March 1933 the number of separate individuals increased 9.3% over February 1933, while the total visits per month slightly decreased. In April 1933 the separate individuals decreased 13.2% over the preceding month, while the visits for the same month decreased 24.1%. During the same months in the preceding years each individual made on the average anywhere from 2.79 to 3.60 visits per month. In April 1933 the average visit per individual per month was 2.00. Individuals make fewer visits per day since March 15th, 1933 than heretofore. In May 1933, in spite of a reduction in individuals over the preceding month, there was an increase in the total visits during that month. As a result of our organization, with the present set-up, we can care for a greater number of patients if necessary. This was made possible to a very large degree by reducing the average number of visits each individual makes per month and day as shown above.

II. Effect on Budget.

During 1933 we expect to operate on a budget of $46,760.47,—a reduction of 55.5%.

The salaries to the non-medical personnel was reduced from $64,071.14 (1930) to $27,887.60 (1933),—a reduction of 56.5%. This was very largely effected by reducing the number of non-medical personnel from 43 in 1930 to 24 today. Those retained had their original salary rates reduced 10%, and an additional 10% cut from the amounts over $3,000. A further reduction was effected by shortening the working week. For the last two months they have received only 75% of these reduced rates. It is hoped that an adjustment shortly will make it possible to pay the personnel these reduced rates in full. On this latter basis 11 of the personnel will be on salaries of less than $1,000 a year; 11, between $1,000—$2,000 a year; and two on salaries over $2,000.00.

In 1930 the expenditure for salaries to physicians, dentists and the optometrist was $8978.85, in 1933 the allowance is $3966.36,— a reduction of 55.8%.

North End Clinic has always had a volunteer service of both professional and non-professional workers in the non-medical group. Since the present drastic reduction in income their number has been much increased. In 1930 the volunteer staff consisted of about thirty, at present it is sixty.

III. Effect on Medical Service.

No patient eligible for clinic care is refused admission unless (a) he is uncooperative (b) resides in a location served by another clinic, or, (c) is in need of hospitalization for which he can pay nothing, in which case he is advised to go to the city hospital.

Referring to the routine laboratory examinations, dispensed with March 15, 1933, we deemed it wise to resume (beginning May 15, 1933) the routine urine and Kahn examinations of all patients admitted to the Diagnostic Clinic which fortunately the reduced laboratory personnel has been able to care for.

However, the depression is not without its ill effects. Though no patient is refused admission or care if eligible we are not infrequently stirred when we are unable to provide what the patients need to get medical relief. Specifically, these patients fall into the following three groups:

1. Indigent patients in need of appliances.
2. Chronic unbenefited patients suffering from organic illnesses such as arthritis, chronic pelvic inflammatory diseases.
3. Chronic patients diagnosed as psychoneurotics.

IV. Effect on Medical Social Work.

A department of six workers, (one trained in psychiatric social work) in 1930, the social service staff now consists of one full time worker and two half time workers. One of the half time workers acts as admitting social worker. Half of the full time worker's day is also consumed in assisting with the admission of patients and with other administrative and supervisory duties connected with admission and hospitalization. The balance of this worker's time is for the most part devoted to other administrative and supervisory duties of the department, such as responsibility for inter-agency problems, etc. This leaves therefore a small portion of this worker's day and the services of the other part time worker for social case work.

Without a doubt, problems social, economic and emotional, persist among our patients. Our social workers, following the general practice in harrassed social agencies with large case loads, attempt to cope with only the most apparent or most serious difficulties.

The medical follow up of patients as the responsibility of the Social Service Department has been reduced to a minimum.

The reorganizations dealt mainly with the difficulties confronted during the depression. We believe we met our difficulties in a satisfactory manner: not only did we make a drastic reduction in our budget and render medical service to all individuals eligible for clinic care but also, if not improving our medical service, we at least maintained adequate medical standards.

Adversity has taught us a lesson. A comparison of the expenditures of preceding years with the 1933 budget convinces one that medical essentials can be obtained with less expenditures on non-medical personnel.

PAY CLINICS TO RELIEVE THE LOAD

The writer has for some time felt that a pay group clinic is essential to provide these services. The Committee

on the Costs of Medical Care in its majority report, also recommended such grouping preferrably around hospitals and clinics. However, to make these services available, adequate quarters are necessary, modern equipment indispensable and the underwriting of a yearly deficit during the formative period essential. These of course require a substantial investment.

The North End Clinic has adequate quarters, and the necessary equipment. Were such a service established in its building, its present personnel would not have to be substantially increased,—not at least during the formative period. In addition because of the large volume of work done in the clinic, the cost per service is reduced to a minimum.

Some of the physicians feel that it is within the legitimate functions of our institution to encourage a medical service to these individuals. We have requested the Board to rent us the building and equipment for such a purpose for the afternoon hours (when the clinic is not in use.) The set-up is brief: The pay clinic is to be a separate entity from the North End Clinic. It is to be managed by a small mixed committee of doctors and laymen. Rental of 10% of gross income will be paid the North End Clinic for the use of the building, equipment, light, heat, etc. Fees charged will range from $1.00 to $2.00 per visit or consultation and the x-ray and laboratory examinations as well as appliances and drugs in proportion. Eligibility will be limited to income groups below $2,000 —perhaps up to $3,000 for certain services or to persons with heavy financial responsibilities. The physicians will be paid for the services they render.

In addition to routine medical care in such a clinic the group of physicians would like to experiment with a complete medical service on an annual fee basis, the same to include both curative and preventive medicine, as well as hospitalization. This would have to be done on a large scale: it is necessary to have the active cooperation of large groups such as factories, lodges or associations, etc. in order to obtain large groups of unselected individuals or families and also to facilitate collection of annual or monthly fees.

I have confidence that the project is in line with the trend of the times, and feel that it will become a reality, —confident not only because a pay clinic of this type would reduce the number of patients applying for medical care in the morning clinic but mainly because I believe that all are cognizant of the need for such medical service in the community. To make such an enterprise financially as well as medically successful, the cooperation of both lay and professional groups is vital.

Effects of the Depression on Cleveland Hospitals and Clinics

By MISS MALVINA FRIEDMAN

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MOST communities have during this depression period had to meet in the case of their hospitals the problems of reduced income from endowments and patients and reduced contributions from community funds and federations. In describing conditions in Cleveland, I shall attempt to tell what has happened in six of the large hospitals there, one of which is a University Hospital, another a City Hospital, and four remaining private hospitals. These hospitals, with the exception of the City Hospital, care for large numbers of both free and part-pay patients. The Jewish clientele of these hospitals is drawn from about one-tenth of the population of the city.

With the exception of the City Hospital, the hospitals have drawn at least part of their support from the Community Fund and although this contribution had been greatly reduced for the years 1930 and 1931, there were no major curtailments of service until 1932.

From the standpoint of the community relations, two major changes, both of which went into effect during 1932, were significant and vital to both hospital and dispensary operation in Cleveland.

In October, 1931 one of the larger hospitals in the community set in motion a plan requiring all patients, old and new, "to bring a certificate from a private physician stating that he has been treated by the physician or that he has applied to the physician for treatment, and that he is in the physician's opinion unable to pay his fee or the fee of any reputable physician;" also, "that when the patient who applies for admission states he does not have a private physician, he shall be referred to some private physician who may or may not give him such a certificate." This plan was looked on favorably by many of the physicians in the community. Many had long been attributing their loss of income as much to the aggressiveness of dispensaries as to the depression which forced

patients to seek medical care gratis or on a delayed payment plan basis.

A group of the physicians in the community requested the Academy of Medicine to study the problem of admissions as applicable to all the dispensaries in the city. Consequently, a committee of physicians was appointed. To this committee were later added representatives from the Cleveland Welfare Federation, the Jewish Welfare Federation, and the Hospital Council.

The recommendations of this committee evolved themselves into a plan which became effective July 1, 1932 and took the form of the following principles:

(a) All social agency workers agree to refer all cases which at one time or another have been under the care of a private physician, back to that physician.

(b) It is agreed that all other persons who now or ultimately might be able to pay something should be referred by the social worker to a neighborhood physician.

(c) The out-patient departments of all the hospitals agree, through their social service departments, to follow the two courses of action outlined above.

Three hundred physicians had offered to give their services under principle "b" and their names were supplied to all social agencies and hospitals in the community.

The effect of the foregoing was threefold. It naturally slowed down the number of new admissions to the various clinics, thereby producing a saving to the institution.

Secondly, it brought into closer relationship hospitals and those physicians who were not in any way affiliated with either a hospital or a dispensary. Thirdly, it gave to patients the opportunity to consult their own physicians freely without fear of piling up future debts.

Statistics available for the last six months of 1932 show that there was a decrease of from 25% to 36% in the number of new patients accepted for care in the out-patient department as compared with the figures for the same period in 1931. However, the decrease in number of total visits to all dispensaries in Cleveland for 1932 as compared with 1931 was 11%.

Another important change which was doubtless hastened by the coming of the depression was discontinuance in dispensaries of 100% registration.

On July 1, 1932 it was discontinued. A committee consisting of the members of the Out-Patient Department Committee of the Hospital Council and a committee from the local chapter of the American Association of Hospital Social Workers gave as their reasons for discontinuance the following:

One hundred percent registration of out-patient and hospital ward cases was primarily designed to avoid duplication. It appears that this theoretical objective was not wholly attained because of the interval of time elapsing between application and report from Social Service Clearing House. The committee also felt that the large amount of expense borne by each hospital and Clearing House was not justifiable.

It was suggested that selective registration be practiced by the hospitals and that social workers in other agencies going into the homes of their clients learn from them about previous illnesses and attendance at hospitals.

Clinic Service:

The past year has seen some definite curtailments in the matter of clinic service to the community. One of the hospitals has been forced to close down two days a week and another one day a week in order to effect economies. From the community point of view, this has worked hardships in certain districts inasmuch as it has meant the discontinuance of any preventive program. In our particular hospital two services only have been curtailed in order to make it possible to hold all clinics in the morning. One of the hospitals has recently taken the stand that only patients in need of acute medical care could be accepted for dispensary service and has also decreed that it shall receive these patients from a restricted area only. Another hospital has found it impossible to accept any more new adult medical cases for several months to come and social agencies have appealed to other hospitals for this service. Dental service which has never been adequate in our community, has been particularly designated for curtailment. One hospital recently announced that it could not accept at least for several months any more new patients suffering from venereal diseases.

Medical Relief:

Hospitals in Cleveland had always had funds for medical relief, that is, for the provision of surgical appliances, braces, glasses, special medications such as insulin, liver extract, etc., but when the hospitals found it necessary to cut their budgets, one of the problems first met was the one of medical relief. Many of us therefore turned to special funds which we knew were in the hands of some of the case working agencies. We were able to use these to a very large extent until the latter part of last year when we were definitely told that they "could not provide braces, supports, glasses, special shoes, or other equipment from either general funds or from restricted funds which were for supplemental food only." We were asked that we keep our lines of demarcation clear, inasmuch as "appliances are a part of medical treatment."

Hospital Service:

During 1931 because of limited appropriations our hospital began selecting carefully the type of patients admitted for ward service. However, all hospitals have had to limit their intake during the last few months to emergencies only. (Two of our largest banks have not opened since the bank holiday; in these banks are 50 million dollars of frozen deposits and $800,000 of Community Fund money.) Minor surgery has been discontinued, the stay of patients on wards has been shortened, and fewer hypertension, cardiac, and diabetic cases have been admitted, provision having been made for them in the home. All hospitals were faced with curtailment of obstetrical service to free cases. Our services to obstetrical patients was cut 50%.

Endowment funds which were especially available for care of crippled children in our community were reduced and eventually discontinued entirely so that we were restricted to emergencies only. Corrective work as such has had to be postponed.

Social Service:

Some of the hospitals in the community have fared better than others in reference to their departments of social service. Two of the hospitals have had to reduce their staffs quite considerably and one has not replaced workers who resigned or left because of illness. Our hospital has been fortunate in its ability to keep its full quota of workers, replacing a worker as late as August, 1932. Medical follow-up in all hospitals has been appreciably cut down as much as 50% in some hospitals. However, social workers in the hospitals have continued to carry out the primary function of their job laid down by the American Association of Hospital Social Workers, namely:

"The primary purpose of a hospital social service department is to further the medical-social case study and treatment. The major activity of the department, therefore, should be medical-social case work."

Psychiatric Service:

Psychiatric service in those hospitals which have had it has not been curtailed, but the demand for service, which is an integral part of psychiatric study, has increased as a result of the intensity of problems both economic and social and the resultant let-down in morale.

Health Service:

Health service which is maintained in two hospitals in the city for adults and children has continued in spite of the fact that this is a service in which the doctors receive a remuneration.

I desire to discuss briefly efforts made by the hospitals to provide for the man of moderate means who for various reasons could not or would not accept endowed service. When the hospitals were faced with the problem of reducing expenses and coaxing up income, serious consideration was given to this large group. Rates were lowered and flat rates for service were adopted. One hospital has reported that 90% of its part-pay work was on a flat rate basis. There remained many in this group, however, who are not able to avail themselves of the flat rate because of their inability to pay partly or fully in advance for service. An advance payment is required in most of the hospitals in the city. To meet this situation, therefore, the hospitals organized themselves into the "Hospital Finance Corporation of Cleveland" in order to "provide a more effective method of handling hospital patients who are only able to have hospital service on a deferred payment plan basis."

Another significant move to increase hospital revenue from people of limited means is the plan of Group Hospitalization. Mr. C. Rufus Rorem, a member of the staff of the Committe on Medical Care and the associate director in charge of medical service of the Julius Rosenwald Foundation of Chicago, recently appeared before representatives of hospitals in our city to explain Group Hospitalization and the plan is receiving favorable earnest consideraation.

Lastly, in a few days there will go into effect a plan to secure for the man of moderate means in our city, the services of specialists in medicine at a charge commensurate with the patient's ability to pay. The Academy of Medicine through a social worker will rate patients sent by a general practitioner. No other patients will be accepted except those sent in this way. Specialists in the community have signified their willingness to accept the rating of the social worker for which patients will pay the sum of fifty cents. This experiment should prove interesting.