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HEALTH NEEDS OF AGRICULTURAL MIGRANTS - II [1]

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There are probably few subjects on which so much has been written as that of agricultural migrants. The fact that much still needs to be done is no reflection on past efforts but is rather an indication of the complexity of the problem. I should like to approach the broad field of the health needs of agricultural migrants by discussing some of the obstacles to adequate health services and by depicting what is being done and what remains to be done in meeting these needs.

It is reported that as early as 1906 the problems of the agricultural migrants were under study by the National Consumer's League. In 1909 a report of Theodore Roosevelt's Country Life Commission included a recommendation regarding housing of farm workers. In 1925, in an article entitled "Sick Wanderers" appearing in Survey, Miss Jessamine Whitney reported on the migrant problem in six southwestern cities, with special reference to tuberculosis. Finding excessively high rates of the disease, she commented: "None of these cities has anything like adequate provision -- medical, relief or institution -- for caring for tuberculous persons whether resident or non-resident." She further stated: "Probably the saddest and most tragic part of the story was the impossibility of finding out what happened ultimately to these tuberculous migrants." These statements are probably as true today as they were in 1925.

My special interest has been the tuberculous patient who is without legal residence. This is an area which is closely related to the health needs of agricultural migrants but tuberculosis is only part of the problem --just as agricultural migrants are only a part of the total non-resident problem. Included in the non-resident category are those who, because they recently moved from one place to another, lost their claim to services in the community where they happen to be. About 5½ million people in the United States moved between States during the census year 1952-1953 and the majority undoubtedly are without residence status, according to the requirements for legal settlement in many States. As non-residents they are often ineligible for whatever benefits may be available to other residents; for example, care in a tuberculosis or mental hospital, and general medical and hospital care, if they are unable to afford private treatment.

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Agricultural migrant workers often face even greater difficulties than some of the other nonresidents, because many never settle long enough in one place to establish any legal residence while they continue in agricultural employment. And as a result of their mobility, they may not be eligible for public care anywhere, even though their typically low annual income would qualify them for various types of health and welfare services if they were permanent residents.

Obviously, then, one of the major obstacles to health services for migrants is the present legal residence restrictions on eligibility for medical care. Residence legislation dates back to the Elizabethan Poor Law of 1602, being based on the philosophy that each local community should take care only of persons for whom they had legal responsibility. The British have long since abandoned these restrictions on services.

Unfortunately, this long out-dated attitude seems to continue to be deeply ingrained in our society. Freedom of movement in response to economic pull has long been acknowledged as a fundamental right and as an important factor in the rapid development of this country. Yet in some States, every effort is made to discourage people from coming in from the outside--unless they have money in their pockets. The need for the services of these "outsiders" may be recognized, but at the same time their presence in a community is likely to be resented by other segments of the population. Should the newcomers seem likely to be in need of any kind of community assistance, they may be quickly informed that they are not wanted.

One of the reasons given for this attitude is a "practical" one--it costs money to provide services. Some people do not see the unsoundness of penny-wisdom. This is particularly true in relation to communicable diseases. Obviously, the uncared-for patient with a communicable disease is a public health menace. Should he remain untreated, he may spread his disease to others and may die prematurely himself. Untimely deaths, from whatever cause, are more than a statistical figure: they are a loss of human resources. Any premature death that can be prevented is an indication of failure to utilize fully the knowledge, skills and resources, which are available to prevent the development of many diseases and many early deaths.

Several States have recognized their responsibilities for caring for people's needs regardless of legal technicalities and have abolished residence restrictions. New Jersey is one of the States which provide health services to migrants. The State enacted its Migrant Labor Act in 1945 providing for health programs for agricultural workers, as follows:

> "The Division through the Department of Health shall make surveys to determine the adequacy of preventive and curative health services available to occupants of migrant labor camps, and where such services are found inadequate, to determine desirable ways and means to make them available. The Commission shall arrange, to the extent of the available appropriations, through the Department of Health for the provision of such supplementary services. Said services may be provided through the use of one or more traveling dispensaries, by a contract with physicians, dentists, hospitals or clinics, or in such other manner as may be recommended by the Department of Health."

Michigan has also made considerable progress and is outstanding by reason of its passage, in 1945, of a law which provides free hospitalization for tuberculous persons without regard to legal residence. Voluntary organizations in Michigan are also active in stimulating and developing health services. The National Council of Churches has, as always, assumed a role of leadership there. The Catholic Church has established a maternity clinic. Another group has set up a Children's Fund for the specific purpose of purchasing medical services for children in migrant families who are unable to pay for their own care. One of the most interesting projects of this kind was the brainchild of a private physician in a community which provided employment for many agricultural workers who come to Michigan. The following excerpt from a feature story in "Grand Rapids Herald" (July 12, 1953) not only describes his particular proposals but also summarizes effectively the health problems which agricultural workers face:

"The future health, social status and educational standards of more than 200,000 Southern migratory workers who each year visit Michigan to labor in its fields and orchards may be materially affected by the the continued activity of a Traverse City physician who has devoted years of his life to the improvement of their working and living conditions.

"He is Dr. E. F. Sladek who, besides carrying the burden of an uncommonly heavy private practice, has been one of the busiest members of the Governor's Commission on Migratory Labor.

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"Because Traverse City is in the heart of the cherry-picking region, he was often confronted during his tours of duty at the Traverse City Hospital with the fact of an ever-increasing number of active tuberculosis cases among Southern cherry-pickers working in the orchards.

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"This particular group, over which there was no control, seems to be growing instead of diminishing in number, and the condition applies not only to those with incipient or advanced cases of TB, but also to those with several other diseases, including those stemming from malnutrition.

"The way of life of the migrant family is such that, by heritage and custom, they have become accustomed to a diet lacking both in quantity and in essential food elements...Contributing factors are the economic status and their unfamiliarity with the use of vegetables and other nutritious foods.

"In illness, their utter lack of previous experience with doctors, dentists and hospitals contributes greatly to a possibly dangerous delay in seeking medical care.

"Many of these people are not familiar with, or concerned about, modern housing, or in the basic concept of good sanitation facilities.

"Recent suggestions (Dr. Sladek) has advanced to the Commission include:

"Legislation to amend the Workmen's Compensation Act to provide coverage for all farm employes, for injuries on the job.

"Legislation to provide a State sanitary code that requires every farm labor camp with 10 or more persons to have a State Health Department permit....

"A legislative appropriation to the State Department of Health for additional personnel and equipment for tuberculosis screening units; for mass examinations on a voluntary basis within the migrant working areas.

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"Further suggestions....include a proposal to provide legislation for adequate temporary relief for needy migrant farm workers....

"Dr. Sladek has also projected the possibility of encouraging the purchase of prepayment medical and hospital care on an employer-employee participation basis.....

"Dr. Sladek further has proposed the establishment of rural and community health councils in those areas employing migrants, particularly from an educational standpoint.

" 'These councils,' he explains, 'could actively stimulate better housing for migrants; classes in nutrition and simple health measures; classes in English for migrants on a progressive basis, area-to-area, as the workers move from crop to crop; participation in community church services; setting up of recreational areas and playgrounds in the crop areas and on the fringes of towns; organization of seasonal day-nursery schools; publication and distribution of pamphlets in Spanish and English covering such subjects as health practices, care of property, local laws, etc.'

"The Traverse City physician has made other suggestions including more specific recommendations for a 'Michigan Migrant Workers Health and Social Fund' as a non-profit organization and has projected a method of financing such an effort."

Legal residence, as an obstacle to health services for migrants, has many ramifications. There are other States and communities, besides New Jersey and Michigan, where various methods are being used to overcome this obstacle. There is probably no one approach that would solve the problem for all communities.

A second major obstacle in extending health services to migrants is the inadequacy of health services in general, which is especially aggravated by shortages among health personnel. A further factor is the uneven geographical distribution of these services in different parts of the country.

Isolated areas particularly are at a disadvantage compared with more densely settled regions. In 1949, isolated rural and semirural counties had nearly twice as many persons for every physician as metropolitan and adjacent counties. The number of physicians and dentists in proportion to population in a county tends to decline with increasing rurality. Well-staffed full-time local health units, likewise, are less likely to be found serving isolated counties than metropolitan counties. In addition, insurance plans to ease the cost burden of medical and hospital care are less well adapted to the rural situation and are used less extensively in rural areas. Group arrangements for insurance coverage of farm workers are extremely rare. Contract agricultural workers brought in from outside the continental boundaries of the United States are more likely to have such group coverage than domestic workers.

Recognition of some of the inadequacies in health service is reflected in legislative measures currently before Congress. One bill provides for extension of the current program for building hospitals, by including provisions for building diagnostic, treatment and rehabilitation centers, and other types of health

facilities. The proposed extension would continue the present requirement that priority of projects be determined on the basis of "relative need of different sections of the population and of different areas lacking adequate hospital facilities, giving special consideration to hospitals serving rural communities....." Another bill provides encouragement to voluntary health insurance plans to broaden their benefits and to include additional segments of the population. The bill also provides for setting up a scheme of re-insurance of voluntary plans to the extent that this may prove necessary.

What effect these proposals may have on agricultural migrants is, of course, not yet known. One can be fairly certain, however, that whatever changes may be made, they will not fare any better than their neighbors who live in the area all the year around--nor perhaps should they. Special services for migrants might only serve to separate them further from the communities in which they live temporarily. Nevertheless, adaptations of existing community services to meet their special needs is essential, in many cases, if migrants are to receive the same services as the rest of the population. Such adaptations include providing health services near enough to where the migrants live, and scheduling the services with regard to their off-duty hours. Another adaptation that is needed is to acquaint the migrants with the services which are available to them. Temporary expansion of services to meet the needs of an expanded population may also be required. In some cases, health education methods and materials may need adaptation in order to fit them to the special needs of the migrant group. Provision for continuity of service is also needed, for the migrant families which move from county to county and State to State.

Changes in the laws, which would remove residence restrictions are likely to come slowly in some States, and are probably far in the future. Meanwhile, the migrant families need services now. When local public agencies do not acknowledge legal responsibility, other ways of providing services must be found to prevent or reduce the extent of disabling illnesses.

A citizen in one community commented that maximum local ingenuity and initiative are required to overcome the difficulties inherent in trying to provide needed services to migrants. A few State and local communities have already demonstrated what can be done when individuals and communities apply the ingenuity and initiative they possess. Nearly everywhere they say they have made only a start and that much remains to be done. Nevertheless, the progress some communities are making is well worth recognition.

In 1950, Fresno County, California, found itself confronted with all the typical problems to be dealt with in serving migrant families. The migrants lived and worked on one side of the county. The county hospital was at least an hour's drive away from the migrant labor camps and the other health services were concentrated also at a considerable distance. Local individuals and agencies decided to do something about these problems. A rural health and education committee was formed, with wide representation from the county. With the help of funds from a foundation, medical care clinics were opened at night in some of the camps. These and a number of prenatal clinics were staffed by the county medical society. Child health, child-care centers, nutrition, education, and safety training were among the other services provided. Overcoming the suspicion of the migrants was one of the initial problems confronting the people who were trying to help.

The rapidity with which migrants move in many areas and the problem of providing some continuity of service is one that still confronts Fresno County and many other communities where local efforts are being made to extend health and other services to migrants. Even if all other factors were ideal--if there were enough facilities, if the migrants were interested in using these resources, and if the community were anxious to make services available--this problem of providing continuity of services to the rapidly moving migrants would still remain.

Various devices have been worked out for keeping track of people with health problems, even though these people are on the move. Some States provide health cards to workers and notify health departments in the State to which the worker goes. A health officer told me that his staff of public health nurses had to be augmented because of the extra work involved in tracing workers who needed health services. Another employed a Spanish-speaking nurse to work with the Latin-American migrants, interpreting to them the need for following through on recommendations. Numerous communities have conducted X-ray survey programs for agricultural workers. During World War II, the Agricultural Workers Health Associations offered health services to farm migrants along each of the main migratory streams and solved some of the continuity problems at that time.

These are some of the facts. This is by no means a complete inventory. There are also many related problems such as housing, nutrition, working conditions, child care, the workers' educational and economic limitations, and resentment which they experience and which they, in turn, feel toward others. We know that these factors, among many others, can contribute to the incidence of disease. We also know that the preventive approach to health problems involves removal of conditions which predispose to the onset of disease or which contribute, once it has taken hold, to further deterioration, long-time or permanent disability or premature death.

We know also that illness is attended by many fears and social adjustments and we have no reason to believe that agricultural migrants are any different in this respect, or are any better able to handle their own social problems, than other people are. There are some indications that they may be somewhat less willing to seek medical care and follow recommendations; the premium is placed on not being ill because sickness interrupts employment and decreases earnings. Apparently there is an assumption, by both the employer and employee, that if a health condition is ignored, it will just go away. All of us know that this rarely happens. In providing health services, we must recognize the need for social as well as medical resources if we hope to do more than barely meet the severest emergencies.

Solutions are not simple, but enough studies have been made and sufficient experiences have been obtained to provide data needed for constructive action. Study committees have generally recognized that the ultimate responsibility rests with official agencies. Voluntary associations and interested individuals, however, are a potent source of stimulation and support for the work of public agencies and have demonstrated their effectiveness over and over again. The projects they have initiated and participated in are legion. The Home Missions Division of the National Council of Churches has been active in many major programs. The Red Cross in several States has worked with the Division and the health departments in providing health education, clinics, and information about

first aid and accident prevention. The Michigan Field Crops Association, an organization that serves growers by recruiting workers, recognizes the economic advantages of providing good housing and encouraging good health practices in general and it has been instrumental in the development of a health insurance program on an experimental basis.

The number and variety of other groups working with migrants in different localities is impressive--the American Association of University Women, Girl Scouts and Boy Scouts, 4-H Clubs, tuberculosis associations, League of Women Voters, Mayors' and Governors' Commissions, medical societies, Lions and Rotary Clubs, nurses, social workers, other professional individuals and groups, and just "plain people."

The value of these experiments and experiences is far-reaching. Complex though our own problems are, other areas have even greater difficulties. Quite recently, I mentioned some of our experiences with agricultural migrants in talking with a teacher from India. She hoped to go back to work with the people in her very rural part of the country--where there are no facilities of any kind; where most of the people are extremely poor and illiterate, and where they lack sufficient contact with the outside world even to know how much better off they could be. There are, of course, many differences between the people of India and our own migrant population. There are also doubtless some similarities. I am sure you feel as I do that, if this one person has the courage to tackle the colossal problem existing in her homeland with so little support, we, with our vast resources, have little excuse for failing to meet the needs of a segment of our population that has too long failed to share in the advantages open to other citizens. I firmly believe that voluntary and official agencies together can and will arrive at some solutions to the health problems of our migrant agricultural workers.