *San Juan Record* March 14, 1940, 1.

³⁴ Mott and Roemer, *Rural Health*, 92, 112.

³⁵ "General Items," *San Juan Record* November 17, 1938, 13.

to Bluff after receiving a report of a small pox outbreak. Dr. Austin was able to vaccinate most of the residents. Although the report proved to be false, the speed of Austin's response demonstrated the value of having a county doctor.³⁶

In connection with the agreement to ensure the health of children, Dr. Austin and Nurse Bayles performed physical examinations of all school-aged children, beginning with the primary grades and progressing through the higher grades.³⁷ The practice replaced the noble efforts of Joseph Harris in arranging health examinations by doctors visiting from Salt Lake City for all the students at San Juan County schools.

FSA home supervisors provided another aspect to the public health activities of the FSA. Visiting the homes of farmers with FSA loans, the home supervisors extended the discussion of public health directly in the heart of rural communities. Like the hygiene classes and training provided by community nurses, home supervisors communicated simple and practical advice to improve the conditions of rural residents. A typical supervisor would oversee the replacement of cotton bedding, distribute sanitary privies, and build cisterns for water chlorination, all proactive practices which established a pattern of healthy living.³⁸

Mott and Roemer argued that one of the most important aspects of the FSA medical plans was the emphasis on preventative care. Public health measures elevated the standard of living within communities, which improved the health of the population.³⁹ The Red Cross rotated nurses through San Juan County until the beginning of WWII.

³⁶ "Local News," *San Juan Record* December 15, 1938, 16.

³⁷ "Local News," *San Juan Record* December 1, 1938, 16.

³⁸ Studt, *Intermountain Healthcare*, 97.

³⁹ Mott and Roemer, *Rural Health*, 408.

With the start of the war, demands on nurses and all health care professionals shifted, and the Red Cross itinerant nursing program discontinued its efforts in the county. The health department nurse funded by the state of Utah would remain though the present day.

Confronting Change

Examining questions about doctor workload, nursing, and public health contributes to understanding the historical legacy of the FSA medical cooperatives. A year after the creation of the health plan, San Juan County celebrated what they considered to be a great success by holding a festival up a local canyon. The festivities surrounding the first anniversary of the San Juan County Health Cooperative marked another kind of compensation for the health professionals. Inviting Dr. Austin, Dr. Allen, Nurse Anderson, and Nurse Bayles, the county thanked the professionals in a way only a rural community could by making them guests of honor for a celebration of the cooperative.⁴⁰

The San Juan Cooperative was turning into a success. 1939 witnessed the growth of the medical cooperative to 185 contracts in total.⁴¹ The growth would be copied throughout the state of Utah, but not in the rest of the western states composing the FSA's region IX. In July 1941, the Southwest Intermountain Committee of the House of Representatives requested information on FSA medical cooperative activities in Region

⁴⁰ "Cooperation Triumphs Once More in New Field," *San Juan Record* July 7, 1938, 1.

⁴¹ "Cooperative Medical Contracts Coming in," *San Juan Record* August 3, 1939 1.

IX. The committee had particular interest in the areas covered by cooperatives, number of families, 1940 expansion, and the types of care covered in each program.⁴² In response, William A. Anglim, acting director of Region IX, explained that in the states of California, Nevada, Arizona, and Utah, only Utah had active medical cooperatives.⁴³

Active involvement of the local Mormon church leadership likely facilitated the establishment of the medical cooperatives and enabled them to thrive after creation. Utah's all-encompassing involvement with the FSA is surprising. Not only were Utahns more likely to be in a medical cooperative, they were also more likely to be part of a standard FSA cooperative. The Beehive state had over 65 percent of the total loans in Region IX in 1941.⁴⁴ Considering the agricultural powerhouses of California and Arizona were in the same region, the percentage of loans going to Utah was almost unbelievable.

Despite the successful startup of the medical cooperative movement in Utah, individual counties still needed to address concerns and adjust their organizations as problems arose. San Juan County's unique challenges included the issues of capitation, coverage, and doctor replacement. The idea of capitation financing caused questions for the administrators of the San Juan Medical Cooperative. Capitation is the prepayment for medical services, whether or not the individual seeks care, forming the financial

⁴² Laurence I. Hewes, Jr., Regional Director of the Farm Security Administration, to Mr. Hollenberg, Assistant Regional Director, San Francisco, July 11, 1941:070 Cooperation SW Intermountain Committee 7-1-41 to 6-30-42, Box 12, Record Group 96, National Archives and Records Administration, Pacific Region, San Bruno, CA.

⁴³ Community and Cooperative Services Developed on Application Form FSA-RR 23, Region IX, June 30, 1941.070 Cooperation SW Intermountain Committee 7-1-41 to 6-30-42, Box 12, Record Group 96, National Archives and Records Administration, Pacific Region, San Bruno, CA. California had medical plans, but those were considered corporations, not cooperatives.

⁴⁴ Community and Cooperative Services Developed on Application Form FSA-RR 23, Region IX, June 30, 1941.070 Cooperation SW Intermountain Committee 7-1-41 to 6-30-42, Box 12, Record Group 96, National Archives and Records Administration, Pacific Region, San Bruno, CA.

foundation of the San Juan County Medical Cooperative. In time, the simple question of a cooperative member caused an extended debate about the nature of this financial agreement: In December 1939, cooperative member Vint Lyman moved from the county and requested a refund of his “contract money.” Could an individual contracted with the cooperative withdraw and receive monetary compensation? The financial stability of the organization required the health care planners to know the annual working budget. Any unexpected credit or debit would cause consternation. After due consideration, the Cooperative denied Mr. Lyman’s request, but advised him that his health contract would be valid through the end of the term, June 30, 1940.⁴⁵

The issue of capitation was not the only concern to confront San Juan County. Medical Historian Ward Studt noted that abuse led to the demise of some FSA medical plans.⁴⁶ In 1943, the county medical committee debated an issue that could be labeled as abuse of the health plan. Early advertising for the medical cooperative promoted the idea of one fee covering health costs for the entire family. The cooperative never clearly outlined the exact definition of a family member. Some members of the association interpreted the contract’s clause on family membership to extend to married children, in-laws, extended family relatives, and adult children. In response, the medical board ruled unanimously to limit the health contract to only the immediate family: a husband, wife and single children under the age of 21. As a concession, the cooperative board allowed individuals who reached 21 to purchase the health contract for the yearly rate without the normal one time membership fee, provided their families were members of the

⁴⁵ “San Juan County Medical Co-Op Calls Emergency Meeting,” *San Juan Record* December 28, 1939, 1.

⁴⁶ Studt, *Intermountain Healthcare*, 110.

cooperative in the year prior to their application. Further the board outlined that if a member should marry during a contract year, the spouse could be added to the contract for an additional payment of \$25.⁴⁷

If only the major issues addressed by the San Juan County were simply defining the terms of coverage, some members of the cooperative would have had no cause for concern. The precarious state of rural health was highly dependent on retaining competent professionals. Although finding a doctor to participate in the cooperative could be difficult for rural communities, replacing a doctor was a crisis. Wayne County witnessed the doctor carousel from 1940 to 1943. In the latter year, Wayne County's physician opted out of his contract. In a 1943 *Salt Lake Tribune* editorial, Fred Brown, president of the Wayne County Medical Association, explained that without a physician the county would face major hardships. Driving to the nearest town with a physician represented at least a fifty mile journey to Richfield. When the doctor left Wayne County no doctor could be located to replace him.⁴⁸

Administrators in San Juan faced this situation in December of 1939 when Dr. Harold Austin fell sick. Unable to fulfill the responsibilities of the position, the cooperative administration faced a real crisis. They dispatched Dr. I.W. Allen to find another physician immediately. The cooperative leadership hoped the new physician would work with Dr. Austin, dividing the responsibilities of the county. When Dr. Austin

⁴⁷ "Health Association Contracts Increase," *San Juan Record* July 15, 1943, 1. The single children over the age of 21 clause seemed to be sizable problem. In 1945, the Association called to the attention of all members that the contract excludes those over the age of 21. See "Health Association Notice," *San Juan Record* July 12, 1945, 1.

⁴⁸ Studt, *Intermountain Healthcare*, 97.

returned to better health, then the county would have the services of two physicians. However, bank rolling two physicians posed a major issue for the members of the cooperative. Financing one doctor in the county proved a challenge for San Juan County; funding two doctors would force the cooperative to raise the guaranteed number of contracts to three hundred, a number of families too high for the county's fledging medical plan.⁴⁹

Expansion of the medical cooperative tested the financial well-being of the organization. Adding a new doctor in the county marked a major step which the cooperative board was not ready to make. The enrollment drive for medical contracts failed to reach the three hundred quota agreed upon to establish physicians in both Blanding and Monticello and to maintain the oversight of Dr. I.A. Allen in Moab. Without more enlistees the health plan would need to be dropped or revised to a sustainable size. The community solicited the help of the local LDS congregations to reach the quota. Local church leaders agreed to query members of priesthood quorums and relief society organizations.⁵⁰

From November 1940 to February 1941, community leaders pleaded for additional enrollment, but few came. The community members who viewed healthcare as a priority had already contracted with the cooperative. New ways of raising funds served as the topic of a mass meeting in February 1941.⁵¹ With limited options, the San Juan Medical Cooperative made large changes for the upcoming contracts. New terms

⁴⁹ "San Juan County Medical Co-Op Calls Emergency Meeting," *San Juan Record* December 28, 1939, 1.

⁵⁰ "Medical Cooperative Committee Hold an Important Meeting," *San Juan Record* November 28, 1940, 1 and 5.

⁵¹ "Mass Meeting on Saturday Evening," *San Juan Record* February 13, 1.

included a membership fee of \$25 plus the regular contract price of \$40. Existing members of the cooperative could waive the membership fee if they renewed by November 30. Membership included hospitalization. Although formerly this aspect was an independent aspect of the medical cooperative, the leaders felt merging hospitalization with doctor contacts would strengthen and stabilize the program.⁵²

Dr. Allen found the second physician in Dr. Wesley Bayles, a recent graduate of the Nebraska Medical College at Omaha.⁵³ Dr. Austin left the cooperative in August of 1940, replaced by Dr. J.E. Roark, who in turn backed out of the contract later that year before setting foot in San Juan County.⁵⁴ Although some circumstances aided turnover, the San Juan Medical Cooperative had five different doctors in less than three years.

Doctors permanently relocating to San Juan County were all new physicians. Although medical schools prepared their students for careers in health care, there was clearly a lack of experience among the physicians in San Juan County. In a similar countywide cooperative in Taos, New Mexico, the two physicians involved recently graduated from medical school and were using the experience to fulfill national social service obligations.⁵⁵ As part of his experience in San Juan County, Dr. Austin was to be mentored by Dr. Allen of Moab.

Increasing the price of the cooperative was a necessity given the contract San Juan had with the Grand County Hospital. The medical center failed to collect on a number of invoices from the San Juan County cooperative in 1938. This situation was not

⁵² "Medical Program Question Box," *San Juan Record* May 1, 1941, 1.

⁵³ "Appointment of Dr. W.L.Bayles," *San Juan Record* June 13, 1940, 1.

⁵⁴ "Dr. J.E. Roark will serve in Monticello," *San Juan Record* August 15, 1940, 1.

⁵⁵ Grey, *New Deal Medicine*, 116.

a position that the hospital wanted to continue. The hospital avoided setting the precedent of short payments by cooperative members and the members further understood cooperative had some limitations.

The changes guided the cooperative to higher enrollments. William Ervin Palmer, the county welfare director, announced in July that contracts applied for were in advance of previous years. He argued that this was possibly the result of the time limit placed by the cooperative board, but more likely was “people [were] beginning to realize the advantages gained through co-operation with the plan.”⁵⁶ Even with the beginning of World War II, the medical cooperative reach an operating level where continued success seemed sure.⁵⁷

In terms of services provided to residents of San Juan County, the medical cooperative was a success. The cooperative raised the level of medical care in the community and established a permanent physician in the county. In the first two years, over \$44,000 worth of health care was provided in the Grand Hospital through surgeries and medical care. Additionally, the cooperative furnished members with home deliveries, tonsillectomies, school services, and office calls. This balanced health service, San Juan residents could easily see the value of for their community.⁵⁸

On the other hand, collection issues frustrated the medical facility in Grand County. Cooperative members purchasing the hospital portion of the health plan were provided hospital services for one dollar per day. After an extended hospitalization, some

⁵⁶ “Medical Co-Operative Plan Progresses,” *San Juan Record* July 3, 1941, 1.

⁵⁷ “Medical Board Meets to Discuss Progress,” *San Juan Record* January 15, 1942, 1.

⁵⁸ “Medical Cooperative Committee Hold an Important Meeting,” *San Juan Record* November 28, 1940, 1 and 5.

patients left the hospital owing money. After the first year of service, the Moab hospital issued an ultimatum to the cooperative: rectify the past due accounts or risk losing the services of the hospital. Although it was very unlikely that the Grand County Hospital would have ended the contract with San Juan County due to the capital building projects they had entered based on San Juan County usage, San Juan County officials addressed the concern with care and tact. The San Juan County Health Committee contacted delinquent borrowers and issued community notices for cooperative members to settle with the hospital. Additionally, a new contract was created for hospitalization. All patients were required to make a deposit when entering the hospital and settle all accounts upon release.⁵⁹ With the new arrangements the hospital and the cooperative continued their mutually beneficial agreement.

Promoting their health plans, the Health Committee repeatedly called on the residents of San Juan County to sign up for the pre-paid insurance plans. This promotion was an ongoing process. In stories patients provided the *San Juan Record*, the convenience and security of the health plans were trumpeted. Promoters viewed membership in the association as an investment in individual and community health. Following the outbreak of WWII, The *San Juan Record* warned that the possibility of epidemics and ill health increased during war due to overwork, change in diet, and shifting of families from one area to another.⁶⁰ Coop prices held steady through 1943 at \$40 with a one-time \$25 membership fee.⁶¹ Price increases did not go in to affect until

⁵⁹ "San Juan County: Medical Cooperative Committee," *San Juan Record* September 21, 1939, 4.

⁶⁰ "County Cooperative Health Association," *San Juan Record* May 27, 1943, 1.

⁶¹ "Notice to Members of Health Association," *San Juan Record* May 3, 1943, 5.

1946, when the price increased to \$45 per family.⁶² Newspaper advertisements for the cooperative declined over time; by 1944, there was only one notice in the *San Juan Record*.⁶³ Firmly established, the cooperative could rely on word of mouth as its primary form of advertising.

The discussion of restrictions and pricing did not slow down efforts to expand the cooperative. San Juan County health professionals still had greater plans for their cooperative. At the forefront was Blanding dentist Dr. Cohn. Although dental care was not a major part of the FSA medical program, its inclusion in many communities suggests that oral care was important. Rural residents rarely made preventative visits to the dentist, and the need for dental care across the country was great.⁶⁴ Through June 1940, there were nine medical and dental plans in Utah.⁶⁵

From the beginning of cooperative discussions in San Juan County, community leaders argued for the inclusion of dental services in their health cooperatives. Of course Cohn pushed for dental services because it would increase his business and financial security.⁶⁶ He detailed the necessity of dental treatment in the healing process and in preventing disease.⁶⁷ Despite that coop leaders excluded dental care from the original county health plan because of the cost. At \$35 in 1938, cooperative membership costs for physician and hospital care butted up against the health care estimates of the county

⁶² "Time to Renew Your Medical Contract," *San Juan Record* June 27, 1946, 1.

⁶³ "Time to Renew Your Medical Contract," *San Juan Record* June 22, 1944, 1.

⁶⁴ Grey, *New Deal Medicine*, 91.

⁶⁵ Community and Cooperative Services Developed on Application Form FSA-RR 23, Region IX, June 30, 1941.070 Cooperation SW Intermountain Committee 7-1-41 to 6-30-42, Box 12, Record Group 96, National Archives and Records Administration, Pacific Region, San Bruno, CA.

⁶⁶ "Medical Cooperative Committee Hold an Important Meeting," *San Juan Record* November 28, 1940, 1 and 5.

⁶⁷ "Dr. Cohn Endorses San Juan County Health Program," *San Juan Record* March 31, 1938, 4.

residents. Adding another health service to the medical plan would have raised the price tag above \$40 per family and discouraged membership enrollment. While dental care could have been added as a rider policy, similar to hospital care, this approach would have further complicated record keeping for the medical cooperative's limited staff. Despite the exclusion of dental care from the original cooperative agreement, Dr. Cohn did not abandon his efforts to get this service included in the San Juan and Grand county cooperatives. Meeting with Dr. Ballinger, a dentist in Moab, Cohn formulated strategies to get the cooperative to invite the dentists into the pool of accepted health practitioners.⁶⁸

In December of 1940, dentists in Utah saw the benefit of cooperating with the FSA. Secretary of the Utah State Dental Association, Dr. D.L. Folsom informed the FSA regional office in San Francisco that Utah dentists wanted to serve low-income farmers. The approval of the dental association made over 4,500 farmers eligible for cooperatives.⁶⁹ The first dental plans were established in Uintah, Duchesne, Sanpete, and Sevier counties in April of 1941. The cost ranged from \$18 to \$22 per family.⁷⁰ Dr. K.W. Merrill, president of the Utah State Dental Association, predicted the expansion of the programs over the course of the next few years.⁷¹

Dr. Merrill's optimism never panned out in San Juan County, nor did the efforts of Dr. Cohn. By 1942, Dr. Cohn had decided to relocate to Independence, Kansas. Like Wayne County, when San Juan County lost their dentist, thoughts of a dental arrangement were largely gone. Some continued to push for a San Juan dental plan. In

⁶⁸ "Daughters of Pioneers Hold Annual Party," *San Juan Record* January 19, 1939, 4.

⁶⁹ "Dentists Plan Aid for Clients of FSA," *Salt Lake Telegram* December 3, 1940, p. 12.

⁷⁰ "F.S.A. Borrowers to Get Dental Care," *Manti Messenger* April 11, 1941, p. 1.

⁷¹ "Utah Dentists Set up FSA Aid," *Salt Lake Telegram* June 26, 1941, p. 24.

early 1946, the women's section of the County Agricultural Planning Committee recommended the San Juan Medical Association establish a cooperative dental program similar to the health association.⁷² With the beginning of World War II, however, attracting a new dentist to the community became more and more unlikely.

Conclusion

American involvement in World War II would contribute to the end of New Deal programs, and hence the end of the FSA. The FSA ran into personnel shortages and US involvement in wars around the world resulted in the movement of rural doctors to the armed services. Additionally rising crop prices lessened the need for farmers to use FSA loans and to create cooperatives. Seeing the demand for their services, physicians became less interested in accepting the reduced fee schedules offered by medical cooperative. Fewer doctors and the increased ability of patients to pay their bills ultimately doomed many FSA cooperatives.⁷³

With the onset of war, the shift of resources to the military came swiftly, sapping the strength of the FSA. Given its history of resettlement projects, the FSA was tasked to organize the evacuation, relocation, and internment of Japanese and Japanese-Americans in the West.⁷⁴

⁷² "Women of County Formulate Program," *San Juan Record* January 31, 1946, p. 1.

⁷³ Mott and Roemer, *Intermountain Healthcare*, 406.

⁷⁴ Harvey M. Coverley, Assistant Regional Director, to Mr. Laurence I. Hewes, Jr., Regional Director, 071 Cooperation Federal Agencies General 1-1-42 to 4-30-42 [2], Box 14, Record Group 96, National Archives and Records Administration, Pacific Region, San Bruno, CA. Utah's response to the proposed movement of Japanese farmers into the state is available in Ethelyn O. Greaves, Area Supervisor, to Mr. R. W.

In May 1942, the San Juan Medical Cooperative Committee changed its name to the San Juan Cooperative Health Association.⁷⁵ Changing the name of the cooperative was part of an effort to deflect criticism from the FSA. Directors of the medical division, like Dr. R.C. Williams, correctly assessed that the terms cooperative or medical co-op could be misconstrued by opponents of the FSA. Jack Bryan, Acting Chief of the Information Division, explained that it was better to refer to cooperatives as group medical programs. Bryan continued that FSA plans were more comparable to group health insurance plans than to cooperatives in the “Rochdale” sense or to the socialistic overtones the term elicited among some Americans.⁷⁶ This change indicated another challenge that the FSA would face after the 1942—the increase of smear campaigns orchestrated by farming organizations and by the AMA.

Hollenberg, Assistant Regional Director, 072 Cooperation States & Municipalities Defense 2-1-42 to 3-30-42 [1] [Japanese], Box 21, Record Group 96, National Archives and Records Administration, Pacific Region, San Bruno, CA.

⁷⁵ “San Juan County Health Association Presents Plan for Year Ahead,” *San Juan Record* May 14, 1942, 1.

⁷⁶ Jack H. Bryan, Acting Chief Information Division, to Frederick R. Soule, Regional Information Specialist, November 27, 1941, 160 Public Relations General 7-1-41, Box 24, Record Group 96, National Archives and Records Administration, Pacific Region, San Bruno, CA.

CHAPTER 4

WORLD WAR II AND THE DISMANTLING OF THE FSA

Following the attack on Pearl Harbor, a new urgency emerged in the FSA. The beginning of the war precipitated a shift in the importance of the FSA. From 1938 to the end of 1941, the FSA had emphasized the rising net worth of the farmers, as well as the number of loans, net income, and repayment statistics.¹ With the beginning of WWII, the organization chose to highlight its importance in two new areas: the “Food for Victory” program and its medical cooperatives.

As a national defense measure, the Secretary of Agriculture wanted the nation to produce substantial quantities of food products to ship overseas to “England and other allied countries.”² While the Food for Victory promotion makes sense given spectre of rationing during the war, the emphasis on health care was not so clear. The only connection the cooperatives had to the war effort was the issue of draftee failure. Medical rejection rates were higher in rural communities than in their urban counterparts, reflecting their higher need for adequate health care. Yet this link to the FSA was only suggestive. FSA leaders made little reference to it after the war started.

In 1942, the FSA made a nationally coordinated effort to highlight medical cooperatives. C.B. Baldwin instructed regional directors to provide information about the nature of the programs in areas that had more than 100 families involved in a medical

¹ Frederick R. Soule, Regional Information Advisor, to Dr. Ethelyn O. Greaves, Area Supervisor, January 23, 1942; Public Relations General 1-1-42, Box 24, Record Group 96, National Archives and Records Administration, Pacific Region, San Bruno, CA.

² FSA Defense Activities: Region IX, May 1941; 160 Public Relations Defense, 7-1-40 to 6-30-41, Box 24, Record Group 96, National Archives and Records Administration, Pacific Region, San Bruno, CA.

program. The FSA passed this information on to each state's senators and representatives. In Utah, the FSA addressed letters to Senators Abe Murdock and Elbert D. Thomas and Congressmen Walter Granger and J.W. Robinson. These letters highlighted the expansion of FSA medical cooperatives. As of June 30, 1941 there were 1,491 Utah families or 8,191 people benefiting from medical cooperatives. The majority of these people were located in Utah's most rural counties in District 1, outside of the Wasatch Front.³

Changing national priorities with the onset of World War II led to a downturn in FSA cooperatives.⁴ This chapter will address WWII's impact on San Juan County's health association, opposition from the American Medical Association, and the ways San Juan County's health experiment influenced the state of Utah. While 1938 through 1942 were years of spectacular growth of the FSA medical plans, the agency's national importance would greatly erode between 1942 and 1946. Stripped of most of its power, Congress transferred the FSA into the Farmer's Home Administration in late 1946. Through this decline, San Juan County continued to be successful in providing medical care for its residents. Although WWII and the actions of medical associations limited the number and scale of FSA medical associations, San Juan County's Health Association continued to witness success by extending healthcare to the region.

³William G. Reidy, Health Services Specialist, to Mr. Fred Soule, Chief, Information Division, January 30, 1942, and C.B. Baldwin, Administrator, to Laurence I. Hewes, Regional Director, January 15, 1942; Public Relations General 1-1-42, Box 24, Record Group 96, National Archives and Records Administration, Pacific Region, San Bruno, CA.

⁴Michael R. Grey, *New Deal Medicine: The Rural Health Programs of the Farm Security Administration* (Baltimore: John Hopkins University Press, 1999), 172.

WWII

Historians and health professionals disagree about WWII's impact on rural health care. Mott and Roemer noted that the war stripped rural communities of physicians by drafting numerous doctors in the war effort. Additionally rural counties disproportionately felt the loss of a physician because they had few health options. Michael Grey explained that although the war was overwhelming negative for rural health care, the Food for Victory plans and the emphasis on small farms did provide opportunities for the FSA to increase its importance.⁵ Both arguments fail to explain how the long term impact of the war would be largely positive for rural communities.

Certainly wartime service pulled doctors from rural areas, but this was only a short term set back. Military training of physicians and reduced educational requirements created an army of physicians by war's end. Speaking in Utah, Reed Farnsworth, medical director of the FSA, addressed medical developments in the post-war era. The medical director expected that group medical insurance would become the norm, perhaps expanding so all people would have access to insurance. Additionally there would be an expansion of medical care throughout the country as an increasing number of doctors returned from war seeking work.⁶

The immediate effect of war aggravated the decline of rural healthcare providers. The armed services pulled over 60,000 physicians from the states and pushed them into military service, which greatly increased the homefront ratio of patients per doctor.

⁵ Grey, *New Deal Medicine*, 130 – 131.

⁶ "Present and Post War Medical Service Discussed," *Iron County Record* (Cedar City, Utah) March 30, 1944, 8.

Acceptable wartime statewide averages held one physician per 1,000 patients, with minimum levels at one physician per 1,500 patients. In 1940, most states were within acceptable to minimal physician levels, but by 1944 the steady decline in the number of physicians available increased the doctor/patient ratio. Twenty-two states fell below the wartime minimums, including Utah. Some southern states like, Florida and Virginia, saw their doctor/patient ratio double to over 2,000 patients per doctor.⁷

Although not hit as hard as Florida or Virginia, Utah's doctor per patient ratio ballooned from 1940 to 1944. In 1940, the state stood at 1,119 persons per doctor, well within wartime standards. By 1944, after a 35 percent reduction in physicians, Utah witnessed an increase in the ratio to one doctor for 1,508 patients, just outside minimum wartime standards. Unfortunately, the Wasatch Front, Salt Lake, Davis, and Utah counties held the statewide average relatively low. Hidden in Utah's doctor-patient ratio was the impact on Utah's least populated counties. When the rural counties lost their physicians, the county's residents had to go without healthcare until the conclusion of the war and the return of physicians to their rural communities.⁸

Initially, fighting in Europe and the Pacific had little impact on the San Juan County Health Association. This situation changed when the sole physician in San Juan County, Wesley Bayles, was drafted in the summer of 1942. This loss represented a potential death blow for the county medical association.

⁷ Frederick D. Mott and Milton I. Roemer, *Rural Health and Medical Care* (McGraw-Hill Book Co., 1948), 206 – 211.

⁸ *Ibid.*

Knowing their precarious position, San Juan County leaders mounted a full scale attack on the draft board action. County commissioners, the county welfare department, the Farm Security Administration, city councils, and civic organizations all appealed to the State Chairman of Procurement and Assignments. Utah's director of the wartime draft, San Juan County believed, held the fate of the San Juan County Health Association in his hands. But Dr. Bayles' case was more complicated than a case of local lobbying. Dr. Bayles was a member of the Army Reserves and not simply a draftee. Circumventing a draft notice was a state affair. As a member of the Army Reserves, Dr. Bayles was not drafted into service, but was called to report to active duty with little consideration to his individual circumstances. The situation presented the county with the very likely scenario that four years of prolonged struggle for community healthcare would end because of a war raging thousands of miles away. The final decision regarding Dr. Bayles' situation came down to the office of the Adjutant General, under the direction of Major General James Alexander Ulio.⁹ It was here that San Juan County turned to its desperate plea in August of 1942. The county's letter to the Adjutant General follows:

We, the undersigned citizens and residents of San Juan County, State of Utah, hereby most earnestly petition for the deferment and relief from military service of Dr. Wesley Lyman Bayles for necessary civilian service in San Juan County, essential to county, city, school and public health plus care of men and families locally engaged in mining and production of vanadium vital to war. Entire county population of some 800 families or 5,000 people, and VCA defense plant officers, employees and families all dependent upon Dr. Bayles for medical assistance, in addition to the examination of 1,016 Selective Service registrants to be processed under Local Board No. 34. Nearest doctor or hospital some 80 miles distant (for average resident) and now overworked. Over 30 confinement cases due within 60 days and not even a midwife available. This is serious. Many families without conveyance or means for transportation, and others handicapped by rubber

⁹ It should be noted that Dr. Bayles was more than willing to fulfill his military responsibilities or to stay in San Juan County. The efforts to keep him in the county were driven by community leaders.

shortage with no trains, busses or public transportation facilities of any kind in service here. Our struggle of years to obtain medical service and our County Health Association with 1,300 people under contract paid to July next will be destroyed if Dr. Bayles is taken. We represent one-tenth of Utah in area. We invite and urge an investigation or comparison with any area in the nation of comparable size or circumstance. We are entitled to, and we must have, medical care. Please defer Wesley Lyman Bayles for San Juan County, Utah.¹⁰

San Juan County understood the audience for their letter. The Adjunct General would likely have little interest in anything but concerns of war readiness. Therefore their petition highlighted the production of vanadium in the county and cited the number of selective service registrants that would need physical examinations. They also highlighted the wartime doctor per patient ratio. Although Utah's average patient per physician would not be greatly affected by the loss of only one physician, the local ramifications would be profound, with over five thousand people in an isolated corner of Utah losing their primary care provider.

Additionally, the health fundamentals that exacerbated the creation of the county health association remained for San Juan County and perhaps became more serious. The nearest doctor, Dr. Allen, was about 80 miles away in Moab. But with war time restrictions of gas and rubber, the distance became more difficult to cover. More important was the shift of healthcare providers within the county as a result of the county health association. The old trauma of child birth was an on-going concern. Only four years removed from the foundation of the medical cooperative, all the midwives in the county had retired or moved. By creating the health association, San Juan County had

¹⁰ "Petition to Hold County Physician Receives Support," *San Juan Record* August 13, 1942, 1.

improved the standard of health care and removed any other options for medical treatment.

Relief came to San Juan County in late August 1942. The panic of the draft notice passed when the Adjutant General granted a deferment to Dr. Bayles from the Medical Reserve Corps of United States Army to meet the needs of the county.¹¹ Utah's first county wide health plan would continue to provide the medical care its residents needed.

Nationally the war effort eroded support for the FSA. The agency had to confront major challenges presented by transforming government policy during wartime or be legislated out of existence. New Deal programs aimed at employment and relief were no longer the necessity they once were. As some historians have explained, President Franklin D. Roosevelt moved from "Mr. New Deal" to "Mr. Win the War."¹² With changes in executive priorities and national needs, leaders of the FSA saw "forces massed against them" and massive "budget cuts" on the horizon.¹³

It didn't help that the FSA already had enemies within the agricultural community. In early 1942, Edward A. O'Neal, president of the American Farm Bureau Federation called for a congressional investigation of the FSA, citing "starting and shocking conditions of waste" that "amount to a national disgrace."¹⁴ The results of the subsequent investigation proved negative for the FSA.

¹¹ "Citizens of San Juan County Grateful for Co-Operation," *San Juan Record* August 27, 1942, 1.

¹² Grey, *New Deal Medicine*, 157.

¹³ Sidney Baldwin, *Poverty and Politics: the Rise and Decline of the Farm Security Administration* (University of North Carolina Press, 1968) 364 – 365.

¹⁴ "Agriculture Leader Asks for Probe of FSA," *Salt Lake Telegram* February 6, 1942, 1.

As critics questioned the need of the agency, the Joint Committee on Non-essential Expenditures learned that the FSA was losing \$1.6 million per year. Though most government agencies do not generate revenue, the FSA's penchant for operating beyond its budget made it a target for increased scrutiny. The chairman of the committee immediately suggested the FSA be liquidated and all FSA activities be transferred to the Farm Credit Administration.¹⁵

With the political conflicts of 1942 and waning support inside the Department of Agriculture, government officials hinted at reducing the FSA's role in farm communities while expanding the work of the Extension Service. These two farm organizations had some areas of overlap. In an attempt to iron this out, Secretary of Agriculture Claude R. Wickard issued a memorandum of understanding. Unfortunately the document did little to alleviate the confusion. William Peterson, the coordinator of the working relationship between the Extension Service and the FSA, believed that the memorandum placed responsibility for all group activities related to farm and home management under the direction of the Extension Service. This reinterpretation of roles did not sit well with the FSA. Area Supervisor of Utah, Ethelyn O. Greaves, claimed there was no change in roles, and that the FSA and Extension Service had an "excellent working relationship in most of our counties."¹⁶ Although Greaves and the FSA argued the confusion was no cause for alarm, more conservative branches of the Department of Agriculture were gaining influence as the FSA was losing it.

¹⁵"End of NYA, FSA Advocated," *Salt Lake Telegram* December 10, 1942, 1.

¹⁶Ethelyn O. Greaves, Area Director, to Mr. R.W. Hollenberg, Assistant Regional Director, 071 Cooperation Federal Agencies – General 7-1-41 to 6-30-42, Box 14, Record Group 96, National Archives and Records Administration, Pacific Region, San Bruno, CA.

Impact on Utah

Although WWII would greatly weaken the FSA nationally, San Juan County's medical cooperative was a point of discussion for the medical community and politicians throughout the state. The Utah House of Representatives put forward a health cooperative measure that would guarantee the right to organize medical cooperatives under the direction of the state board of health. This measure was not intended for the entire state of Utah, but allowed individual counties or restricted districts to form cooperatives if they could establish an agreement with local medical associations.¹⁷

Interest in the operations of the San Juan County Medical Cooperative drew people from the entire state of Utah to San Juan to monitor the progress of the southeastern county's health system. Dr. Francis W. Kirkham came to San Juan County to speak in a LDS sacrament meeting, but he explained that while in the county he planned to investigate the health cooperative.¹⁸ From the cooperative's inception, Dr. Allen and Dr. Austin believed San Juan County was making advances in cooperative medicine.

The idea of a countywide medical association spread from San Juan to other counties in Utah. Certainly, FSA agents and the newspaper publicity had some role in this movement of ideas, but the diffusing of cooperative health care also followed people. In late July of 1938, the Emery County farmer William E. King visited San Juan County to explore the possibilities of relocating. After measuring the prospects, King returned to

¹⁷Uarda McCarty, "Under the Capital Dome," *San Juan Record*, March 9, 1939, 1.

¹⁸"L.D.S. Church Items of Interest," *San Juan Record* September 29, 1938, 16.

Emery County, but not before he gathered all available information about the cooperative medical association. This type of association, he felt was the only rational solution to the rural health problem and he hoped to establish a similar program in Emery County as quickly as possible.¹⁹

Shortly after King's visit, Emery County FSA agent Mark W. Johnson directed a meeting at Castle Dale, the county seat, to discuss plans for a cooperative medical program. Johnson argued the San Juan County Health Cooperative was the result of the efforts of FSA. Johnson offered to extend FSA loans for the amounts of the cooperative fees. Emery County had a significant need for health care with over 500 families on relief rolls. A.G. Jewkes reported that the single greatest need among this population was medical assistance. Emery County was in a financial position to start a health care cooperative with the school providing \$400 for the care of school children and the county providing \$400 for the care of the indigent poor. These finances represent forty percent of the cost of the San Juan County cooperative. Emery County officials appointed W.O. Bickmore general chairman to study the most appropriate cooperative structure for county.²⁰

Garfield County began to explore FSA medical cooperatives in 1939. Although Garfield residents found many aspects of the FSA program suspect, the need for health care was unavoidable in Garfield County. A resident of Garfield County, Vernon Davies, commented, "One of the most serious problems which confronts this district is to raise

¹⁹ "Former Resident San Juan County Pays Us Visit," *San Juan Record*, August 4, 1938, 1.

²⁰ "Emery County Now Studies Plans for Health Cooperative," *San Juan Record*, October 13, 1938, 1.

the health standard.” With the travel between thirty and one hundred and fifty miles and the cost prohibitive, residents of the county felt the need to make improvements.²¹ Like Emery County, Garfield County residents felt its best choice was to create a health association similar to San Juan County’s.

One of the last arrivals to the field of FSA medical plans was Uintah County. The Uintah Basin Health and Service Association opened for service in 1941. Of the initial pooled funds of \$7522, over half came through loans via the FSA.²²

Finally, San Juan County’s neighbor to the north, Grand County, would follow its example. In February of 1939, the Moab Lions Club voted unanimously to create a medical cooperative “patterned after the very successful organization now operating in San Juan County.”²³ Of all the Utah counties to mimic San Juan County, Grand County seemed the most likely. After all, Dr. Allen, the San Juan medical director, practiced in Moab, and Grand County Hospital served as the care facility for San Juan County. Unlike Emery and San Juan, Grand County did not need a physician, but moved to improve its quality of care through a cooperative. After soliciting support for the Grand County Cooperative, a *Times Independent* article concluded by explaining that local leaders were contemplating the “erection of a larger hospital and ways and means are now being considered to finance its construction.”²⁴ A larger hospital was the next step in improving Grand County’s healthcare infrastructure.

²¹ Vernon Davies, “Garfield County’s Relief Problem” *Garfield County News* (Panguitch, Utah) April 13, 1939, 5.

²² Earnest M. Morrison, Associate RR Supervisor, to R.W. Hollenberg, Assistant Regional Director, October 4, 1941; 160 – 01 Public Relations Commendation 7-1-41[1], Box 27, Record Group 96, National Archives and Records Administration, Pacific Region, San Bruno, CA.

²³ “Lions Sponsor Medical Unit,” *Times Independent*, (Moab, Utah) February 16, 1939, 1.

²⁴ “Committee Launches Drive to Promote Medical Association,” *Times Independent*, February 23, 1939, 1.

San Juan County's example would extend into Colorado. In 1939, the community of Dove Creek, Colorado, organized a health insurance plan. Despite having a statewide plan provided by the Colorado Medical Association, Dr. Black of Dove Creek modeled his health insurance plan providing low cost medical care, medicines, and hospitalization to all members of his Medical Insurance Organization after the San Juan County plan.²⁵

In most measurable aspects, participants and administrators of the San Juan County Health Association found that the program had been successful from "all standpoints."²⁶ After a year of operation, the medical association continued to draw attention. In June of 1939, a convention of Utah social workers invited the San Juan County welfare director, William Palmer to address the convention of their annual conference held at Zion National Monument to discuss the county's health association.²⁷ Palmer outlined the success of expanded healthcare San Juan County experienced through cooperative medicine.

The 1939 Utah legislative session included a bill that would allow a form of "socialized medicine" within a restricted area.²⁸ San Juan County's efforts to provide health care for its residents had an immediate impact on the rural counties of Utah and the state as a whole. However, the success of collective action would lead to troubles with the governing bodies of the medical profession. Links between communal efforts and the right wing term "socialism" were easy to make. And the FSA had clear intentions of

²⁵ "Dove Creek Dots," *San Juan Record* January 19, 1939, 8.

²⁶ "Moab Lions Club Sponsors Grand Co. Medical Unit," *San Juan Record*, February 23, 1939, 5.

²⁷ "Additional Locals," *San Juan Record* June 1, 1939, 13.

²⁸ "Under the Capitol Dome" *Kane County Standard* (Kanab, Utah) March 10, 1939, 5.

building a socialized form of health care. As early as 1936, Resettlement Administration officials were sending out copies of articles about socialized medicine in Sweden: salaried doctors, state run hospitals, and fixed medical costs.²⁹ Within the US in the 1940s, FSA counties only lacked the state run hospitals. It was this political charge and rhetorical connection to nationalize health care which, in combination with funds diverted to the war effort, that would bring an end to the FSA supported health plans.

Downfall of the FSA Cooperatives

The decline of Utah's cooperative medicine programs is a complex story. National narratives do not adequately describe the ways Utah coped with growing support for a national health care system. The expansion of health insurance plans throughout the state of Utah based on FSA models would greatly improve the quality of health care in the state. At the same time, the war effort would pull physicians from Utah, reducing the supply of health care professionals. In the end, the FSA would fall victim to its plans to organize a collective society, but in Utah collective action would be successful through the 1950s.

From the earliest days of the San Juan County Health Association, powerful forces opposed the FSA's path breaking work in health care. Following the publication of two articles in the *San Juan Record* which labeled the majority of the health profession as

²⁹Marka Hellstrom, "Socialized Medicine in Sweden," (undated), Box 34, Record Group 96, National Archives and Records Administration, Pacific Region, San Bruno, CA. Reply letters are dated December 1936.

“money mad doctors,” the Utah State Board of Health issued a statement censuring the “obscured corner of Utah” for presuming that state funding of the program was guaranteed.³⁰ Although the *San Juan Record* reported that the Utah State Board of Health would contribute funding to the San Juan Health Medical Cooperative through the monthly Maternal and Child Welfare Clinics, funding did not come as planned. Dr. Edward M. Jeppson, director of the Utah State Board of Health, scolded San Juan County for presuming that the Utah State Board of Health was willing to bankroll the cooperative project. Dr. Jeppson explained the Board of Health would not be “authorizing or assisting in the advent of the socialized system of medicine.” Instead, funds from the state were only to be used to supplement a physician’s salary.³¹

C.S. Wilkenson, editor of the *San Juan Record*, outlined the flaws in Jeppson’s chiding of San Juan County and had some pointed words for Dr. Jeppson. Wilkenson called Jeppson a “disciple of greed and selfishness” who was tender over the subject of cooperation or collectivism, a subject that threatened Jeppson and the medical profession’s opportunity for “profiteering.” Labelling one of Utah’s chief doctors a tyrant, the cooperative champion Wilkenson continued by noting that state law obligated Utah State Board of Health to contribute to San Juan County’s local health program so long as the Board continued to conduct clinics throughout the state. The law required the director of the Board of Health to fund health projects in every county in Utah, and failing to do so would put it at odds with state law. Although Wilkenson’s explanation of

³⁰ San Juan County when tallying the money they could use for the medical cooperative included state money devoted to Maternity and child care efforts in the county.

³¹ “Afraid of Socialized Medicine,” *San Juan Record*, July 21, 1938, 4.

Jeppson's flawed logic was correct, Wilkenson did not help San Juan County win friends or influence the medical profession.³²

Arguments against socialized medicine in the mid-twentieth century revolved around two primary issues, cost and the quality of medical care. Dr. John Z. Brown, speaking to the Salt Lake District of the Utah Federation of Women's Clubs, explained that efforts to collectivize healthcare would tremendously increase taxes. Additionally Dr. Brown believed that any efforts to collectivize healthcare would lower medical standards.³³ The Utah State Medical Association's two major concerns about cooperatives were first that the cooperatives were not always financial strong enough to provide improved medical care. Second, the USMA worried that the cooperative contracts with patients only and neglected the rights of physicians.³⁴

Nationally, the American Medical Association consistently labeled medical cooperative as "socialized medicine," "communistic," "un-American," and "an infringement of their rights." As noted previously, the AMA's rhetoric was largely directed at the FSA and other government agencies dabbling in health care. The *San Juan Record* and C.S. Wilkenson attempted to counter the AMA's arguments by explaining that almost every attempt to improve the condition of the average family had been called un-American or communistic by those who should be leading the charge.³⁵ The situation in San Juan County remained the same. There were people suffering, never to see a

³² "Afraid of Socialized Medicine," *San Juan Record*, July 21, 1938, 4.

³³ "Civic Medicine Plan Attacked," *Salt Lake Telegram* November 21, 1938, 13.

³⁴ "Cooperative Medical Aid Plans Announced by Utah Physicians," *Salt Lake Telegram* December 12, 1938, 1.

³⁵ "San Juan Medical Cooperative to Celebrate," *San Juan Record* June 29, 1939, 4.

doctor, because they could not afford one. In the minds of the rural residents, cooperative health care was not a radical transformation in the relations between business and government, but only a shift in billing practices. Rather than a fee per service structure, cooperative health care paid doctors an annual salary, which might limit earning potential but also guaranteed a living wage.³⁶ Some inside the medical profession shared this belief. Dr. H.L. Schiess from southeastern Idaho explained that “Many of the [more experienced] doctors were afraid of it [the FSA], especially the older ones. They were afraid the government would take over medicine and it would become socialized, but I was young and couldn’t see it that way.”³⁷

Dr. Schiess was not the only doctor with this opinion. Collective medicine had some strong advocates in Utah, most notably, the Utah State Medical Association. Pledging help to the needy in 1938, USMA president Dr. George M. Fister said that no resident of Utah would lack medical aid due to an “inability to pay for doctors’ bills.” Breaking from the traditional method of simply writing off physician fees for those unable to pay, the USMA favored a more active approach. Dr. Fister explained, “call it socialized medicine or cooperative medical care or public medical care, but with all energy and speed the association will extend free or extremely low cost care to the remotest corner of the state.”³⁸ The USMA proposed a collective health insurance plan of its own, supposedly modeled after a Colorado physicians’ plan that proved to be quite successful.³⁹ Sharing the same terms of service as the San Juan County’s Medical

³⁶ “America’s First Cooperative Hospital --- Money-Mad Doctors,” *San Juan Record* May 19, 1938, 1.

³⁷ Studt, *Intermountain Healthcare*, 94-95.

³⁸ “Utah Doctors’ Parley Studies Socialized Medicine Question,” *Salt Lake Telegram* September 1, 1938, 1.

³⁹ “Doctors Start Insurance Plan,” *Salt Lake Telegram* February 18, 1941, p. 10.

Cooperative, the primary organizational difference was with the USMA plan physicians held all of the controls of physician compensation, services provided, and patient rights.

USMA formal announcement of their prepayment health plan came in December 1938. The services provided were very similar to San Juan County's health plan, the cost was not. Although the USMA's estimated cost was \$25 dollars per family, remarkably similar to the \$25 per family in San Juan County, the final price for medical aid and hospitalization reached \$48 per family.⁴⁰ This sum was largely out of reach for most low income families and did little to help communities without medical practitioners. The FSA did not provide loans for the fees, so families would have to front the premium prior to service.

Despite the complaints of some critics, the USMA support for cooperatives seemed unwavering. Although their health insurance plans would not find the success of the FSA plans, they set a key standard among cooperatives. Physicians need to be involved in planning and be volunteer collaborators in any health plan. Furthermore, all cooperatives had to be based on a sound actuarial basis. Some critics could easily fault the USMA for attempting to circumvent a government movement into health care, but this analysis would be a mistake. The USMA had a responsibility to protect the interests of its membership, licensed physicians. Although the USMA wanted to maintain control of health standard, it was also attempting to expand health services. This action was ultimately the goal of national health care movements.

⁴⁰ See "Cooperative Medical Aid Plans Announced by Utah Physicians," *Salt Lake Telegram* December 12, 1938, p. 1. and "Here's How Plan Works," *Salt Lake Telegram* December 12, 1938, p. 1.

While Utah found acceptance and success for the FSA medical cooperatives, nationally the FSA experienced opposition from the start. In 1939 an “anti-FSA movement” had sprung up in the West, the prominent labor sociologist, Carey McWilliams reported.⁴¹ The movement against the FSA, primarily in some farm groups and conservative sectors of the medical profession, remained quiet until 1942 when the war effort and waning support for the New Deal began to peak.

A miscalculation with the AMA—who held the power to end cooperative health care—marked the beginning of the end for FSA cooperatives. Early in 1942, the AMA seemed to be on fine terms with the FSA. In a 1941 annual meeting the AMA praised the FSA’s policy of working with local and state medical societies and its efforts to rehabilitate American farmers. A few misguided events involving the FSA’s experimental health plans would turn the AMA against the Washington bureaucracy. It was not until the FSA began to plan the expansion of medical plans without involving national health care leaders that the AMA came out in open opposition to the FSA.

One of the biggest mistakes that FSA made in 1942 was limiting discussions with the AMA and state medical associations about the experimental health plans. The original development of the FSA medical cooperatives was done with collaboration with AMA, but with the experimental health plans the FSA planned first. The experimental health plans were the next phase of FSA medical cooperatives—a county-wide comprehensive health plan with price controls which limited premium fees to a set portion of a family’s

⁴¹ Anita Batsch, Executive Secretary for Patricia Killoran, to Fred Soule, Farm Security Administration, February 11, 1939; 160-01 [Public Relations-Commendation [1935-1940], Box 27, Record Group 96: National Archives and Records Administration, Pacific Region, San Bruno, CA.

income. Before the FSA could share their plans with the appropriate medical associations, materials detailing the experimental medical plans fell into the hands of the State Medical Association of Texas, which forwarded the materials to the AMA.⁴²

The FSA did not plan on slipping a new medical program past the medical associations. A full month prior to the leak of the Chief Medical Officer of the FSA R. C. Williams advised that medical plans should not be created unless it was “very clear that the local physicians are definitely in favor of such a program, and if there is indication that the State Medical Association will not attempt to block it.”⁴³

Original plans recommended that Utah include one or two counties for consideration to be an experimental medical care program. Counties suggested were “San Pete, Box Elder, and the two or three counties in the Uinta Basin.”⁴⁴ Due to the efforts of Agriculture Workers Health and Medical Association in Arizona and the California Physicians Service, the FSA used a wait and see approach to other group health programs. R.C. Williams explained that after gaining experience with the experimental plan in California and Arizona, then he “would be glad to consider...[an] experimental health program in a selected county in California, Utah, or Arizona.”⁴⁵

⁴² F.D. Mott, M.D., Senior Medical Officer, to L.I. Hewes, Jr., Feb. 25, 1942; 071 Cooperation Federal Agencies – General 1-1-42 to 4-30-42 [2], Box 14, Record Group 96, National Archives and Records Administration, Pacific Region, San Bruno, CA.

⁴³ R.C. Williams to L.I. Hewes, Jr., Jan. 31, 1942; 071 Cooperation Federal Agencies – General 1-1-42 to 4-30-42 [2], Box 14, Record Group 96, National Archives and Records Administration, Pacific Region, San Bruno, CA.

⁴⁴ J.T. George, Senior Medical Officer, to Dr. R.C. Williams, Chief Medical Officer, Dec. 20, 1941; 071 Cooperation Federal Agencies – General 1-1-42 to 4-30-42 [2], Box 14, Record Group 96, National Archives and Records Administration, Pacific Region, San Bruno, CA.

⁴⁵ R.C. Williams to L.I. Hewes, Jr., Jan. 17, 1942 and S.F. Farnsworth M.D., Regional Medical Officer, to Dr. R.C. Williams, Chief Medical Officer, Feb. 4, 1942; 071 Cooperation Federal Agencies – General 1-1-42 to 4-30-42 [2], Box 14, Record Group 96, National Archives and Records Administration, Pacific Region, San Bruno, CA.

Utah was excluded for two main reasons. The first issue was financial.

Experimental plans explored ways to adjust payment for insurance to a percentage of a family's income. Secondly, FSA leaders wanted to locate experimental plans in areas with shortages of doctors or facilities. The early success of Utah medical cooperatives likely limited the state during the experimental process. Previous to 1941 in Region IX, only Utah had embraced the principle of cooperative medicine.⁴⁶ But serendipitously, the FSA excluded Utah from consideration, as the experimental plans would cause a major issue with the AMA and the usually supportive state medical associations.

A four year struggle from 1938 to 1942 to maintain control of the health care system came to a head with the FSA's proposal of experimental health plans. The American Medical Association could not question the impact the Depression had on the practice of health care, nor the mood of the country, so the AMA allowed changes in the industry. With thousands of people going without health care due to financial limitations and President Roosevelt organizing a national conference to address changes to America's health care system, the AMA understood concessions needed to be made. In response, the AMA called an emergency meeting of select delegates in Chicago in 1938. Reaffirming their previous position, AMA President Dr. Irvin Abell denounced the federal government's attempts to socialize medicine or to make medical care a "political issue." But the emergency meeting favored a number of government ideas to improve health care. The key aspect allowed states and local governments to maintain control of health.

⁴⁶ William A. Anglim, Acting Regional Director of the FSA, to Dr. R.C. Williams, Chief Medical Officer, Jan. 10, 1942, 071 Cooperation Federal Agencies – General 1-1-42 to 4-30-42 [2], Box 14, Record Group 96, National Archives and Records Administration, Pacific Region, San Bruno, CA.

Included in the favored proposals were hospital service insurance, the extension of the U.S. public health service, the creation of a federal department of health, disability compensation, and help for the indigent. Summing up their concessions, President Abell explained “the role of federal government should be principally that of giving financial and technical aid.”⁴⁷

Some members of the AMA had more radical ideas for the transformation of health care. Dr. Charles A. Dukes made a proposal that addressed the control of the AMA. The AMA or state affiliates, like the Utah State Medical Association, should set fixed prices for health procedures. The AMA reserved these price lists for doctors’ eyes only. Dr. Dukes proposed groups of physicians advertise their services and the costs. This approach would increase the transparency in the profession and allow patients to know the price tag of a procedure before acquiring medical care. Of course advertising prices could cause some patients to avoid receiving the health treatments they need. Sticker shock would certainly discourage the lowest income patients.⁴⁸

In spite the divisions within the AMA, President Roosevelt pushed forward a long term health program, which resembled President Abell’s argument. Roosevelt’s plan called for the immediate increase of federal and state expenditures on health care. These funds would target the poor to assist in “medical and hospital care, to establish clinics,

⁴⁷ Joseph W. La Bine, “Weekly News Review: ‘Sell-Out’ of Czechs Fails to Erase War Dangers,” *San Juan Record* September 29, 1938, 14.

⁴⁸ Joseph W. La Bine, “Weekly News Review: ‘Sell-Out’ of Czechs Fails to Erase War Dangers,” *San Juan Record* September 29, 1938, 14.

encourage vaccinations, develop maternal and child welfare clinics, and stimulate disease-control measures.”⁴⁹

Publishing in Boise, Idaho, the *Idaho Statesman* attacked those who advocated for a fundamental shift in health care, primarily those in favor of the cooperative movement. The *Statesman* argued that cooperatives attempted to take business from established doctors. The *San Juan Record* countered that the *Statesman*'s analysis seemed focused on the well-being of a few doctors while the needs of the majority of citizens were ignored.⁵⁰ The economic realities of the Depression necessitated a shift in the medical profession.

The discussion of the problems within America's health care system was not limited to small, rural communities like San Juan County. National columnists highlighted the issues surrounding America's health care system. Edward Pickard explained that class sat at the heart of the health conundrum. Middle class people were too prosperous for relief and too poor to afford their doctor bills. Additionally, the lowest income classes had some of the highest rates of “acute illness.” These facts demonstrated the riddle confronted by the health profession. Striking the balance between profits and health coverage, doctors encountered problems on both sides. Without profits, doctors could not live and practice the healing arts that moved them to join the dynamic profession. But extending coverage to lower social classes meant tempting the wrath of the American Medical Association. Doctors willing to operate low cost clinics risked having their licenses revoked. In November 1937, 430 physicians objected to the AMA's

⁴⁹ Joseph W. La Bine, “U.S. May Force Orient Peace Through Guam Defense Gossip,” *San Juan Record* February 2, 1939, 2.

⁵⁰ “Editorial Department Continued,” *San Juan Record* September 1, 1938, 13.

position and started advocating public subsidies for hospitalization, public health works, research, and education.⁵¹

Pulled by two opposing camps, 1937 witnessed the struggle for the transformation of the American health care system. At the heart of the struggle was the Roche Program, an \$800 million proposal, which would nationalize health care throughout the United States. On one side of the debate was the progressive-minded Dr. Hugh Cabot of the Mayo Clinic. Disdaining the “medieval” state of health care in some parts of the US, Cabot pushed for a fundamental transformation of the practice of medicine. Striking back, Olin Wes, General Manager of the AMA, announced his shame in sharing the same profession as Dr. Cabot. The editor of the AMA Journal, Dr. Morris Fishbein, added that although “medical care” was important, it trailed behind the key Depression era problems of “food, fuel, clothing, shelter, and a job.”⁵²

Mixing a curious twist to the struggle for the identity of American health care, the Assistant Attorney General Thurman Arnold confirmed the government would be prosecuting the AMA under federal anti-trust laws for their opposition to low-cost clinics. The case against the AMA centered on a clinic in the District of Columbia organized by 2,500 government employees, called the Group Health Association. Arnold charged the AMA and the Medical Society of the District of Columbia with attempting to close the Group Health clinic by intimidating and shunning physicians and doctors. Group Health Association physicians faced exclusion from Washington hospitals, threats

⁵¹ Edward W. Pickard, “Shall U.S. Pay your Doctor? Professional Opinion Divided,” *San Juan Record* August 4, 1938, 15.

⁵² *Ibid.*

of expulsion from the AMA, and were “made unwelcome at consultations with other doctors.”⁵³

Although the AMA did not wholly support the FSA, the AMA was cautious in its opposition. Conditions from all over the English speaking world were moving towards “greater intervention of government in medical care,” a situation that caused the AMA to rethink its approach. A head-on approach did not seem likely to change the trajectory of health care. Instead they focused on the principle of “all features of medical service in any method of medical practice should be under the control of the medical profession.”⁵⁴ Grey noted that FSA experimental health plans were early models for national health care. These efforts were one more step towards further government involvement in medicine. Confidentially, Mott advised his staff that the national FSA office was working toward health care for all individuals. When FSA leaders came out in full support of national health insurance during the debates surrounding the Wagner-Murray-Dingell Bill in 1943, many of the formerly supportive doctors turned against the FSA.⁵⁵ Physicians explained the “drive to federalize medicine... stems from a well-organized group, part of whom hold positions in Federal government; and has recently been concentrated on the farmers.”⁵⁶ The FSA had little support within government circles. The decreased support of physicians further undermined the position of the FSA.

⁵³ Ibid.

⁵⁴ A.M. Simons, Assistant Director Bureau of Medical Economics, American Medical Association, “Medical Service Plans of the Farm Security Administration” November 21, 1942, presented at the Annual Conference of Secretaries and Editors of Constituent State Medical Associations; 163-01 Public Relations Articles & Press Releases 10-1-42 – [3-3-43] [1], Box 31, Record Group 96:National Archives and Records Administration, Pacific Region, San Bruno, CA.

⁵⁵ Grey, *New Deal Medicine*, 128 – 129.

⁵⁶ Ibid, 166 – 167.

FSA leaders understood that the end was near for their agency. Therefore, national FSA leadership felt there was little to lose by supporting the push for national health care with both versions of the Wagner-Murray-Dingell Bill in 1943 and 1945. The agency's official position on the national health insurance law was that its medical care delivery program was "grounded in economic rather than in ideological or political goals."⁵⁷ With the national health care bills, the FSA moved from the economic motivations to an ideological approach. As one insider explained, "There was about us a touch of that Roman salute, 'Hail Caesar, we who are about to die salute you.'" Furthermore, the alternatives of private and government sponsored group health insurance was not promising for low income families or rural communities. FSA leaders believed that private and physician lead group insurance plans held little opportunity for rural and low income families. Additionally Mott really believed the FSA medical plans had "significance for the future of medical care."⁵⁸

With the creation of the highly controversial experimental health plans and outright support for national health care, the AMA denounced the FSA as a socialist organization, turning the full weight of organized medicine against the agency.⁵⁹ Combined with the shifting government priorities following WWII and an emergence of Cold War rhetoric, the FSA was finished. In April of 1946, Congress passed the third version of the Farmers Home Administration Act. Effective December 31, 1946, the law

⁵⁷ Grey, *New Deal Medicine*, 154.

⁵⁸ Grey, *New Deal Medicine*, 155.

⁵⁹ Grey explained that many of the national leaders supporting the Wagner-Murray-Dingell Bill, including FSA leader would later be called before the House Un-American Activities Committee to answer for their socialist actions in the health industry. See, *New Deal Medicine*, 164.

officially terminated the FSA, transferring all responsibilities to the newly formed FHA. With the new law, all of the FSA medical cooperatives were disbanded or transferred to local government agencies.⁶⁰

Conclusion

Dwindling support among physicians and shifting priorities within the federal government lead to the disbandment of FSA. In a standardized message, the county supervisors of FSA announced the end of their administration. Congress transferred all functions of the FSA to the new Farmers Home Administration. When Congress completed the transfer in November 1, 1946, the FSA ceased to exist.⁶¹

Despite chaos in the FSA and the medical coops, San Juan County's Health Association continued to succeed in its original mission of providing improved medical care to Utah's geographically largest county. The war decimated FSA efforts to extend health care. Mott and Roemer explained the war removed manpower in terms of FSA employees and physicians, and the number of FSA clients who chose to participate simply declined. From a high in 1942 of over 600,000 medical plan participants, the FSA saw a decline to fewer than 200,000 in 1946. Although the decline weakened countless

⁶⁰ Grey, *New Deal Medicine*, 165.

⁶¹ See "F.S.A. to continue to Operate until New Assn. is Ready," *Iron County Record* August 29, 1946, 7, "FSA will Continue to Operate Here, says Supervisor," *Garfield County News* August 29, 1946, 1., "FSA and Part of the FCA Consolidate Offices," *Garfield County News* November 14, 1946, 1., and "FSA Official Outlines Farm Loan Changes," *Salt Lake Telegram* March 28, 1944, 13.

medical associations, San Juan County's remained viable, likely due to the changes made after the resignation of Dr. Roark in 1942.

CHAPTER 5

CONCLUSION: LONG TERM PROSPECTS AND SAN JUAN COUNTY HOSPITAL

The number of FSA medical cooperatives steadily increased from 1938 through 1946 when Congress formally disbanded the organization and created the Farmers' Home Administration. Medical cooperative participation peaked in 1942 with 613,854 people in 117,460 families enrolled. From 1942 to 1946, the medical aspect of the FSA slowly lost steam. At the conclusion of the FSA program, only 236,780 people enrolled in cooperatives, approximately one third of the all-time high. In 1943, the coverage of cooperatives extended to 1120 counties, but by 1946, the coverage had declined to 951 counties.

Mott and Roemer argued that these declines resulted from the enlistment of rural physicians into the armed forces, increased incomes for physicians, increased incomes for farmers, and the reduction of FSA staff. A larger factor may have been the decline in the number of FSA borrowers nationwide. Unlike San Juan County's cooperative, once a FSA client repaid their loans, the individual was no longer eligible for the group health insurance.¹ Mott and Roemer noted that there was a push to extend service to non-FSA families and this effort expanded progressively throughout the FSA's tenure. Unfortunately, in 1945 the non-FSA families represented only 7.9 percent of all medical cooperative membership which was not large enough to save the cooperatives. Medical societies and private practitioners met the addition of non-FSA clients to the cooperatives

¹ Frederick D. Mott and Milton I. Roemer, *Rural Health and Medical Care* (McGraw-Hill Book Co., 1948), 405 – 407.

with defiance. Physicians believed that wealthier farmers could finance their own health care without any reduction of service prices, and therefore most physicians would not accept non-FSA members without a substantial increase in premiums. Of course, a rise in premiums would negatively impact the low income farmers the medical cooperatives were created to benefit. Higher income residents never benefited from the medical cooperatives.²

Joining a medical cooperative entitled members to benefits that were not easy to quantify. Mott and Roemer noted that farm families repeatedly testified to the security membership in a cooperative provided. Knowing that they could call on a doctor without excessive fees was just as beneficial as the actual medical services rendered.³ The residents of San Juan County attempted to explain the benefit to the region. Dorothy Adams stated the “health of these people had been neglected so terribly. But the situation passed. We became a very healthy people, because we had this doctor and we could afford it.”⁴

In San Juan County, extending professional health care through medical cooperatives was the most important legacy of FSA activities. FSA plans stimulated some rural communities to address their urgent health needs. When a county had the size and limited population like San Juan County, there was little hope such areas of the United States could be “effective in attracting practitioners.” Only through the guaranteed

² Mott and Roemer, *Rural Health*, 414.

³ Mott and Roemer, *Rural Health*, 409.

⁴ Dorothy Adams, August 4, 1973, p. 7, Southeastern Utah Oral History Project, L. Tom Perry Special Collections, Harold B. Lee Library, Brigham Young University, Provo, Utah.

income ensured by a cooperative could a doctor be attracted to the most rural areas of the country. Without the salary from the original San Juan Medical Cooperative, Dr. Austin would have been unlikely to relocate to San Juan County, nor would the county's native son Dr. Bayles have returned to the county.⁵

San Juan County's Medical Cooperative proved to be very successful. In this health plan, a rural community collaborated to bring a lasting improvement to the healthcare of Utah. Community leaders like Joseph Harris endlessly advocated for the residents to embrace the health plan. Despite perceived opposition from medical leaders, the county was able to attract and maintain a physician. While managing the promotion of the health plan and contracting with a physician, the San Juan County officials built an organization that was responsive to the needs of the county's residents and met the requirements of the state medical society. Although a number of citizens never embraced collective principles, they also benefited from the access to healthcare. Without the FSA health association, the access to quality care would have remained limited. As the AMA attacked the FSA, San Juan County was able to preserve its health plan and extend it into the 1950s.

Why did San Juan County's cooperative succeed when others failed?

San Juan County's neighbor to the north, Grand County, struggled to create and operate a cooperative. Despite public agreement that a medical association would benefit

⁵ Mott and Roemer, *Rural Health*, 409 – 410.

the county, very few families joined. In 1939, 111 families joined. With the limited finances, Grand County planned to discontinue the association after only one year.⁶ Year after year, the county extended deadlines and the result was disappointing.⁷ Grand County's obstacles were not uncommon for FSA medical plans. Medical cooperatives were underfunded and difficult to promote. Yet San Juan County's medical association would prove successful long after the end of the FSA.

Historian Brenda Taylor devoted a portion of her dissertation to examining the failure of a FSA medical plan in Ropesville, Texas. In Ropesville, Taylor found the ideal community for a medical association. She explained that Ropesville had high rates of illness and high interest in a cooperative plan coupled with residents weighted down with medical debts.⁸ Despite the optimal conditions, the community failed to embrace collectivized medicine, much to her frustration. Ropesville's failure provides a juxtaposition to San Juan County's success.

In analyzing why Ropesville failed, Taylor explained the primary cause was based on the lack of strong leadership from a community member advocating for the medical association. Support from community leaders was perhaps San Juan County's most important aspect. San Juan leaders actively willed the medical association forward--particularly the Mormon leaders, who time and again, could be counted on to solicit

⁶ "Commissioners of Two Counties Meet," *Times Independent* September 7, 1939, 1.

⁷ "Commissioners of Two Counties Meet," *Times Independent* September 7, 1939, 1 and "15 Days' Grace Given on Medical Plan," *Times Independent* August 1, 1940, 1.

⁸ Brenda Jeanette Taylor, "The Farm Security Administration: Meeting Rural Health Needs in the South, 1933 - 1946" (Ph.D. diss., Texas Christian University, 1994), 124.

support from their congregations. Other successful cooperatives, like the Lake Dick Association in Arkansas, had able leadership and wide backing from communities.⁹

Also, Ropesville faced delays from the local medical establishment. The Lake Dick and San Juan County associations saw quick implementation of the cooperatives. From the original idea to the functioning cooperative, San Juan County took only one year. Utah's largest county had substantial support from the region's only physician, Dr. Allen in Moab. Supervising San Juan County's new doctors added to Allen's income and tied San Juan County residents to the Grand County Hospital. All agents involved, Dr. Allen, the hospital, and residents of San Juan County-- profited from the arrangement.¹⁰ Each had clear incentive, financial and otherwise.

What Ropesville did have was Lubbock twenty-five miles to the northeast with four hospitals and numerous medical staff. The presence of health care professionals was not a luxury of San Juan County. As the residents understood from the beginning of the cooperative and through the Dr. Bayles draft crisis, perhaps the only way the community could receive modern health care would be through collective action. The market of San Juan County was too small in population, large geographically, and too poor to attract a physician.

Nationally the idea of group health insurance restricted to the poorest of rural areas was fraught with worries. Limiting memberships to low-income farmers created "actuarial unsoundness."¹¹ Including higher income families would have brought greater

⁹ Taylor, "The Farm Security Administration," 120.

¹⁰ Taylor, "The Farm Security Administration," 92.

¹¹ Taylor, "The Farm Security Administration," 181.

income to the cooperatives but was consistently opposed by the AMA. This income problem was fundamental to the voluntary nature of the cooperative. Healthy families would opt out of plans because they did not feel that they received their share of health care. Their withdrawal would leave a disproportionate number of sick and unhealthy on the cooperative rolls, which in turn could undermine the fiscal stability of the cooperative.

Ropesville's medical plan limited its membership to only FSA clients. Accepting all members of the county from the inception of the cooperative, San Juan County did not face the "actuarial unsoundness" of membership restrictions. Nevertheless, the abandonment of membership due to good health was always a concern for the San Juan Health Association. Time and again, the *San Juan Record* and the Health Committee would trumpet the virtues of cooperation. A few early members did leave because they did not receive forty dollars' worth of health care in the year. Nevertheless, San Juan community leaders never failed to remind them that everyone would need health care someday.

One Final Legacy

In 1945, the San Juan County Health Association began discussions with the War Assets Administration about purchasing four buildings in Monticello. These buildings would be home to a county hospital. Seven years after discussions about contracting with the Grand County Hospital for services, San Juan County appeared poised to get its own medical facility.

In 1943, San Juan County financed 43 percent of the operation costs of the Grand County Hospital.¹² Although the counties were of comparable population size, the discovery of the near equal financing of the Moab facility frustrated some San Juan County residents. Local leaders called public meetings, hosted by local LDS churches. In Blanding, Mormon bishop John Rogers conducted the meeting. Financing the operation of hospital would be the San Juan County Health Association.

In August 1945, San Juan County's old FSA representative Dave Evans returned to the county in a new role, as regional Health Service Specialist for Region IX of the FSA, representing the California, Nevada, Arizona, and Utah. Evans outlined to the community the steps needed to maintain a hospital in the county. Most importantly, Evans urged to the county to develop a hospital plan that suited the needs of the people.¹³

Reports of Vanadium Corporation of America (VCA) buildings sold in 1946 caused some excitement. Residents believed that the staff house in the buildings would be suitable for a hospital.¹⁴ Unfortunately, the excitement was a little premature. VCA buildings did not officially become the property of San Juan County until 1947.¹⁵ During the spring of 1947, San Juan County purchased properties and retrofitted the buildings to create a twelve room hospital. After nearly ten years of traveling to Moab for their hospitalization needs, county residents had a hospital one year after the FSA ceased to

¹² "Citizens in Monticello and Blanding Meet to Discuss Hospital Plan," *San Juan Record* October 19, 1944, 1.

¹³ "Plans to Maintain Hospital Discussed," *San Juan Record* August 9, 1945, 1.

¹⁴ "Airport, Hospital Discussed by Lions," *San Juan Record* March 7, 1946, 1.

¹⁵ "Hospital Assured for San Juan County," *San Juan Record* June 26, 1947, 1.

exist. The hospital opened in July 1947, although physicians admitted two expecting mothers before the official opening.¹⁶

In the next couple of years, the county continued to maintain its financial success. The 1947-48 financial year, the Medical Cooperative sold 343 contracts, contributing over \$17,000 to the hospital's budget, representing over half of the annual operating funds.¹⁷ Residents not connected to the cooperative spent just over \$10,000 in patient fees. The numbers clearly indicate that the cooperative enabled the healthcare successes.

The county health plan remained a key element of the healthcare planning of the Four Corners region of Utah into the early 1950s. The spirit of cooperation within San Juan County slowly deteriorated as healthcare costs increased and the competition for medical service between the county's major towns led to a schism in the health association. In 1944, Blue Cross/Blue Shield insurance plans began to make inroads throughout Utah. Not until 1952 did these private insurance offerings reach San Juan County. Blue Cross/Blue Shield gained a footing when the financial stability of the county hospital was called into question. When faced with the choice between rising premium prices and expanding participation or simply adopting a Blue Cross plan, Monticello adopted the Blue Cross plan.¹⁸ Blanding held on to the Health Association for only one more year, before switching over to the national plan. The nationwide benefits

¹⁶ "San Juan County Hospital Opens," *San Juan Record* July 3, 1947, 1.

¹⁷ "San Juan County Hospital Financial Statement," *San Juan Record* August 5, 1948, 1.

¹⁸ "San Juan County Hospital Suggests New Program," *San Juan Record* February 14, 1952, 1

were simply too good to pass. It would not be until the oil and uranium boom of the late 1950s that Blanding would get a hospital of its own.¹⁹

Despite the major advancements, Robert McPherson noted that in 1961, the county ratio of 3,000 patients per one doctor was much higher than the national average of 830 to one.²⁰ The statistics did not represent the feelings of the community. In reflecting on the role of the cooperative in developing the community's medical resources, residents had glowing reviews. Former FSA employee and resident of San Juan County, Maxine Redd Frost commented, "Now we have a very good hospital and doctors here and we have lots of confidence in them. We think we are very fortunate to have as good facilities as we do."²¹ Moving from midwives to university trained physicians marked a major shift for San Juan County. This change was made possible by the FSA's San Juan County Health Association organizing the region's financial and social resources. When questioned about life in the county without doctors, Marie Ekins Redd related, "It wasn't pleasant to think about, but we got along."²² With the establishment of the cooperative, the fear of pregnancy was reduced, the emergency trips to Moab were gone, and the "medicine chest of Ben-gay, castor oil and epicac[sic]" were past.²³ Questioned about the county's greatest accomplishment during the era, John

¹⁹ Leonard Bartell, July 20, 1973, p. 12, Southeastern Utah Oral History Project, L. Tom Perry Special Collections, Harold B. Lee Library, Brigham Young University, Provo, Utah.

²⁰ Robert S. McPherson, *A History of San Juan County: In the Palm of Time* (Salt Lake City, Utah: Utah State Historical Society, 1995), 277.

²¹ Maxine Redd Frost, July 29, 1973, p. 4, Southeastern Utah Oral History Project, L. Tom Perry Special Collections, Harold B. Lee Library, Brigham Young University, Provo, Utah.

²² Marie Ekins Redd, July 20, 1973, p. 8, Southeastern Utah Oral History Project, L. Tom Perry Special Collections, Harold B. Lee Library, Brigham Young University, Provo, Utah.

²³ Reta Bartell, July 23, 1973, Southeastern Utah Oral History Project, L. Tom Perry Special Collections, Harold B. Lee Library, Brigham Young University, Provo, Utah.

Rogers cited the medical association. “People hadn’t had much medical attention and there were lots of things they needed attended to. They worked the doctor nearly to death...It was an accomplishment during that period.”

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