

***Intervals* - Episode 7**

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Sites of Public Healthcare in the Nineteenth
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Introduction

CHRISTOPHER BRICK: Hello everyone and welcome back once again to the *Intervals* podcast, a public humanities initiative of the Organization of American Historians.

I am your host Christopher Brick, here on behalf of the OAH Committee on Marketing and Communications, and here as well to welcome Dr. Megan Birk to deliver our seventh guest lecture of season 1. Megan's talk, "Poor Farms and Poor Health: Sites of Public Healthcare in the Nineteenth Century," introduces us to an institution that functioned like an early form of public hospital in the late

1800s, dispensing medical care for those too indigent to afford private services, and calling attention to the way that poverty and public health have shaped one another across time.

For much of the 19th and early 20th centuries, the poor farm, sometimes called the almshouse, provided needed resources for the elderly, dependent, and poor. Many of those in need were also sick. Chronic disease, physical disability, and acute illnesses commonly contributed to admissions. Bodies of those rundown by difficult physical labor and the debilitation of long-term poverty often ended their days at their local poor farm.

The medicine practiced in these institutions, which numbered more than 2,000 by 1900, involved county-contracted doctors, the amateur nursing skills of the institution matron, and sometimes the assistance of hired practical nurses who doubled as household staff. They treated people who recovered and left, but also handled palliative care, like that of a man whose "leg had decayed so that the bone below the knee was entirely severed and pieces of bone came out. He was a very offensive case. Worst case ever had for stench."

When county officials needed to create quarantine space during pandemics and outbreaks of diseases such as smallpox, they often used the poor farm as the site of those encampments. Doing so associated those simply sick with the unfortunate shame of poverty. Using poor farms for public health care also ensured that not all residents had equal access to those services.

Across the country local governments determined whether to admit African, Asian, Native, and

Mexican Americans, and if they did so it did not guarantee the same level of care as whites. In rural areas, and particularly before the rise of the public hospital, however, poor farms were often the only places people could go when their illness was too severe to be cared for at home.

Drawing from her upcoming book on poor farms, and using records from doctors, superintendents, poor farm admissions, and charity associations, this presentation will detail ways in which poverty factored into public health care, the prevalence of poor farms as sites of public health care, and discuss their role in the evolution of public health care policy.

Dr. Megan Birk is an Associate Professor of History at the University of Texas Rio Grande Valley, and the author of *Fostering on the Farm: Child Welfare in the Rural Midwest*. Her book about poor farms and social welfare is forthcoming from the University of Illinois Press, but if you're one of our listeners you don't have to wait for the book to get a sense of this story. Megan's here to share some of that story with us today, and here she is: Dr. Megan Birk on "Poor Farms and Poor Health: Sites of Public Healthcare in the Nineteenth Century."

Lecture

MEGAN BIRK: Hi, I'm Dr. Megan Birk from the University of Texas Rio Grande Valley. I'd like to thank the OH and NEH for giving me the opportunity today to talk to everybody about public healthcare at the poor farm.

First let's start with what is a poor farm: it's an institution where aid is provided to the poor. Throughout US history a lot of counties, townships, public municipalities, have been responsible for taking care of their own poor and sick. And traditionally, counties used two kinds of aid, often simultaneously. They used indoor aid, or indoor relief, which is what a poor farm provides. It is an institution where people have to go in order to receive the aid. There's also outdoor relief, which is direct aid that can be paid out in the form of groceries, or having rent covered, but it also used to include doctors' bills.

The fact that this particular type of aid, that outdoor relief, became prohibitively expensive for a lot of counties, especially the part about the doctors' bills, is one of the reasons why poor farms became so popular and so common in the United States. That type of aid for sick people who needed a doctor, who needed maybe to get taken care of but outside of an institution, before the Civil War cost counties anywhere between two and five dollars a week, prohibitively expensive and difficult to budget for. It was hard to say how many people might need that type of care, and how long they might need that type of care.

So, the poor farm kind of emerges as a popular way to consolidate expenses and consolidate the care that people in the community need into one singular institution. The poor farm has lots of synonyms, it goes by lots of different names, so you may be more familiar with the idea of an almshouse or poor house. Sometimes they were referred to as a county hospital or an infirmary, and those last two were important because by referring to a poor farm or an almshouse as a county hospital or an infirmary,

people were immediately making the connection between not just these sites as locations of poor relief but also that health care is intimately connected with that type of relief need.

No matter what you called them, because they were named different things and different places at different times, there were more than 2700 of them operating in the United States by 1910. That's kind of the apex number for this type of institutional care. Some were open for a few years, others more than a hundred years-- so some of them really have some longevity. Generally speaking, I think the word 'almshouse', or 'poor house' gives this connotation of this big, kind of hulking prison-like structure where people are trapped and miserable, and there's a reason for that reputation--truthfully in some places that is exactly what they were like. But what's interesting is that 'poor farm' as a term really describes a majority of the institutions that were open in the United States.

They're smaller, most had fewer than fifty residents and a lot had fewer than 100 residents, so they're not spaces that are housing hundreds and hundreds of people at a time, and most of them feature a farm--both for the reason that having something located in a farm was a way to acquire land as an investment for counties, but it was also viewed as an option that was healthy for people--it might get them outside, it might get them some fresh air, it may allow them to do a little bit of work. All of the counties and towns and township districts that opened poor farms as their resource or one of their resources for public relief, they are using them as a way to replace and also supplement those previous relief tactics that were

so expensive; and that very much included health care for people.

What they looked like is important: so, I mentioned this sort of image of this giant menacing brick building that looks scary and today is used as like haunted houses around Halloween, but their physical structure actually makes a difference when we are thinking about the fact that they provide healthcare to people. They were, especially by 1900, 1910, large, brick or wooden buildings, two and three and four stories tall; they usually had porches, a lot of them, for people to sit on, and obviously lots of farm and out-buildings nearby—lots of windows, which tended to be open for ventilation when it was warm, and in a number of places there are separate sections of the building that would be considered kind of the infirmary or hospital ward where sick people could be isolated, or where sick people could receive their care.

Some go so far as to have a separate building on the grounds that is specifically for the sick and sometimes also specifically for people who have been designated as insane but non-violent and sometimes but not always non-violent, but that is very sort of like a 19th century terminology for lots of different conditions that today would have separate diagnoses.

The idea of having a separate building is not always a good one because sometimes those buildings are being kind of retrofitted for the purpose of holding sick people. There's an Illinois county for example, that reportedly used a coal shed as their sick house—they had too many sick residents, they didn't have enough space, they needed to get them out of the main building and so they repurposed the

coal shed for that use; and that is a very telling example. Although it is certainly not true of all poor farms, they are not always great at providing what would be considered kind of the most sanitary, up to date, hands on healthcare. Usually at the institutions there is staff living on-site, but that does not necessarily mean it is medical staff.

There's a superintendent, that's a person, generally a man—not always but usually—who is in charge of the institution itself and usually also the farm. His wife tends to be hired in the position of matron, their family usually lives on site, and there are staff, especially domestic workers and farm hands who sometimes live in the institution or on the site. Some of the designs for poor farms not only separate and segregate out the sick from the main residence, but they also segregated and separated people of color so that institutions had separate wings or separate wards for Black residents and then different ones for White residents.

But in Southern poor farms is where you are more likely to find a cottage style design for the entire institution—so instead of having perhaps one large building that is segregated inside, there would just be separate small cottages on the site as a way to segregate Black from White residents—so that all of their living was to be done in those separate spaces. It is not always the case in Southern poor farms, but that is where the cottage system is most likely to be found although not exclusively. Interestingly, although it was done to separate people based on race, it also was a way to help keep the contagion of disease lowered a little bit, because people were not living in a large congregate style institution.

The population of a poor farm and their needs as health care recipients changes over time, and it is an important demographic transition. Before the Civil War there were roughly even numbers of men and women inside US poor farms, and in some places actually, women outnumbered men. The average age those residents is around forty years old. But in the period after the war, the average age of poor farm residents increases every decade, and the ratio begins to heavily favor men, so that by the 1910s and 1920s, the population on average in US poor farms is between the ages of 55 and 60, and it tends to be men.

Poor farms housed lots of different types of people. It's one of the reasons why they were heavily criticized as being terrible places, because it is sort of combining all of these different folks in one space. But we are talking about transiting labors, homeless people, the elderly, women abandoned by husbands, orphans, single mothers, people who have been designated as insane, people with disabilities and the sick. County officials, local officials, made the determinations of who was allowed access to the resources of the poor farm, and that includes the resources of healthcare.

To give you an example of how this access can look different for different residents, there's an account from a Texas poor farm, of a Black resident who is noted as being really well-liked by the other institutional residents and by the management, but despite that designation he lives in a jail building out back-- That is how his housing situation is described. And here is the sort of health care circumstance that he finds

himself in at the end of his life. He was suffering and had been suffering for quite some time, silently, with a rectal fistula. It was so severe, and he had been dealing with it for so long that when he finally reported the problem, nothing could be done to help—the doctor finally came, saw this man, declared there was nothing to be done and that was just sort of the end of it.

That isn't typically the type of health care that you would expect to see in poor farms being given to White residents, but because he was physically isolated from everyone there was also a sense that his condition was being isolated from view and also from anybody who might have bothered to step in and help provide him with some sort of health care.

The ailments that bring people to poor farms can include something serious and a sort of life ending circumstance like that man's condition, but the menu of things that contributes to people using a poor farm runs the gambit between chronic conditions that will eventually kill someone and acute injuries and acute illnesses where people will recover at the poor farm and then go out and lead potentially productive lives where they are able to self-support themselves through work.

I thought it would be useful to go through some of the ailments as some sort of snapshot of a one day at a poor farm. Here is a one-day snapshot from a poor farm in California during the early 1900s-- So on the list of ailments that residents were suffering from are the following: hearing trouble, broken bones, rheumatism, paralysis, female trouble, asthma, tuberculosis, varicose veins, kidney trouble, bad cold, bowel trouble, flu, and sore hand. So just one snapshot that's the range of

illnesses that people at that age at that time are dealing with.

What's interesting is that if we switch times and we switch places, and we use a different kind of menu option of ailments in a poor farm, it will look very similar—so I'll do that, so that everyone can kind of see what I mean: At an Ohio infirmary, in the 1870s, the intake records labeled roughly 50 reasons why people were there, and out of those fifty reasons, 20 of them were just listed as 'general sickness'. So, something's wrong with this person, it's a health problem, but we will not say what it is. But then, there's a whole list of other very specific conditions, so out of the 50 reasons we got 20 general sickness and then the following: broken leg, strained ankle, dislocated hip, very sore foot, bruised thigh, rheumatism, sore foot cut from axe, heart disease, sore throat, fever, shot in hand.

So, some of those are injuries and ailments that people are going to recover from and some of them are probably going to be long-term issues that may prevent people from working or being able to find work. Poor farms took in people who lacked funds for health care but over time, people who cannot afford to see a doctor, who cannot afford to have problems taken care of properly, it's a compounding issue. Being poor can be expensive, because things get progressively worse because they aren't fixed when they immediately happens.

They cause larger debilitating issues later on that just sort of build over time—build even over the course of a person's life cycle, and so at one point they can build to a moment where that person can no longer work and can no longer support

themselves. So, the poor farm assists in that space where sometimes the effects of being poor over the course of someone's lifetime come to pass that at the end of their life or towards the end of their life they are so severely sick that they need somewhere to go because they have nowhere else to be.

Combining all of these people together, people who have shot themselves on the hand or someone shot them on the hand, with people who have rheumatism so severe they can no longer work and take care of themselves, with people of all sorts of conditions and circumstances that bring them to a point where they need institutional care or need relief of some kind—that combination that poor farms provide assistance for all of them—is one of the reasons why reformers really tended to be critical of poor farms. There are plenty of other reasons to be critical of poor farms, but this combination is one of them—that there are not just sites that provide healthcare, they combine people who need health care with people who are just out of work or homeless or perhaps moving from place to place to find work.

What's interesting is that most places, especially in the late 19th century, lacked hospitals. This is particularly true in rural areas. So in the 1870s we are talking about roughly 120 hospitals across the United States not serving rural areas—really any of them. And although that number increases exponentially by the time, we get to the early 20th century, most hospitals are still not located in rural areas or serving the needs of rural people with healthcare.

And so poor farms existed in that void—it's one of the reasons why so many of them were smaller in population serving, again, less than fifty and less than a hundred people, and located on a farm. There is a need for healthcare and there's a need for relief that poor farms are fulfilling.

There are lots of connections between poor farms as institutions and the need for public health care. First and foremost is that idea that I mentioned earlier, where the expense of caring for the sick is a strong motivator to open an institution. The goal here is to keep your doctors' expenses as low as possible, keep the healthcare expenses low, and if you have a lot of sick people in one space, the doctor can make one visit, see multiple people and then he won't charge the county to, say, go to five or six different houses over the course of a day.

Poor farms provide services for acute illness, chronic illness, injury cases, so people are recovering at the poor farm and leaving, and people are coming to the poor farm because they are not going to recover, and they essentially need a place to die that is safe and not out on the street somewhere. Chronic illnesses were difficult to care for at home, especially if the person who had the illness wasn't a member of your immediate family.

Caring for chronic illnesses can be expensive, it can be time-consuming, it adds a lot of work to people's day, particularly women. It increases laundry, it might change what you can serve at mealtime, or you might have to provide special meals for people. And so, that type of care tends to be reserved for people's very close family members. so, a lot of the people who use the poor farm for healthcare needs are people who either

separated from their families by distance or who do not have any immediate family willing or able to provide that type of care.

I think it's useful to think about how many people we are talking about. So, we talked about how many institutions we are talking about, but in 1890 the census reported that there were 73,000 people living in almshouses in a single day. So that's the single-day census number of 73,000 people. 13,000 of those people were reportedly classified as sick, but interestingly, another 8,800 of those people were classified as crippled, which is a phrase that really encompasses a lot of different circumstances and conditions and was not itemized particularly well.

So, it is hard to know what kind of care those people needed. We are looking at you know roughly around the neighborhood of 20,000 of the 73,000 people who might need some type of specialized healthcare. What's interesting is that, in addition to that single-day census number, during the course of a year, roughly 70,000 additional people would have used poor farms—they would have come and gone already.

So if we then had to multiply this example forward, we really are looking at maybe closer to 150,000 people in the course of a year that would have used a poor farm for some length of time, and more than 20,000 of them, or again roughly a quarter, who need some type of healthcare while they are there—they are dealing with sickness or perhaps some type of disability that may require a little extra assistance.

The notion that healthcare and poverty are kind of inextricably linked was important not just in our current moment today but also historically. Social welfare reformer Ames Warner, who became kind of nationally prominent for his studies of poverty, tried to classify the causes of poverty-- what was it that made people poor? And he expressed kind of genuine surprise that sickness appeared to him to be the leading contributory factor for institutionalization. So what he meant was that overall, homelessness was the reason most likely to be given by someone who was coming into a poor farm. So a majority of people are reporting, if they report at all, that they're homeless--they have nowhere else to go. But Warner's saying here that he's shocked--that sickness and illness is the leading contributory factor to their institutionalization.

It's not just that they have nowhere else to go, it's also that they're sick. And so those things go together. So he lists illness as being a very significant and complicated factor for why people are poor and then, as an extension of that, why they are struggling to stop being poor. So he's sort of entering into that debate about whether people are worthy or unworthy of aid and whose responsibility it is for their plight. He's saying, "according to my examination from the late 19th century, this is an issue of people being poor because they're sick."

When counties and locations decided that they were going to use an institution to kind of consolidate their relief efforts, it's interesting that they used it for other things. So we have counties that build asylums on their poor farm property. We have counties that build hospitals or pair a hospital

with their poor farm, and poor farm property and buildings are used as quarantine sites for disease outbreaks.

That kind of brings me to my next point, and one that I am sure people are curious about given our current moment. But during the flu epidemic of 1918 and 1919, poor farms are a major player in the public healthcare scene. Counties faced increasing aid costs during that pandemic because more people needed to see a doctor but did not have any money for a doctor, so they see more people in need, sort of asking the county to cover those healthcare costs, but they also saw poor farm populations increase during that pandemic.

Some poor farms actually locked down for resident safety during that outbreak, so they won't let visitors come in, they wouldn't allow merchants to deliver things, they tried to reduce the time doctors came in and out of the poor farm because if a doctor had been out seeing flu patients they didn't want the doctor in the poor farm—so we see them trying to cope with not just an influx of people who have a need for their services, but also trying to take care of the people who already live there.

Onsite quarantine space at poor farms was perhaps surprisingly common. Smallpox outbreaks, typhoid outbreaks in communities, often meant that poor farms space was used as a way to house people who just couldn't take care of themselves at home for that period of time, with the hope that they would recover and then go home.

But they needed a place to be, and in the absence of hospital space for that recovery to take place,

counties did often use the properties of the poor farm because it was already in their possession and they already had it staffed, and it was a way to provide temporary shelter and quarters. Another outbreak or epidemic issue that poor farms dealt with regularly was tuberculosis. It pops out in that list of reasons why people are there.

Tubercular patients were common in poor farms, even though specific facilities were developed to take care of them—but having tubercular patients with the other population in poor farms could obviously be dangerous because of how contagious tuberculosis could be. So at some poor farms there are tubercular residents that are segregated, especially for sleeping, and their lounging area tends to be in the infirmary, if there's a separate space for that. Other conditions that were dangerous or troublesome at poor farms include typhoid, people with syphilis—generally labeled or considered to be unworthy of relief no matter whose fault it was that they had syphilis.

They pop up in poor farm records from time to time, but not with the regularity that you might expect when you read progressive era accusations about poor farms—that they are just housing everyone with syphilis. They are actually—there are cases of syphilis amongst poor farm residents, but it is not nearly as common as it might seem from critics who are angry about poor farms, and the type of care they provide for certain types of people.

Most poor farms, even though they are dealing with all of these different healthcare issues, are not staffed 24 hours a day with healthcare specialists. So, the work is being done mostly by staff—by superintendents and their wives—the matrons—the

hired help for the house if there is any, farm hands if there is any of those.

So, there's one affecting case of a Nebraska matron. The poor house takes in a family of five, they are suffering from typhoid—so they are very sick, and they are very contagious. She takes the whole family to the sick house, which at this poor farm happened to be at a separate structure, and because there is nothing else to be done, she stays there with them and she does not go back into the main institution, until all five of those people unfortunately died.

But she stayed with them the whole time, at enormous danger to herself, so that she doesn't bring that disease back to the residents of the poor farm, who included her own children—her family lives there because they work there. There are lots of accounts of the healthcare provided at poor farms being done by normal people who are not trained in any sort of healthcare profession, but because their job is to take care of the people who live there, a lot of times that means fulfilling lots of types of healthcare jobs.

There are doctors and nurses, but the hiring of them and how poor farms are staffed with healthcare professionals is interesting. County officials usually hired a doctor on contract. Frequently, actually, doctors bid on the county poor farm business. There are two different contracts that most commonly pop up: one is to pay a doctor for every visit a set fee—so let's say it's three dollars a visit—and every time that doctor comes to the poor farm he's going to make a minimum three dollars.

That is the best case for the doctor, but the worst case for the county. Counties really, if they were being fiscally very responsible, would pay a doctor annually-- so a set fee for the whole year including an unknown number of visits to the poor farm to deal with an unknown number of cases. So this way, in most circumstances, the county is really going to get its money worth out of this contract, and those negotiated fees that they were dealing with before a poor farm was constructed sneak up, they can't predict, they do not know how much things will be--that contract of the annual fee was really meant to mitigate that problem.

Being the poor farm doctor was not necessarily the most prestigious position a physician could have. One critic had this to say about doctors providing that service: "The country doctor has usually been some man who needed the practice so badly that he would underbid any other physician in the county for work." There's some truth there, in the fact that doctors did have to bid for the contract and typically the lowest contract won the bid, but from a county's perspective the lowest contract was a cost-saving measure, and healthcare expenses for poor farms were still pretty steep. In 1900, all of the county poor farms in Illinois, and almost every county in Illinois had one, spent \$25,000 that year on doctors' bills--a not insignificant amount of money.

Frequently, if there was a financial problem or a lot of people staying at the poor farm-- the depression of the 1890s is a great example of this-- Poor farm population increase, the need for all types of reliefs skyrockets, and so county officials are trying to figure out ways to cut down expenses, and in a couple of counties in Ohio,

county officials reported they were going to try to minimize the number of visits to the poor farm made by the doctor because they were paying on that different type of contract—they were paying on a per-visit fee contract. So, consolidating all of that into an annual bill was much easier.

Despite the idea, at least by this critic, that you are going to get the worst doctor who needs the business the most, some poor farm doctors appear to have done a very conscientious job. One doctor from a Texas county said, "I have done what is in my power to mitigate the sufferings of these unfortunates and smooth their pathway to the tomb." He's really talking about what we would talk about today as palliative care, but part of his job is to deal with those chronic cases and those chronic residents who are essentially there at the poor farm to die, and it is his job to make them comfortable.

Interestingly, poor farm doctors are also consulted about the conditions of the institutions. They pop up in records continuously. They are being asked by state officials and county officials how are things, what are the meals like, are the residents well taken care of, do they have enough bedding, do they have enough clothing, because the doctor is the person who although he is affiliated with the institution, it's not his job to feed people, it's not his job to make sure they are clothed and so he's an interesting checks-and-balance on the management of the institution, and in that capacity, really had the ability to make conditions for residents, whether they were sick or not, much better than they might have otherwise been.

Nurses do show up on poor farm records, but they are more commonly there after 1910, and definitely into the 1920s. so nursing is often provided by the staff, often the female staff but often sometimes the superintendents are reportedly giving various types of healthcare to residents, which I will talk more about in a minute.

Nurses are also more commonly found on the bigger institutions' staffs, so places where there are more than 50 residents, more than 100 residents, are more likely to have someone listed specifically as a nurse. In California they did something interesting where not only do they pair the poor farm and the county hospital—they do that very often, that pairing—but they also used nursing students as a way to get more professional nursing into the institutions overall, as a practical experience for the nursing students to the benefit of the residents that needed the care.

I thought it might be helpful to talk about some specific poor farm doctors to give an interesting image of what this job could be like, and how the care was for residents. I'm going to start with George Palmer, who was a poor farm doctor in Illinois in the 1870s.

Palmer is a great example of somebody who made things better for residents by being an outspoken critic for what he saw in the poor farms when he visited. So Palmer gave a lot of testimony about improving the diet and nutrition of poor farm residents as a way to improve their overall health. And at one point he is testifying to a group of people about all the different poor farms that he's visited in his capacity as a poor farm doctor because he has done some visiting in other places,

and he had this to say: "One Illinois county has a contract with a dentist to pull the teeth of poor farm inmates.

There is no provision for saving teeth; if the inmate is writhing with toothache, he must take his choice: lose a good tooth on contract or grin and bear the pain. The supervisors can see no reason why a popper should want to save his teeth or why he should be permitted to do so, and yet a cheap filling would cost a little more than the primitive and mutilating operation of extraction."

So not only is Palmer advocating for things like better food, he is really hound in on this one circumstance where there is no reason to be pulling people's teeth, but they think it is cheaper and easier, so that's the tactic they are taking. They are not fixing a toothache, they are not trying to medicate or take care of it by saving the tooth, they're just going with the easiest cut-rate dental care available.

About thirty years later after George Palmer, Theo Hardisty is in the same region in central Illinois, and in the 1910s he is leaving behind very detailed medical records of some of the residents he is encountering at the poor farm. To give you an example of the scope of his work, in 1914, Hardisty treated 106 poor farm residents, and he did that over roughly 35 visits during the course of the year, so he is there fairly often. What's interesting about the records that Hardisty left behind is that it shows a clear engagement with the Eugenics movement.

Hardisty was most interested in those patients he was seeing, who he considered to be 'feeble-

minded', which at the time was the catch-all term for any number of different conditions, all of which would have different diagnoses today. But Hardisty is attributing some of their body movements, sometimes physical disabilities and sometimes seemingly intellectual disabilities or psychiatric conditions, to this notion of people being feeble-minded.

His foray into that is unique. There are other doctors that used poor farm populations as a study pool, but Hardisty leaving behind these very distinctive records is interesting. He doesn't seem to have treated any of his patients badly, or in a way that could be perceived from the records at least, to be unethical. But that was not true of all poor farm medicine.

As a way to introduce this idea, there's a record from Wisconsin that I am going to use—this is from the 1880s, this record was left behind by the superintendent who was actually the person providing the care to this patient. This is how his condition was described: "A leg has decayed so that the bone below the knee was entirely severed, and pieces of bone came out. He was a very offensive case, worst case ever had for stench."

So, we have someone whose leg is rotting away, and what's being recorded by the staff is that it's really gross for them. There's almost nothing about what it was like for the patient who did, if you were wondering, pass away due to his condition. So we get a very clear sense that sometimes the care is perhaps not the best, perhaps not the most compassionate.

The penultimate example of this is Dr. Alvin Fouser from Summit County, Ohio, who in the 1880s was one of the poor farm physicians serving that farm. He was indicted for body snatching, and in the course of the investigation related to his work as a potential resurrectionist, he was also accused by staff and residents of possible malpractice.

Essentially what they said, they implicated Fouser in hastening the death of residents as a way to increase his body snatching business. Fouser, in the complaint that was filed against him, he's accused of stealing bodies out of the poor farm cemetery and then selling them for \$5 a person, \$5 a body, to medical schools and colleges across the state of Ohio. Fouser denies these charges and he's never brought to trial for the body snatching because a subpoenaed witness mysteriously just doesn't show up. There's a number of things that could go wrong there, but he doesn't actually get to go to trial, so we don't get the full picture of what the case against Fouser was going to look like.

But the investigation after the indictment indicates that not only did he seem to help speed up death by not treating people who were sick, not giving them medicine, not providing them the care that people thought they needed, he is also accused by residents and their families of trying to charge them double for their care. So he is paid by the county, as the poor farm physician, but he is also trying to charge people's families to visit them at the poor farm and take care of them, so he is double billing. He certainly seems, at least based on that kind of cursory glands, to be an unethical poor farm doctor, and he does lose his position in the infirmary as a result of those charges.

As you probably noticed, not all of the health care that's provided at these institutions is done by doctors and nurses. There's a lot of matrons and superintendents and staff taking care of residents. J.S. Myers from Wisconsin was the superintendent who wrote the account of the man with the leg condition. His diary of his job provides an extra glimpse at what it was like to be a staff member at a poor farm dealing with just the day-in and day-out of poor farm stuff in addition to the healthcare needs of residents.

In 1879, Myers reported there had been an outbreak of disease at the poor farm-- He doesn't detail specifically what it is, but he did say it was requiring between two to three hours of his time every single day. This is on top of him running the farm, and running the institution, which had between 75 and 100 residents usually.

At the same time this is going on, his infant daughter dies of cholera and phantom. While he's dealing with the child's illness and then death, he writes that the farm was gripped with illness and he administered medicine all day to more or less all of the poppers, some of whom are really bad with dysentery. On the day his daughter died, he wrote the sick need almost constant care, but there was no nurse on site at this poor farm. Other types of cases that would have required a lot of care or input from the staff include a family group that came to an Ohio poor farm in 1880. The family had seemingly been suffering with illness but also malnutrition.

The mother dies, and the three youngest children are taken to the poor farm, and at least one of

those kids are suffering from rickets. So, rickets we know we are looking at a bone deficiency of some kind. She's not able to fully recover, and there is some type of undocumented physical disability as a result of those Rickets. And so she spends the next thirty years in that poor farm as a resident, so she grows from childhood to adulthood in that institution as a result of the illness. While she's there, there is another case of this older man, he's a civil war veteran, he is dealing with a condition that is described in the records as not just scurvy—he has scurvy, it's affecting his teeth and gums—but he is also dealing with chronic diarrhea that is causing a rectal problem.

This is the type of case that would have been very difficult for poor farm staff to care for because of the amount of cleaning that would've been needed to be done, but it's also the type of case that would have been hard to take care of at home, and obviously it wasn't going very well because he also has scurvy, so he was not getting enough to eat of the right things, and he is dealing with this disease that probably would have benefited from a special diet of some kind. He's in and out of institutions—he goes to the veteran's home, he goes to the poor farm, he's not able to self-support.

These types of cases litter poor farm records, and so the staff is taking care of people with lots of different circumstances. In Kansas, state visitors found a superintendent who was tube feeding a resident, and another that was sedating sick residents, both without the immediate supervision of a doctor. Kansas provides some interesting cases because staff were paid more when residents had specific healthcare or nursing needs, so there's

actually an additional stipend when people need additional care.

The poor farm clearly fills a fairly important void in public healthcare needs for a long period of time, but where did the poor farm go? By the early decades of the 20th century, poor farm residents are getting older, as I mentioned before, and with their age comes more illness, sometimes of a more chronic type.

This increases the healthcare costs for counties, and it complicates their care-- they need more things, and they need more specific things. This is where the structure of the building comes back. When you have ambulatory cases, people who need wheelchairs, people who can't get up and down stairs, a large two and three- and four-story building is not particularly suited to the type of care that older and infirmed residents need. Poor farms truly began to close in large numbers after the Social Security Act.

Recipients of social security initially were not able to live in publicly supported institutions like poor farms, and over time, and it happens fairly quickly, between 1935 and 1945, hundreds of poor farms closed across the United States, but some of the funds that were going towards poor farms are transferred to other types of public institutions; county hospitals for example, but also county nursing homes, reflecting the fact that residents are older and they needed a different type of care.

Often, county nursing homes were actually built on the site of former poor farms, sometimes it is an easy way to see where the poor farm used to be if

you could figure out where the county nursing home is or was—it is not always the case, but it is sometimes. Then there's a study pattern of closures-- the 1940s, 1950s and 60s-- as more federal funds were made available for public healthcare, elder care and rural hospitals.

What's interesting is that when we think about the space that poor farms occupied in the public healthcare spectrum, especially in the late 19th and early 20th centuries, there are similar voids today. Today rural America is dealing with an absence of healthcare providers, dealing with the closure of hundreds of rural hospitals in the last decade, and interestingly enough, a few poor farms remain open today—they are not called poor farms anymore.

Typically if they are still open today they are known as county homes, but the county homes that do exist in a few places, maybe just a dozen, a few more, are serving a very similar population as the last generation of poor farms did; they are serving adults with certain disabilities, they're serving people who need public care but are not eligible for other public programs, and older people who perhaps need something like a nursing home but no spaces available for them, so they are at the county home. So there still is this gap that poor farms used to fill or helped fill that is still taking place today across all of America.

Thank you.

Q+A

[segue from lecture]

CHRISTOPHER BRICK: As easy as it is for me to appreciate a lecture as wonderful as Megan's, I have to say that I am even more grateful for what a fantastic guest she was to host for the Q+A. For those of you who are interested in data, this conversation, we had to pare it back quite a bit. It went long past an hour. It could have gone long past two hours if we had let it. Kariann Yokota was with me and Megan as well so all three of us were making rather merry, and I hope you enjoy.

Here it is.

[beginning of group conversation]

CHRISTOPHER BRICK: Megan Birk, welcome to the podcast!

MEGAN BIRK: Thanks, Chris! Happy to be here today.

CHRISTOPHER BRICK: Wonderful! Wonderful to have you and it's also wonderful to have our wonderful Chair of the Marketing and Communications Committee, Kariann Yokota. Welcome, Kariann.

KARIANN YOKOTA: Thanks, it's always great to be here and I'm looking forward to our conversation.

CHRISTOPHER BRICK: Yeah, well, me too because Megan you taught me a lot about social provision in the public health context, right? And so, that is, a lot of the talks in this series have focused on aspects of social control. The thrust of your talk was really about social provision. The first thing that came to mind for me as I listened to your talk and then relisten to your talk was that Charles Dickens quotation in the beginning of *The Christmas Carol* he says "Are there no prisons?" asks Scrouge,

"Plenty prisons." says the gentlemen laying down the pen again. "And the union workhouses," demand Scrouge, "are they still in operation?" "They are still, I wish I could say they were not." "The treadmill and the Poor Law in full vigor then."

MEGAN BIRK: Yeah, it's, I use the phrase sometimes that it's the sort of place that you wouldn't chose to go but if you need it, you're glad it's there. Because alms houses and poor farms particularly, there is a need there, and they differ a little bit as they develop over time from the English workhouse system, so if we stepped farther back in US history, you would or you do find a lot more overlap between that kind of Dickensian, very cold, big, crowded, everyone kind of you know unraveling the rope the be recycled into something or picking rags. There is very much this ethos in the United States about working for care. That if you need something you have to work for it but there's an interesting transition that happens over time and it is not necessary a conscious transition. I think it is a transition of necessity, that the people who are coming to local governments, counties, townships, towns, need things and they need them because they cannot really do much of anything. They have been injured, they are sick, they are homeless, and so in some ways it becomes kind of a stop-gap measure.

And in that capacity when counties and towns decided to invest in a farm to use as their institutional care provision they're doing so not necessarily because they're confident that the people who are going to stay there can work those farms, you know, farm work is hard, its physical, its taxing, that's true for men and women, that's true for hired hands, its true for children who are

doing farm work. So, they don't necessarily think that they are going to be able to run a 100 to 200 acre farm using the people that live there. What they're hoping is that the farm will offset the expense, it will provide food, they will be able to sell some of the extra products, and it will offset the relief expenses that they are experiencing already. Because in a lot.

CHRISTOPHER BRICK: Right, but there's no expectation that this is something that is owed to anyone by virtue of just their membership in the community.

MEGAN BIRK: Yeah, you know there are examples of places where they were expecting someone to work, but you have to look and see who they're asking that of. So sometimes transient men, people who were accused of having a drink problem, they're expected to do some work because the notion is that their behavior is in some way kind of causing them to then need this assistance. But when you look at an institution that is full of elderly people, the sick, women who are alone but with a couple of children, they are not your, you're not going to staff a farm with those people, you're just not.

But you had kind of asked about the physical space because that's one of the things that when people think of a workhouse, when they think of an alms house, that is very Victorian England. Because we have visual markers, you know cultural markers of that, you know movies, films, things like that. A lot of poor farms in the US were smaller. They look some of them start as modified farmhouses, you know two and three story, where they keep enlarging them over time. So, they will add a wing here and then they add a wing over here until the most common

physical design is a three or four story building that has the shape of maybe a "c" or an "e" and those wings are designed to kind of separate people inside the wings of the institution, most often by gender.

They didn't want men and women mingling inside that space, but there were also ways they used that to physically segregate people based on race, depending on the location of the institution and really the kind of tone of the county government itself. And then it is an operating farm, most of them, there's a kind of max number that I use in the book, it's about 2700 is the best estimate I have for how many poor farms and alms houses were operating in the US at one given moment. Is a lot, it's a lot more than people realize because they're local, so local municipalities have those places.

CHRISTOPHER BRICK: A lot of the origination for the policy itself seems to be happening at the local level, the county level and then each of these institutions is going to look different, and be different, and bear different kinds of resources and services. It sounds like every county might have had some built one of these at one time or another or hosted one of these at one time or another. But I can't think of an opportunity I had to go see what one of these looked like so I just want to hear your reaction to this question.

MEGAN BIRK: I'll start with the later. You can visit some of them. A lot of counties let them crumble, and a lot of counties, you know the value of the institution, you know that tangible value, was in the land, so when it came time to sell the farm, they just sold everything. You know farmland is expensive in the United States, especially in

the later half of the twentieth century when a lot of these places closed. So some of the were just allowed to dissolve where they stood. But there are some that exist in the eastern part of the United States.

There is actually an article that someone documented how they had been repurposed and many of them are private family homes, which was fascinating. And in the Midwest a number of them are county historical sites, and the society is housed inside the poor farm. That's true in a number of places in Ohio and Michigan, you can see the structures you can go inside, they've preserved some rooms so you can go and see how they were set up. I found one out in the barrier islands that is both a county historical society and a wedding venue. Which was a fascinating repurposing of a poor farm building.

So, they are up, you can see some of them, certainly not nearly as many as used to exist but you could. And then to just of get at your previous point, microhistory I think is going to become increasingly important when people want to talk about social provisions in general. There is no clear diving line for when places, or if places, decided we're going to stop one kind of aid and start another kind of aid.

It's especially, when it comes to health care costs, that is a web that is very difficult to pick apart, because they built institutions to house sick people, to house poor people, then they built more institutions to separate them based on condition, but they're still giving out money, they're still paying doctors' bills, they're still covering grocery costs. There is no, outside of

large cities where private charities were able to kind of rationalize how direct aid was given, when it came to county governments doing that work, they did it case by case.

So, if Miss. Smith down the street has a sick child, and if the county pays for the doctors' visit, she can keep working and that will keep them in their home, they pay for the doctor because its more costly for them if Miss. Smith and her kids become a complete dependent on the county. And so they're making those choices, you know if somebody breaks a leg at work and he's going to be laid up and the family might starve, they're going to send a doctor to set the leg, they may pay their grocery expenses for a couple of months to get them back on their feet and they're making a real kind of localized cost analysis of whether direct aid, direct health care expenses, whatever it is, whether that's going to be cheaper for them in the long run rather than institutionalizing someone.

And so, it's interesting to watch them make those moves because it's not something that we really associate, especially by the time we get to the progressive era, everyone's talking about this sort of rationalized charity and were not doing direct aid, and this makes people lazy, and then you look at the local records and county governments are just writing checks and they said "look we can't afford to institutionalize everybody who falls on hard times, so you do whatever you're going to do and the control then kind of is with us to do what we're going to do for our people."

KARIANN YOKOTA: Well, if I can follow up, and go from microhistory to a macro view of your talking and your lecture. So, we started the conversation

with what I think everyone thinks of as Dickens and Victorian English model of the poor house with the sick house, and I was wondering if you could provide the schematic or general timeline, how an English, so this, I'm a transatlantic historian so I'm always thinking about comparisons and contrasts between the two systems, so how do you get from this Victorian model in England to the current socialized medicine, NHS system, versus the American poor farm morphing into the health care system that we have in the United States today?

MEGAN BIRK: It is, that is a complicated stage of events but I will streamline it as best I can. People here stated using the English poor law model, that is the blueprint for the British colonies, it is the blueprint for the early states, and state after state decide that any provisions for the dependent needed to be localized, it need to be county based or township based. And so that law, that idea of that law was passed on from the East to the Midwest to the South to the West. It moved as people moved. And so for a long time, local provisions were where it was at, especially at the county level, but around the turn of the 20th century there is a kind of a diversion where we see unions and other kind of fraternal societies concerned about their memberships' health and safety.

Life insurance policies, widows' benefits, they start to kind of dip their toes into our members as a collective, our members as a group, what provisions do they need? And so that turned in to, if you join us, we will help pay medical benefits, so they start becoming kind of brokers of health care for particular groups of people. And that becomes a kind of early group insurance plan, it

isn't but you can sort of see the beginnings there and so there are groups of people in the United States who benefited from that, is you joined into some sort of kind of shared expense program.

But one of the big changes came during the Great Depression where there is a real need to, or desire, to move aid and provisions away from the local governments, who are broke, they're out of money, and so they're struggling to figure out how they're going to deal with the volume of need. And they've had a burning desire on the part of the progressives, some of whom are influencing New Deal programs, to rationalize it in a bigger way, under a bigger umbrella so this is kind of the moment where they see that opportunity, but there is no socialized healthcare that comes out of that plan in part because of the resistance to certain New Deal provisions by the Southern block, the southern democrats at the time.

They do not want to share any of those provisions with African Americans. And so, when there are programs that are designed to help lots of different poor people who need assistance, they are always logger heads, so the system that develops is this very kind of disjointed, it gives power to the states to use federal program money for things eventually like Medicare and Medicaid, for things like our food stamp program.

There's federal money there but it's state administered. And the same thing is true if some of these other, like the hints of socialized programming that the United States has, that power sharing comes from this desire to keep things segregated and to keep power at the states where they could kind of hyper-segregate where they spent

that money. And that has been a bit of an Achilles heel the whole time, so that move from local workgroups identities shared systems, instead of moving directly in to some sort of federalized program, ran to this blundered state federal concept, it was the only way the legislation was going to get passed so they did it and it comes up in all kinds of different program, aid for families with dependent children, you can see it, you can see it all over the place. There are lots of really good books that do a lot better job than I did, because I was rushing through that but...

KARIANN YOKOTA: It's really good actually, not to cut you off, but it's a recurring theme in some many aspects of American history, but its interesting to think about how two societies which come from the same origins, it's an Anglo-American colony, how they could diverge so dramatically in the case of the type of health care system that is developed in both countries.

MEGAN BIRK: Yeah, it's an interesting pattern and its we are still dealing with the long lasting and long reaching effects of that today. This sort of woven together system where there's a lot of tangled jurisdictions and its interesting that in the nineteenth century, the late nineteenth century, there was not a lot of tangled justifications for poor farms and what they were providing to people.

It's like, and your municipality was in charge there and the state might sort of send some visitors around to check things out but because there was no state money involved, states had very limited abilities to kind of course correct or make recommendations. Every once in a while, they would

try to send standardized architecture plans for a new infirmary, for a new hospital, for a new poor farm, and county officials, you know, would look and say no thank you, or sometimes a more stern "get out, it's not your money, it's not your plan, were going to make this decision because were paying for it." so when they stopped paying for it, they also lost control of how it was going to run.

KARIANN YOKOTA: Interesting.

CHRISTOPHER BRICK: You brought up A.F.D.C. (Aid to Families with Dependent Children), and this is sort of a spinoff of where Kariann was going with her question because I think that that's an important one. We talked a little bit about race, is that sort of the variable that is, that accounts for, you know, in good part, is that what -- that to me would seem to be one of the biggest distinctions, our system of racial hierarchy versus what exists in the United Kingdom in the early 20th/late 19th century, where privilege is more arranged along class lines and along status lines. I'm just curious -- is that -- is race a very central variable in explaining those two distinctions that Kariann was suggesting in her question?

MEGAN BIRK: You know, it isn't exactly. By the time we get to the 20th century, it very much is, but I'll explain my answer there. It is clear that in the southern states, it can be more of a variable, but its very difficult to figure out why certain counties decide to open a poor farm at all, or don't, and how they decide which populations will be allowed to benefit from those resources.

There are clearly counties, and this is true in the Midwest as well, where there not welcoming to

anybody other than white people. But they never explain why that is, and then so you look at the demographics of the county and you can see that clearly over the late nineteenth century, some of those counties are essentially becoming like sundown counties, they may have started with a more diverse demography and by the 1900s and 1910, the diversity has left and its clear, you know, the histography of racism not being a southern problem, you can see that people are moving.

So, in the institutional setting, there are poor farms where that aid is being given to whomever and then there are poor farms where it isn't. And I can't pin point for sure that there is a meaningful action on the part of anybody that is like making that step. There's no clear distinction between why one county in Alabama has a sort of two-part poor farm, one serving black residents and one serving white residents. And then two counties over they have a poor farm but its only for white people. In the same state, in the same area, it's a very localized choice that they've made and the same is true in Ohio, you know, and it, pick a state and you can look at one record and see some different groups of people, pick another record and you might not see the same thing, so its hard to really confidently say "Ah ha, they are making these choices based primarily on this one particular issue." I think its definitely true in some places and then possibly true in others.

CHRISTOPHER BRICK: Yeah, and the reason that Aid to Families with Dependent Children, that program brought me to that question is because I think about how intensely -- you know AFDC is the only title of the Social Security Act later repealed, in 1996, during the Clinton Administration. And I

think it's impossible to ignore how implicated the racialization of that program during the 1980s in particular, the Regan/Bush years, him talking about welfare queens and the like.

MEGAN BIRK: Yes, and they very -- in that example Chris, and they vary specifically on the definition about worthy and unworthy and they are crafting that around a race based narrative. And in the late 19th century, especially in counties, there is less discussion about worthiness. They are more likely to identify it as behavior based and not sexualized behavior, not implicit, sort of like single mothers. They're not pinning down that these people can not be in here because they are bad, they're just looking at somebody that needs a meal and a place to sleep and so in we go. And, you know, its that idea of worthiness, in the 80s they didn't say it that way, but that's exactly what they meant. They're harkening back to this kind of late 19th century idea of worthy poor and unworthy poor and they're setting a new baseline for that based on both race and then perceived behaviors, that they are going to make those connections to, and so that's, yeah, I definitely see the connection there.

KARIANN YOKOTA: Well, and I wanted to ask you to talk some more about the southern states and the transition from slavery to what you're talking about, right? So, you know, if you, I'm think about slaver historians, the historiography of the studies of slavery, right, and one of the points is that under this dehumanizing and brutal system of chattel slavery, the one thing was that when an individual was too old to keep working, they did not put them out on the street to die, you took care of aged slaves, and that after the Civil War,

this wasn't the case, so you basically see the replication of this brutal system of exploiting labor but without the social, having to take care of aged slaves.

Now, that's not my field of study, but that's what you read in just the general historiography, so I'm wondering if you, in your work in the origins of your story of the poor farms, if it talks about, if you talked about that transition from a slave system in the south to social welfare and how, if you could tell us something about how the south or former slave owners thought about or talked about this social responsibility for former slaves?

MEGAN BIRK: Yeah, they do not talk about any sort of social responsibility for the formerly enslaved. What they do do is set up a system of share cropping as kind of the labor option of choice which is, you know, a captive labor system that is controlled through racialized violence and endemic poverty. And they are hesitant and unwilling to give a lot of aid, direct or otherwise, or indoor, because they want those people to stay and work, and they want them to work for as little as possible.

They, so, regionally speaking, the South as a region has fewer poor farms on a county by county basis than other sections of the United States for that reason. It is, it draws from a long history of souther municipalities not necessarily paying into any sort of collective activity at all, especially not one that would be used by everyone. But there's also this issue of the carceral state in the south, the rise of imprisonment, and then prison labor and chain gangs and convict labor.

People who would have stayed at a poor farming other parts of the United States, let's take transient laborers just as an example. Lots of transient laborers coming in and out of poor farms in lots of other parts of the country, they're moving for work, they don't have a place to stay for the winter so they go to the poor farm and they hangout. Then in the spring, they go back out and work.

Transient laborers are not welcomed in the south and you were certainly not allowed to be a transient black male laborer in the south because that's how you end up in prison. And they're very clearly imprisoning people in some of the southern states that in other states would have maybe wintered in the poor farm. So, there is a distinction that has to be made between why aren't there so many people in poor farms in the south, frankly its because some of them are in jail. Not because they've done anything wrong, but because laws have been designed to put them there so that they can labor for free. So there's a connection there. There is a connection there.

KARIANN YOKOTA: Now, I'm so glad that you brought that up, I think that's so important to link those two systems.

MEGAN BIRK: Yeah, its different but it is also the case that when poor farms, or any sort of social institution, when it has been made most unpleasant to certain groups of people, like Black Americans, who in some places when they're admitted to the poor farm, they are put in an outbuilding or they're kept in a basement, or they have to stay in the attic as a way to physically segregate them inside the institution.

They do not want to go there, because they are going to be treated badly and there is an awareness of that. And so it discourages people from using those institutions if they know that is going to be akin to essentially sleeping on the street anyway and how that is interpreted sometimes by the sort of white power structure is, "see those people can live in much greater poverty, they can do with less, they will take care of each other."

Well of course if that's the alternative, if you were going to stick them in a disgusting basement all winter, then I will certainly do my best not to have to go there. So, when the treatment is substandard compared to the treatment of other residents, when they're not given the same health care. They're a couple examples in the podcast lecture of, you know, black poor farm residents not being given the same health care provisions that the other residents seem to be given.

So, no I would not choose to go there necessarily unless I absolutely had no other option and the way that that is filtered is "see, everything is fine, they can handle it, they don't need to be here anyway." It's a self-fulfilling prophecy of sorts. And, so those two things are very important distinctions of why there's some substantial differences there.

KARIANN YOKOTA: And is there, in the early 19th century, in the north, were there poor farms or their equivalent and would immigrants be treated in similar ways to people of color or, I'm trying to draw these comparisons between regions, but also, I mean ultimately what I was hoping to be able to talk with you about is how the responsibility of

the state extends to what group, or how it extends to what groups of people and I think today we are talking a lot about those who are undocumented but living within the nation state, within the borders of the nation state.

And as a society, how do we define who we are responsible for taking care of and is it based on, in this case we're talking about racial differences, and also I think its an important thing to talk about citizenship status, and in the 19th century these things were much, in the early 19th century at least, these things, citizenship was much more fluid, right, and we didn't have the modern passports and the visa system so maybe that was less of an issue but can you tell us a little about that, and about who the state feels responsible for?

MEGAN BIRK: Yeah, in the Antebellum period there is a lot of discussion about immigrants using alms houses and poor farms, who those immigrants are. The Irish of course take it on the chin during those discussions. People blame them for increasing the need for these structures. There was recently, I guess it was maybe a couple years ago, there was a book, I think the authors last name is Herodía, he wrote a book about Irish expulsion out of the United States, particularly Boston and New York paying to deport people. And they used alms house populations heavily to find people who they wanted to deport, saying look, you know, you're a public charge, out you go.

After the Civil War is over, and the number of poor farms increases, counties have a bigger need to their building structures, they're developing that kind of localized system, they're still discussing

whether is native born or immigrants who are in those places. And they start measuring it, so by 1880, that's the first year that the US census does the special census, that's the very kind of offensive and notorious one. It's for delinquents, idiots, the insane, they refer to it as a special population and they pull out a separate section to count and categorize institutionalized people but also people living in homes with their families who have some sort of condition.

And so they start taking demographic measurements then at the ten year intervals of poor farms, how many people are in them on a given date and how they break down in terms of age, race, and nationality. And, probably to the surprise of no one, regions of the country who have immigrant intakes, have a higher population of immigrant poor farm residents. But one of the interesting numbers that they pulled by 1903 or 1910, they ask those immigrant poor farm residents "how long have you been in the United States?"

I think, expecting that the answer would potentially be, "oh, we just got here." It's that whole like, "we're letting people in that can't self-support" but the number actually, people had been here, they were older people that had been here for over 10 years. And their ages were higher, they were just simply immigrant born people who had been here for quite some time. They had worked clearly, they were sick, they were old, they couldn't support themselves anymore, and so they went were all, you know, where a lot of native born people went, which was to the poor farm.

So, I don't think that they got the result they were expecting but it also, you can see states over time

maturing in that statistic. So in the 1880 census of special populations you can see some of the newer states that are bringing in more immigrants, especially from Europe, places like Minnesota, out in the plains some of those homestead states, their poor farms in that decade seem to have more immigrants in them than they do in 1900 because people are settled, they've gotten citizenship, they've been here for a while, so you can see the change over time and it weakens the argument that folks tried to make about immigrants as public charges because that does not necessarily bare out in the records.

And official records, not just anecdotally from county to county, the big composite records they were taking, it's in a couple of decennial censuses, it's less than half of everybody in an alms house or poor farm is an immigrant. And it changes over time a little bit, 1890 there's a little bit of a fluctuation but it's an interesting statistic, they, I think they really, I think some people really would have hoped that they could have proven that some of these immigrant groups were definitely to blame for this dependency problem that we have but statistically there was not enough evidence to use poor farms or alms houses at least to make that case. They're taking care of everybody. And it's interesting to, county by county you can see which immigrant groups have come to the county and how that changes over time.

CHRISTOPHER BRICK: I did not know about this special census; this is fascinating stuff. So could you just talk a little bit more about that?

MEGAN BIRK: Yeah, so I think that the most notorious, at least to 18th century historians is

the 1880 version of dependents and delinquents. So they did the normal census and they marked in some cases when they thought that someone in the household could be classified as a special category. So you can sometimes see this on the manuscript version as people marked as insane or idiotic, is the terminology they would have used, and so they're marking it, and then they went back and took a special count where they itemized county by county, township by township, those people.

And they tried to specify the conditions, depending on who the enumerator was, some of the records are more thorough than others and obviously, some families were less inclined to provide that information to them but if somebody was classified as being feeble minded, they wanted to know why, was it from birth or did something happen? And so you can see sometimes people writing down "was kicked in head by horse" or "blind from birth" but they, deaf, blind, they are running through the categories and it's a very fascinating document of its time.

It's very valuable for medical historians, social historians, but it is not duplicated in that exact form ever again. But they do start asking different questions in the census records that follow. So, you'll see people marked, especially if you look at institutional census records, where they go to the building and they enumerate just like they would in someone's household and so they run down the list of everyone and they mark what potential conditions that might have brought that person to that place. And so they're kind of keeping track.

CHRISTOPHER BRICK: The terminology itself of "poor farm", the word farm connotes also morality,

agrarian, is any of that pastoral mytho-poetics of the health-inducing effects of the countryside and the frontier if you will, the wilderness, is that implicated here, that kind of ideology as well?

MEGAN BIRK: It is to some extent. Yeah, the agrarian ideal. So, for a lot of people in a lot of places, a farm is just a very utilitarian space. Where you see it most substantially is at those institutions that were paired with and insane asylum. The language of what agrarian ideologic is best for is best exemplified by insane asylum care. Poor farms took care and housed a lot of people who were classified as insane, especially those considered as "harmless insane." Which meant that they did not necessarily need to be restrained, no violent outburst to speak of because poor farms don't have, they don't have the staff to take care of that, they also usually don't have the equipment.

That's how they got themselves into trouble in the antebellum period, they were restraining people, they were caging them, they just didn't know what to do. But there were some poor farms that on the same property there was a county asylum or a separate building so the language of what's outside farm ideologic, fresh air, healthy work is good for, is very evident there.

They want old, sick poor farm residents to enjoy it but in terms of therapeutic value, it is always very closely tied to the work and opportunities of able bodied, a heavily charged term, able bodied insane or the feeble minded who are still able to contribute something, and so they're the groups for whom that is seen as being most useful. Its peaceful.

CHRISTOPHER BRICK: Yeah, the health care aspect to this, these are health care delivery systems, right? When does the transition happen from what you described as "poor farm like," when does that terminology start to disappear and what causes it to happen? So, there is a transformation that happened at some point to what you call "hospital or nursing care," and what happened to the people who were living there when that transition occurs? I guess this is a three-part question, and what kinds of sources, do we have sources that speak to that experience?

MEGAN BIRK: The transition happens in a couple different stages. Early in the 1800s, even into the 1890s, there are a couple of places that mandate a name change. Ohio and California are the two largest entities that do this. Ohio switches theirs to infirmaries, so you have "the such and such county infirmary." They haven't made any changes to the institutions, they didn't go in and build a hospital to connote the name, they just thought it sounded better, it was less stigmatizing.

And California opts for county hospital titles, so sometimes they're jointed county hospitals and poor farms, or county hospital and home, and so their sharing that sort of space. And so fairly early, some places are saying, "you know this whole poor thing has a strange connotation that we don't like, we don't want to shame the people who live there." Which kind of speaks to Kariann's earlier question about who deserves care in the state's eyes, sometimes its care but also kind of respect, like how do we refer to these people so that they don't have to feel ashamed of needing to live there? But

then, the 1930s and 1940s especially, the effects of the New Deal start to kick in.

The poor farm population had gotten older, it was more common to be a home for the elderly, there nursing homes were private, they weren't really a thing yet, and so lots of elderly people who didn't have anywhere to go end up at a poor farm if they are poor. And so two things happen, one is that there is additional money for county hospital construction that starts coming out in the 1940s. And so, you're going to get federal and state money for county hospital as opposed to a poor farm. They're not going to give you any money for the poor farm. And so there's a move to try and move patients, residents from the county funded institution into something that is state or federally funded because it alleviates the counties from that expense.

But there's also a role that social security plays. In the original version of social security, of course, lots of people are left out, domestic workers, farm workers, they are excluded. They make up a huge population of poor farm residents. But you couldn't except your social security funds and live in a publicly funded institution. So it cuts poor farms off at the knees, they can't have people taking their social security check and then turning it over to the county.

So, lots of counties immediately try to figure out, "how do we get these people who are eligible for social security out? We don't want to pay for them anymore." so they, there is a noticeable increase in the number of nursing homes, private, but also some public, church-based homes, fraternal homes, wherever they can kind of shuffle people out to,

even boarding homes, someone who has multiple rooms in their home, social security recipients can pay rent and get their meals paid for. So they kind of almost go back to an earlier system. So that is a very significant change that happens over time and there is a move by the 1950s and 60s, if counties still have a poor farm open, they sometimes will transition it into the county nursing home, it's really a reflection of the population at that time.

And what they need, they need long term nursing care and not necessarily much of anything else. So, there are records, interestingly enough, there are oral histories, people who worked at the institutions during that time who recounted what it was like. But there are also some really interesting records from the institutions themselves, so nursing home records get into some issues with HIPPA, but poor farm records do not. And so a couple of institutions where they made the move from a poor farm to a nursing home, nursing home was on the same property, the county already owns the land, so they just sort of build a new building and shuffle people across the yard and now you live in the nursing home.

And they did the same thing with the records, they just picked the record books up from decades of poor farm residency and they plopped them over at the nursing home and so there are some people from the 1970s and the 1980s who have lived at the poor farm for like 40 years who when they died at the nursing home, the nursing home staff went back to the poor farm record and wrote it down because the intake record for that person was in the poor farm ledger from the 1940s or 1950s.

So, they didn't have nursing home intake records, they had the poor farm record, so they just hopped right over and wrote their obituary stuff inside some of them, they're little notations, some of them are really lovely, very nice memorials about, "this was a very kind person, she enjoyed these things, the staff will miss her very much." Still that, interestingly personalized, they really knew...

CHRISTOPHER BRICK: So the institutional side of the records, in some cases your able to divine a little bit of the substance of who the patients were and who the recipients were?

MEGAN BIRK: Yeah, and to, just to kind of finish your question about how the residents felt. They struggled a little bit, some of them, they talked about how this was their home, they didn't want to leave, they were afraid, they weren't sure about the new building, people who were, just as an example, had their vision impaired, they had memorized the poor farm so they could get around really easily because they had been there for so long so they were intimated and sort of didn't know what to expect. And so there was some hesitancy there about moving on to a new type of institution that was less familiar than, and the kind of pseudo-home that they had been in, some of them for an extended period of time.

KARIANN YOKOTA: I wanted to, Megan, give you a chance to talk about a part of the lecture that dealt with quality of care, of medical care, in these poor farms, and I'm wondering if they'll be podcast listeners who, like me, as their listening to your lecture started, was reminded of the stress of choosing one's insurance plan. And I, when

you're talking about it and trying to link budgetary decisions, with the method of paying the doctors, with quality of care, and thinking about HMO vs PPO versions of health care, right? And so I was wondering if you could talk a little bit about that and I thought you did a good job, you're trying to balance giving us examples of doctors that were truly caring and comparing them with doctors who were selling bodies, so extreme examples on both sides of the spectrum, but again I think modern day listeners will, at least I did, think about the different choices we have to make about quality of care and budgetary concerns.

MEGAN BIRK: By and large, as a generalization, I think a lot of the doctors that provided care to poor far residents did a conscientious job, understanding that there may be very little they can do to fix the problem, but they certainly might be able to provide people with some comfort. I also think that they provide a little bit of companionship which is interesting, one of the things that comes up in the 20th century nursing home experiences is the loneliness.

Poor farms can be lonely places, but the doctor is somebody who, by the virtue of coming weekly, monthly to see that person regularly, and so you can tell that sometimes relationships that are building at least in familiarity. I think they, many of them, did the best they could with the time they could be there and the condition the people arrived in, some of which is not fixable, and so by and large, those people were fairly compassionate, but the residents themselves had no choices. Sometimes they can ask for a doctor and one won't be sent for because there's a judgement on the part of management about "do you really need a doctor or

are you just fussy today?" and even the doctors will say, there's a record from Illinois, the doctor says "he always wants to see me and nothing doing," is the sort of very rural expression. There's nothing really wrong with the guy he just feels like he wants that sort of attention. But they have no choice in the matter at all.

KARIANN YOKOTA: Well, I think that's very heartening that you found that. I wanted to get at the idea of in America, at least in the United States, the idea that to get great, so it's good, like I said I'm happy to hear you found that as a general rule that there were compassionate health care providers, I think it's true today as well that really most people are trying their best to help their patients.

However, because of the way the health care system in the United States has been set up, there is the idea that only the rich get the best care. Where as, you know I spent a lot of time in Great Britain and in the UK and I really pressed people there, like "so even rich people use the NHS?" "Yeah." "Even rich people have to wait to get surgery that's not emergency surgery?" "yes, everybody waits in line," so it's a completely, well at least maybe in my opinion, but it's maybe not a completely but it's a stark difference in the way people there versus here are thinking about one's wealth versus getting top notch care. And so beyond just of having a choice, that idea that you have to be rich to get the best here. I'm wondering if, how your study kind of can inform us or help us think through these ideas, or these problems.

MEGAN BIRK: So, at the time that counties were paying doctors on a contract to be the poor farm

doctor or be the doctor that did the direct aid visits for people who couldn't afford one. People in the states with money would just pay the doctor to come see them at their beck and call, they would have a family doctor who they paid and some of the best early hospitals in the United States were private hospitals, they are not public, and the public hospitals are where you definitely don't want to go. They're not nice, they're not clean, they're not considered to be appropriate sites for any sort of health and recovery at all and so private money definitely heavily influenced what kind of healthcare people got.

There is an interesting, it doesn't come up all the time, but there is a little sort of tad-bit of resentment sometimes amongst taxpayers, not rich taxpayers but just sort of your average everyday person. When the poor farm residents get something like a doctor who automatically comes every week to check on everyone or when something happens a doctor will be called, and taxpayers are covering that expense. Every once in a while it'll pick up in a newspaper story, you know it must be nice to be at the poor farm and have the doctor come when you call them because for a lot of regular people, that's an expense they're really not going to do unless they have to.

In rural areas, it often required you to leave, go get the doctor, bring the doctor back with you, its hours' worth of being on a wagon, being on a horse, it takes a long time. At the poor farm, those visits are fairly regular and it's not, they didn't make those complaints just about doctors. When a poor farm installed indoor plumbing and rural residents of the county didn't have it yet, you get people saying like "oh, it must be nice for the poor people to get plumbing because I don't have

that yet." and so there's some back and forth about what is being provided at taxpayer expense versus what a taxpayer is sort of eligible to get with their own money, the county usually are pretty clear about their getting a bulk discount, they're taking care of x number of people at x number of dollars.

There is definitely a have and have not system when it comes to access to doctors, access to good hospitals, clean hospitals, nursing care, things of that nature.

CHRISTOPHER BRICK: How did they handle health-related issues like pregnancy or mental health in these different subgroups of patient and patient care and patient needs?

MEGAN BIRK: Pregnant women are arguably the most kind of contested poor farm resident. There's a lot of concern about poor farms taking in pregnant women, single pregnant women specifically, that that would somehow, like if you're going to take care of them, that will encourage more of them, it will encourage them to get pregnant, it will encourage the behavior because here you are sitting here as this maternity hospital.

You know, the truth is that there are more women giving birth at poor farms in the 1880s and 1890s than there are by the 1910s and 1920s and that's when the real outrage kicks in because of the eugenics movement has sort of latched on to this issue of institutionalized women reproducing institutionalized populations of people. And so they are very upset about pregnancy in poor farms at a time when there aren't really many pregnancies in poor farms anymore.

But it is an outlet, especially away from cities where there is no other outlet available for women who get kicked out of their home, women who don't have a place to go, and in some ways, although cleanliness at poor farms is not something that they were known for, that's also true of a lot of homes, a lot of farm homes. Women in rural areas worked sometimes right up until the moment they gave birth and then sometimes the day after they're back at it. So when we talk about conditions and is it better to go to a poor farm and why would you go there, frankly I can see why having a bed, having people around you, and having maybe like a couple of days to just be able to recover with your child would be a benefit to some women who were looking for a safe space to give birth.

The other thing about poor farms is that they did not necessarily always take custody of babies. Frequently young women, if they wanted to, left with the child. That's not always the case but you see lots of single women leaving with that baby and I don't know where they've gone all of the time, I don't always know what happens to the child but it's a way to retain custody at a time when if you went to a place in the city, if you went to a religious home, they may take that child from you as a sort of part of you being there. It's one of the interesting aspects of kind of specialized care at the poor farm, they do not provide any mental health care services.

They house and contain people who are dealing with mental illness, who are dealing with cognitive disabilities or intellectual disabilities. They would not have labeled them as that. But, they are not treating them, and so, when asylums open and

become more prevalent at the state level, you know state funded asylums, poor farms try to send people there, they want to get them out of the poor farm, get them into state custody, because it's a money issue also, the state is going to pay for the state care, but the county has to pay for the county care.

But those state asylums fill so quickly with people who are considered incurable that states actually start paying county poor farms to take them back. It's how you end up with county asylums in some places, the state has literally paid them by person to take care of them instead, so there's this shuffling of people that happens and some of this shuffling is women of childbearing age who are considered to be disabled or mentally ill, the state wants them because they're going to contain them, they're going to control their sexuality, they're going to insure, they think, that they won't reproduce. Obviously later that becomes sort of forced state sanctioned sterilizations.

And then when those women get older if they're still in institutional custody, they ship them back to the poor farm because then, if nobody at the poor farm is babysitting them all day, it doesn't matter. So, there is an intertwined relationship between different levels of institutionalization, different labels for conditions at the time, but poor farms were multiplicitous institutions. They house all kinds of different people all together which is one of the reasons people disliked them. They thought that specialized care for each sort of category of people was the more appropriate option and poor farms are the opposite of that. They're combing the old and the sick and the young and the pregnant and the temporarily homeless, everybody is

all together in the same space and that's considered a, not a best practice for the late 19th century especially.

CHRISTOPHER BRICK: Is this what you're working on now? I mean, you are so, you really know this material and this content inside and out, so what are you doing with it at the moment?

MEGAN BIRK: Yeah so, the book will be out at the end of this year with the University of Illinois press, so it's done, its ready, it's almost ready for everyone to see.

CHRISTOPHER BRICK: Congratulations! Yay!

MEGAN BIRK: Thank you, and actually, my relationship with poor farms is long lived, because my first book is about dependent children and their kind of institution to farm care network and some of that starts at poor farms.

Poor farms are not good places for children, they don't want dependent children living in them, so they figure out ways to get them out, so that relationship is not exclusive to poor farms, poor farms pop up in *Fostering on the Farm* but I became very familiar with how to records looked when I was working on that project and so I immediately knew "I'll be back for you, I'm going to cycle back around" because there's so much more there than just kids, it's the huge sort of population spread. And I have a feeling, maybe not this next go around, but I'll revisit some of this again because I'm curious, there are people who aren't at the poor farm who also were considered public dependents and so I am curious to kind of dig into that a little bit more when I have the chance.

CHRISTOPHER BRICK: Alright, well Madam Chair, I think this maybe the first Q+A we've done that went past an hour and it could be....

MEGAN BIRK: No, I'm sorry.

CHRISTOPHER BRICK: No, it's because we have so many questions because you're so interesting to talk to and you've left us with so much to keep thinking about and it sounds like to research because it sounds like there's a lot of content there to mine, to explore, to publish about, you're doing that.

MEGAN BIRK: There's so much more work, so much more room.

CHRISTOPHER BRICK: Awesome, thank you.

MEGAN BIRK: Thank you very much.

KARIANN YOKOTA: Thank you.

CHRISTOPHER BRICK: Megan Birk, everyone!

Conclusion

CHRISTOPHER BRICK: And that's a wrap. Please join us again next week for this season's very last smallpox lecture, by Dr. Kelly Hacker Jones entitled, "An Eruptive Fever Comes to Muncie." We'll catch you then.