PRACTICAL MEDICAL ECONOMICS.*

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It is an interesting and significant observation that the economic depression through which we are passing (or which we hope is passing) shows the least losses in the food industry with a close second in pharmaceuticals. The figures then rapidly decrease to include every known industry ending probably in diamonds and real estate.

Such being the case and in view of our extensive educational system with a marked emphasis on hygiene, it would seem that our enormous tonnage of pills and potions, galenicals and ointments should give us a health record to brag about. Our 60,000 drug stores report total sales in 1930 at $1,650,000 of which 40% are pharmaceuticals. But what are the further facts? In contrast to this our draft board work of 1917 brought to light a number of compelling facts, principle of which that one-third of our men between 18 and 31 years were declined for active service for physical reasons.

The Cincinnati Public Health Federation reported that out of a group of 1000 office employees 781 showed physical impairments of significant importance. Seventy-five per cent of them were between 30 and 35 years of age and 361 of the 781 had cardiovascular defects.

Equally important is the disclosure that 728 of the 1000 employees examined had physical impairments of which they knew nothing. It is a startling fact as reported by our statisticians that 38.2% of our people get *no* professional medical care and 79% get *no* dental care. No wonder the draft boards report as above.

Of so simple and so important a matter as vaccination against smallpox it is alarming that only 21 per cent of city children under six have it done and only 7 per cent of rural children. Serious as are these figures the large percentage of unintelligent self-medication employed by those who think they cannot afford professional care or for other reasons, is far more serious.

We are told that our total medicine bill is $715,000,000 of which 70% is for self-medication, meaning home remedies and patent medicines.

There are probably 135,000 physicians in active practice in the United States. We should say in practice not knowing how active they are. This is one of the practical problems of our study in medical economics, especially when you consider that one-third of our physicians enjoy or suffer from an income of less than $2500.00 (1929).

The dental profession reports a large percentage of unused time, though not so large as in the medical profession.

The under employment and unemployment of private duty trained nurses is simply another feature of over-production and faulty distribution.

Hospital facilities present the same irregularity in empty beds *versus* such figures as above as against an enormous number of untreated patients actually needing professional care.

It is reported that our 132,000 trained pharmacists compound on the average of 1200 prescriptions each yearly, whereas a professional pharmacist could fill ten

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times that many. They say that with our present equipment our pharmacists could easily fill 1,000,000 more prescriptions a year.

Think of these figures and correlate them with the out-of-work physicians, dentists, pharmacists and nurses. The awful record of those killed in the World War shows 50,285 but against that we report 88,088 deaths from tuberculosis; 119,818 from cancer; 36,000 from auto accidents and 135,848 infants under 1 year. The work is here to be done.

The curriculum in our professional colleges in medicine, pharmacy and dentistry is second to none. We have the knowledge. We have the mental equipment. Also there is a big need for treatment but between the two is a great gulf fixed: and the important problem is how to bridge the gap.

This paper does not aim at solving these problems in a national way but simply to act as a sign board pointing the way. More specifically the thought is to show ways and means by which the individual pharmacist can coöperate as a middle man between your professional clientele and the needy public in your community.

For instance your neighborhood physicians have probably had four years in high school, five years in a medical college and practical experience in a hospital, and with all this, one-third of them average an income of less than $2500.00.

The thought is to encourage an increasing number of pharmacists to make this a personal matter in meeting your community needs—your dentists, physicians, yourself and your public.

Those figures as above given on self-medication will spell one thing to the merchandising druggist and another thing to the professional pharmacist. Is your aim to increase self-medication or decrease it? There is only one answer if you have fully understood the principles of pharmaceutical ethics and that is to aim to decrease self-medication. Back of all of it is ignorance of both pathology and drug action, often coupled with empiricism.

It has been shown that we have the equipment and time. If we are over-equipped on a basis of the available work, whose fault is it? Whose fault is it, this under treatment or neglected treatment of needy patients and the unemployment of our physicians, dentists, hospitals, nurses and pharmacists?

While finding the answer to the cause of these problems we should give closer attention to a solution of them.

One of our popular magazines (neither medical nor pharmacal) made an intensive survey of existing conditions and found that:

619 patients with colds treated themselves while 242 consulted physicians
528 patients with burns and scalds treated themselves while 55 consulted physicians
518 patients with constipation treated themselves while 77 consulted physicians
537 patients with cuts treated themselves while 56 consulted physicians
262 patients with heartburn treated themselves while 24 consulted physicians
444 patients with sore throat treated themselves while 163 consulted physicians.

This magazine found that:

401 physicians recommended a proprietary magnesia preparation
293 physicians recommended a proprietary aspirin
244 physicians recommended a proprietary hexylresorcinol
152 physicians recommended a proprietary antiseptic solution
76 physicians recommended a proprietary inhalant

27 physicians recommended proprietary cough drops
22 physicians recommended a proprietary chewing laxative
210 physicians recommended a proprietary "rub."

While hundreds of other physicians encouraged self-medication by recommending other proprietaries, one wonders how many of them learned their therapeutics *via* the radio.

The Public Library record on a borrowed book "Medical Care for the American People" showed it had been out 46 times in 25 months or the limit of time allowed for that book, as evidence that the people are interested.

What can we do to sustain this interest as evidence of our knowledge of practical medical economics? The academic listing of the facts is of value only as we use them.

The Chicago Dental Society has a committee on "Industrial Diagnostic Service." This speaker is familiar at first hand with the work of this committee in one industrial group. Of 640 employees only 65 of them needed no dental work. Most of these had just had dental work completed while a very few had a perfect set of 32 teeth. They claim that not three per cent of our people by and large show a complete set of 32 teeth which have neither had nor needed treatment by a dentist.

As a part of the practical application of this diagnostic study, 181 of these employees of the group referred to, had started or finished their dental work within two months. One hundred and eighty-one employees needing dental care were changed from prospects to paying patients.

A dozen medical societies widely separated throughout the country have done like our dental friends just quoted and made the survey that unearthed many a pathological condition needing treatment.

To get down to some practical applications based on the economic study seven effective suggestions are submitted.

In the first place a plan utilizing our knowledge of urinalysis is offered. This subject should not be studied simply to pass a college or board examination. This knowledge costs money and should be made of value. Physicians have the knowledge, too, but by their laws of ethics they cannot tell the sick public in the community and they are therefore limited to their (relatively) few patients. Therefore very few of them do or care to do urinalysis. Urinalysis is submitted as one method of bringing to light some hidden unknown pathology—not much but some. The subject need not be gone into deeply. It will take only a little equipment, little space and a little time to show indican, sugar, albumen and blood. Such work should never be done like prescriptions—while the patient waits. The specimen is put aside and the work done during spare time.

For ten years now your speaker has noted a 10 by 12 sign in a drug store in probably the highest rental property in New York City. It simply says "Urine Analysis $1.00" and year after year he has asked one clerk after another whether that is a joke or a real advertisement, and he is informed that it pays. The writer has passed a gem of a little store, clean as a pin in a very poor section of Philadelphia. It carried a sign "Urine Analysis" on the outside window sill; he has been informed that they average five tests a week or the equivalent of $250.00 per year.

Information gained in this way is never an encouragement to self-medication; therefore the customer should not be alarmed. Do not say sugar, say glucose and

mildly suggest "to see the physician some of these days and have that condition cleared up." Never mention Bright's disease, never say diabetes, but if properly used, that information (paid for by the customer) will go a long way in creating good-will for you on the part of one physician after another.

As a practical good-will builder there is no thing in your store that will prove better or even the equal of this.

A second suggestion is a Baby Clinic. This may be as simple as a baby scale conveniently placed so that mothers and nurses can stop in and do their own weighing. On the other hand it might profit to employ a nurse on a half or whole day a week for other measurements. Even so simple a record as these may unearth some pathology that needs attention.

Next and without going into the matter at length the desirability of an annual schedule of twelve studied professional windows of ten days each is emphasized. *Some* will prove simply interesting. *Some* will create good-will. *Some* should actually sell goods. *All* should sell your store.

Nobody knows how many people are subject to cold in the head. Everybody knows what it is. Nobody has a specific cure. Everybody treats it.

For a piece of team-work with the physicians try this. The use of *M. Catarrhalis* Bacterin is an approved scientific method of treatment. Based on a satisfactory experience of years, some of the industries employ the Bacterin treatment in routine. The regulation three doses, a week apart, give only four to six weeks immunity, meaning three or four series of injections each season.

Any physician can do this work. They all know how but again, their rules of ethics forbid their advertising the fact.

Here is where the window display will go a long way as a practical solution of this phase of medical economics.

Picture the figures as given to us by the statisticians. It has been estimated that we suffer from a financial loss of one hundred million dollars in this country from cold in the head between Christmas and Easter. This indicates a pay-roll loss of at least eight days for 2,000,000 wage earners. A real problem in Medical Economics.

The fourth suggestion is another real piece of service both to the nursing profession and the sick public in the community. There are times when a nurse is needed badly—a real emergency. The drug store should be a center of information along this line. The druggist will be in position to render an appreciated bit of service if he makes and prepares a nurses' directory. Addresses and phone numbers should be included with a column to indicate whether off duty or on duty and therefore not available or available.

Never mind whether the local hospitals and other units have such a directory, the druggists will be equally effective on a service basis to the physicians, their patients and the nurses themselves.

Such a list should be kept up-to-date and up-to-the-minute, meaning coöperation with the nurses themselves so they will not be called for service when engaged with a patient.

Suggestion number five has to do with Hay Fever. It is estimated that there are some 2,000,000 such patients every year with symptoms recurring on a time table regularity. In the Great Lakes Goitre belt those patients expect evidence of their

first symptoms on August 15th. This means a systematic program if a pharmacist is to render the maximum of service to his community.

Window displays should be scheduled for the simple skin test for all who suspect hay fever so that with a positive diagnosis the regulation pollen protein treatment can be started in time.

Distinguish between the preventive treatment for patients known to have hay fever and the remedial treatment of those who never had it and who wake up August 15th with enough symptoms to make sure of the diagnosis. The pollen treatment given before August 15th is preventive. The nasal douches, nasal sprays and vitamin treatment are for use after August 15th.

These observations will readily enable druggists to organize their windows to do for their physicians and the sick public what they cannot possibly do for themselves. To the best of the writer's knowledge there is no other ethical method by which to bring to the attention of the hay fever patients in their respective communities the ability of the physicians to successfully treat them.

In closing only two more suggestions are offered. The first is with reference to the frequently suggested and often neglected physical examinations. The figures and references at the beginning of the paper emphasize the importance of the matter. The difficulty is the insufficient "drive back" of the thought to see that the examination is made. Nobody is responsible, so it is neglected. Here again physicians have the ability, equipment and time which hangs heavy on their hands—unproductive time that should be made to pay.

The listing of physicians should be considered who will do this work. The list should be exposed in large type as a window display, center piece surrounded by borrowed equipment. The druggist and clerks should read up on the work to answer questions surely to be raised and the result will be an increasing amount of professional good-will worth a lot to the druggist.

It is not easy to believe, but it is said that 79 per cent of our people get no dental care. These statisticians cannot estimate the amount of pathology resulting from this neglect, but a partial picture may be had of the illness of various types resulting therefrom.

Anything that the pharmacist can do to center attention on the need for systematic dental care with regularity will contribute just so much to solving the problems of medical economics.

Over the counter suggestions are in order. A small circular in every package of every dental product sold—brushes, pastes and powders calling attention to the value of dental work will help a lot.

"See your dentist twice a year
Buy your dental products here."

While there is a similarity of needs in California and Maine the specific problem that affects the druggist's bank balance is a community affair, no matter how it may be nationally scattered.

Finally, these suggested answers to the problems of medical economics have nothing to do with committee action of the drug associations and clubs. They are a personal matter to be accepted or rejected by the individual pharmacist, as personal as his bank account and just as vital to his continued growth and stay in business.