COSTS OF HEALTH MAINTENANCE AMONG OKLAHOMA FARM FAMILIES

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An adequate measure of the costs of health to any social class is practically incalculable. Such a criterion as we should like to use for this purpose would have to include the costs involved upon the farmer by his loss of productive power and working efficiency when he is incapacitated for work as well as his costs of drugs and medicines, and hospital and doctor's services. Both tangible and intangible costs must be defrayed, but statistical analysis limits us to those expenses which are made direct and out-of-pocket in the course of a stated interval of time.

The data of this study are taken from eight typical cotton producing counties of Oklahoma, and represent a random sample of the farmers in those counties. (1) The schedules have been classified according to the tenure status of the operators, and represent full owners, part owners, share

[1]The schedules were taken by W. W. Fetrow and L. D. Howell of A. & M. College, in McIntosh, Kiowa, Tillman, Greer, Stephens, Carter, Love, and Jefferson Counties in 1926.

TABLE I. EXPENDITURES FOR HEALTH BY OKLAHOMA FARM FAMILIES BY TENURE OF OPERATORS. 1925

Tenure Groups	Total Families	Percent of Total	All Health Expenses		Medicines		Dental		Doctor and Hospital	
			Average	Percent of Average	Average	Percent of Average	Average	Percent of Average	Average	Percent of Average
Total & Av.	508	100.0	$75	100.0	$22	100.0	$ 7	100.0	$46	100.0
Full Owners	139	27.4	$82	109.3	$20	90.9	$10	142.9	$53	115.2
Part Owners	56	11.0	$80	106.7	$25	113.6	$10	142.9	$45	97.8
Tenant Share and Cash	275	54.1	$75	100.0	$24	109.1	$ 6	85.7	$45	97.8
Croppers	38	7.5	$41	54.7	$14	63.6	$ 1	14.3	$26	56.5

and cash tenants, and croppers. This division, to some extent, is tantamount to both a social and an economic description of the farmers in each group. Obviously there are social consequences of tenure, and ownership or any form of tenancy generally represents the degree of success a farmer has attained, since owning a farm free of mortgage is the ultimate of most farmers.

Table I shows the relation of the average family expenditure for health to the tenure status of farmers. Quite generally, the families of owners and part owners of farms have more to spend for health than tenants and croppers, the latter being the more often forced to live near the level of minimum subsistence. Another reason for this may be that owners are older, on the average, and that their children are more mature, than is the case of tenants and even part owners. As we ascend the scale of the agricultural ladder, we should expect to find that those families of greater means will employ a higher type of medical service and will require these services more often than those of less ability to pay. This assumption seems to be borne out by the data of this table.

A general observation is that the elements of personal taste an deference to fashion play a bigger role in the use of family funds among the higher economic and social strata than among the lower. The poorer classes are compelled to live nearer the physiological minimum level than the more wealthy. Within moderate limits, this applies to health expenditures in much the same way as to clothing and household expenses. Our analysis shows that full owners have approximately twice as high a family average of expenditure for health as do the croppers, and that the part owners and tenant families occupy an intermediate position.

The quality of the family dwelling is to some extent a fair index of living standards in the anaylsis of several family living budgets. It is also a potent factor in the frequency of various diseases, especially tuberculosis and lung diseases in general. Poor housing is a contributing factor toward a high morbidity rate for such diseases, and would, therefore, tend to accentuate the curve of expenditures for health maintenance, were there no opposing conditions of offset this influence.

TABLE II. HEALTH EXPENDITURES OF OKLAHOMA FARM FAMILIES ACCORDING TO THE VALUE OF DWELLINGS. 1925

Value of Dwel'ng	Total Cases	All Health Expenses: Percent of Total	Aver. per Family	Percent of Aver.	Medicines: Aver.	Percent of Aver.	Dental: Aver.	Percent of Aver.	Doctor and Hospital: Aver.	Percent of Aver.
Total & Average	503	100.0	$75	100.0	$22	100.0	$ 7	100.0	$46	100.0
Up to $599	241	47.9	$74	98.7	$25	113.6	$ 5	71.4	$44	95.7
$600 to $1,199	160	31.8	$77	102.7	$21	95.5	$ 7	100.0	$49	106.5
$1,200 and up	102	20.3	$74	98.7	$15	68.2	$10	142.9	$47	102.2

Table II shows that for health maintenance in general, there is a norm of expenditures which characterizes families living in the moderately valued houses, while those who live in poor dwellings cannot afford to spend as much as the average for health, and those who live in the best houses do not need to spend as much for health as the average family. This table also shows a distinctly inverse correlation between the value of dwellings and the absolute amounts spent per family for drugs and patent medicines and a direct positive correlation between the value of the house and the amounts spent for dental hospital, and doctor's care. In other words, the poorer classes buy their own medicines and practice home remedies upon themselves more than the wealthier groups while the latter resort to professional and skilled aid in sickness more often.

From the crude analyses made here, one can scarcely find justification for definite generalizations relative to the laws governing the expenditures for health made by farmers. However, some tentative conclusions may be offered. First, the poorer families will sacrifice health in order to satisfy the more immediately pressing needs of life such as the desire for food, clothing, and shelter. The gratification of these wants cannot conveniently be postponed. Second, social and economic conditions may serve either as stimuli toward a greater interest in health, or they may be detrimental to the attainment of this end, depending upon whether or not the social and economic status of an individual is high or low. Third, with farmers as with the laboring classes of the cities (3) the greater amount of health education and professional services is needed among the poorer families. The poorer farmers are most likely more often victimized by fakers and healing media than are the more well-to-do. Finally, if we are to improve to general health conditions among farmers, the task can in all probability be more effeciently accomplished through influences elevating their economic and social status than in any other way.

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[3]Generally, the percentage of the family income spent for health varies inversely with the size of the income. See Zimmerman, C. C. Incomes and Expenditures of Minnesota Farm and City families, 1927-28, Minn. Agri. Exper. Sta. Bul. No. 255. June, 1929, pp. 24-25.

[4]For a discussion relative to this point, see Monthly Labor Review, U. S. Dept. Labor, Vol. 29, No. 5, Nov. 1929, pp. 45-47. This report shows that the great incidence of morbidity among city dwellers falls upon those who are virtually defenseless.

*Not taken by sweeping.

Total number of insects collected in order of their abundance