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The Health of the Migrant Worker

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A MIGRANT WORKER is a person engaged in agricultural pursuits whose work necessitates his traveling for a portion of the year beyond normal commuting distance from his home. Thus he must set up temporary residence in other places for at least brief periods. Frequently other members of his family travel with him for all or part of each crop season. They may travel within a single state or move into or across several different states.

Included in the group for which the migrant health program of the Public Health Service has concern are both intra- and interstate domestic migratory farm workers and their families; excluded are foreign nationals imported under contract for temporary work in agriculture, and permanent community residents such as farm owners, farm family members, and year-round farm employees.

The program for the importation of foreign workers under Public Law 78 was formally brought to a close in December 1964. As a result, during the 1965 crop season, foreign migratory workers were being replaced by domestic farm workers drawn chiefly from Texas and the states of the Southeast and the Southwest.

Work Force

Many domestic migrant workers are "hired" through an "employment agency" system operated by the Department of Labor in which the growers register their needs. The Department of Labor then tries to match the requests with available manpower, as determined by negotiations at home-base areas from which migrants normally come. In addition, however, sizeable numbers of domestic migrant workers are so-called "free wheelers" who simply take a chance on finding work on the basis of knowing a particular employer or having worked in a particular area in previous years. The migrant farm work force that registers with the Department of Labor has been estimated variously at from less than 50 to about 90% of the total force in different parts of the country. Exact work force figures are difficult to obtain because of the difficulty in getting accurate counts of "free-wheelers" or "walk-ins."

The number of persons actually moving in the stream of farm migration probably approximates ¾ million or more each year. They are drawn from a labor pool in home-base counties and states which probably numbers 2 or 3 million persons.

Agricultural migrant laborers find employment at the peak of the crop season in about 48 of the 50 states. Nearly 1000 of our 3000 counties use 100 or more at the peak of a normal crop season. Michigan, Texas, California, New York, and Florida are among the states which head the list of those dependent on an outside supply of labor.

However, the peak number of workers in a state or community is somewhat deceiving when one tries to equate this with the problems to a community in providing needed health services for the workers. A large community that is amply supplied with health resources and that has prepared to handle a large number of migrants may indeed be able to accommodate an influx of 10,000 workers and families. Contrasted to this, as small a number as 300 migrants may pose a tremendous burden to a small community if its health resources are inadequate even for its permanent residents, and if no planning has been done in anticipation of the migrant influx.

Some domestic farm workers who leave home for part of the year to harvest crops are able to find nonagricultural jobs when farm work is not available. Even when earnings from other occupations are included, however, the total earn-

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ings of domestic agricultural workers average approximately $1,000 per year per worker, according to estimates made by the U. S. Department of Agriculture. The pay rate is usually established at the "going rate" for harvesting or other crop work to be done in the particular local work area. It is usually set by local employers before the season starts.

In some instances, migrants prefer to specialize in certain crops, not so much because they disdain working in others, but simply because they gain experience and consequent superior skill in picking beans or tomatoes, for example, and in view of the typical piece-rate basis of payment, earn more money working at this crop.

Women and children who migrate do remunerative farm work to some extent. Because of the family's needs in order to survive, there is a real temptation to allow children to work in the fields instead of seeking out schools for them when the family arrives at a work location. The average annual income *per family*, including the earnings of the women and children, has been estimated at under $3,000.

As is recognized, a sizeable portion of the American public moves intermittently for work in other kinds of industry such as building and highway construction. However, most of these workers are covered by minimum wage laws, have unemployment compensation to tide them over periods when no work is available, and have fringe benefits, including in many cases some type of health insurance protection. Agricultural workers in general lack these benefits. Those who migrate annually also lose local residence status and, therefore, fail to qualify for the local services available to others in their income group.

We have no way to compare the migrant agricultural worker's educational level directly with that of factory workers. We do, however, have some information regarding the agricultural worker's general level of education. Usually his children are taken from school to make their trek northward before the school term has ended in the home-base area; they return to the home-base in the fall after school starts. Thus, they typically fall behind their peers in educational accomplishments. The average educational achievement of migrant adults is about the fifth grade.

Health Service Barriers

Language difficulties are common. The largest number of migrant workers are Spanish-speaking. Many are unable to speak English and therefore have great difficulty in communicating with health workers, especially when they are in northern work areas in which few people speak Spanish. In addition, approximately 20,000 Navahos and members of other Indian tribes enter the migrant work force during part of each year. These people frequently are also unable to communicate in English so that difficulties arise in obtaining services of any kind.

In addition to linguistic problems, other cultural barriers interfere with the provision and use of health services, not only among the Spanish-speaking Texan and the Indian but also among the southern Negroes, Puerto Ricans, and low-income Anglo-Americans. All of these groups may differ in some respects in health understanding and practices from the middle-class "Anglo" culture represented by the community in which they may find themselves for part of the crop season. This may lead to a failure on the part of the predominantly Anglo-American health workers and communities to understand the health concepts of the migrant worker. On the other hand the migrant may frequently misunderstand modern scientific medical concepts. As a result, much of the effort to improve the health of migrants needs to be funneled along educational channels focused on the workers and on their temporary communities.

To help overcome workers' language and educational deficiencies in making work arrangements, the system of crews and crew-leaders is in fairly common use on the East Coast but less so in other parts of the country. Under this organizational pattern, one crew member—usually one who is fluent in English and has more education than the average worker—makes work appointments with growers in northern work areas (often through the Department of Labor's federal-state recruitment system), agreeing to supply a given number of workers at a given time and for a given period. This crew-leader then recruits the workers, usually in his home territory, and often provides them transportation to the job, withholding a certain amount from each worker's pay to reimburse him for transportation or other costs. In some cases the reimbursement for various services rendered by the crew-leader may amount to a few cents for each unit of the crop picked, such as a bushel of potatoes or hamper of beans.

There is often a fairly rapid turnover in crew membership, especially among persons not related to the leader. The original crew may start

out from Florida, work in North Carolina, perhaps drop off a few members and add a few in North Carolina, and go on to work in Delaware or New York, again with some change in the composition of the crew at each stop.

In addition to the change in the composition of the crew during migration in a particular crop year, there is also a change in the composition of the migratory force itself from year to year. As some people settle and find other types of work, new people join the migrant stream because of their inability to find work in their home-base areas or because their own small farm no longer is able to compete in the agricultural market. Lacking skills or knowledge of other work, they tend to seek employment in agriculture.

This seasonal and annual turnover in population poses obvious problems in trying to measure accomplishments in a health program. It is like trying to measure the achievements of health services set up to serve the members of a parade. Parade members in one city block might be fully immunized at one point in time but a few minutes or hours later, an attempt to evaluate the immunization effort in the same block might reveal a very low level of immunization.

When the workers are on location they are usually housed in buildings provided either by the grower on his farm, by a farmer cooperative which provides housing for workers that may serve as a reservoir for several farm employers, or by a company which contracts for a crop. In addition, in some cases a local housing authority may make housing available. The charges for the housing vary from no charge—typical in cases where the housing is provided by the grower for his own workers but no others—to fairly standard rental charges. Usually, public-housing authorities charge rent.

Of concern to many citizens, and of special concern to the migrant health program, is the fact that in many areas the housing provided lacks an adequate supply of water suitable for drinking and other household purposes. It is also frequently lacking in proper sanitation facilities. Even if the facilities are adequate and approved for a given number of people, the number actually occupying the housing during the crop season may far exceed the number for which the housing has been certified. Overcrowding increases the health needs of workers and families who may already have greater needs for health maintenance and health care than local community residents.

Most migrant families make their own provisions for buying, preparing, cooking, and storing the food that the family consumes. Cooking and food storage equipment is often provided by the family—frequently on a makeshift basis. In some cases, where male workers are not accompanied by their families, growers may provide a facility where workers may purchase or cook their meals. Food is sometimes taken to the fields, particularly the luncheon meal, either by each worker or family, or by a vendor who sells sandwiches and soft drinks. In many cases, no provision is made for proper food storage in the fields.

The domestic migrant is in most cases an American citizen or eligible for citizenship. Accordingly, he is free to come and go as he pleases. Many health departments offer screening for venereal disease and tuberculosis for local migrant workers as a protection against spread of these diseases to the local community, but there are no requirements for either health examination or certification of freedom from disease in order to work in agriculture.

Experience indicates that migrants generally have no greater incidence of venereal disease and tuberculosis than other similar low-income nonmigratory residents. The migrant family does suffer, however, from diseases such as diarrhea, respiratory infections (including pneumonia), skin diseases, frequent pregnancies and complications of pregnancies, muscular aches and pains, and accidents and trauma. In past years, most communities have been able to provide little if any treatment for these conditions.

Most migrants, in leaving their homes to harvest crops, lose their residency status so far as their eligibility for county hospital and local welfare services is concerned. Even when a community is willing to provide them with health care, frequently additional assistance and supplementation of the existing health resources are needed in order to provide for a migrant influx that may in some cases double the population of the community during the height of the harvest season.

Migrant Health Act

The Migrant Health Act of 1962 was designed to help communities make adjustments in community health services in order to meet the health needs of migrant farmworkers and their families. Thus a setting would be provided in which migrants could be encouraged to take in-

creasing responsibility for meeting their own health needs.

The 1962 Act enabled the Public Health Service to make grants to public or voluntary nonprofit groups to pay part of the cost of family health service clinics in providing general medical care on an outpatient basis to workers and other migrant family members. It also enabled payment of part of the cost of other types of project services to improve migrants' health conditions or services and further authorized expanded effort by the Public Health Service to develop and supplement state and local project effort.

Up to July 1965, 63 migrant health projects had received grant assistance. These projects provided services in one or more counties of 32 states and Puerto Rico. Most of the projects provide family clinic, public health nursing, health education, and sanitation services. Some add dental, nutrition, social work, and other related health services.

About 15% of the projects are under voluntary group sponsorship. Most are sponsored by state or local public health agencies. Regardless of sponsorship, each of the projects involves many community groups which have a contribution to make to the improvement of migrant health conditions and services. Such groups include local physicians, growers, agricultural extension groups, church organizations, welfare agencies, educational institutions, and many others. On the average, about 40% of total project costs are met from other than grant sources. These other contributions are often in kind rather than in cash. They may be in donated facilities, equipment, supplies, transportation, services which in some cases include medical and nursing care, or other items needed for project operation.

The law enacted in 1962 was for a 3-year period. An act providing a 3-year extension was recently passed by Congress and was signed by the President on Aug. 5, 1965. The extension expands the scope of the grant-assisted services to include in-hospital care in short-term general hospitals. The experience of project-sponsored clinics indicates that such an expansion is needed and will be welcomed by many project directors. Much frustration has arisen from the fact that project staff members could take patients only as far as the hospital door and at that point had to "pass the hat" in order to get the bills paid so that patients could be admitted.

There are also geographic areas where need exists but no projects have yet been developed. This lack and the continuing need for grant assistance in some of the areas now receiving migrant health grants indicate that program extension and expansion are necessary if the illnesses and injuries of migrants are to be treated adequately whenever and wherever they occur and prevented to the fullest extent possible.

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