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More than one million persons move each year in response to seasonal farm labor demand. The movers include men, women and children of all ages and from many backgrounds. They live and work in the south during the winter crop season and in the north during the summer. Farm employers in nearly one-third of the Nation's counties use at least a few migrant workers at the peak of each crop season.

The people move along fairly well-defined routes, and at fairly predictable times. But vagaries of weather, prices, and other conditions affecting the production and harvesting of crops create variations in the general patterns.

Heterogeneous as migrants are, most share common characteristics--

minority group background;
subsistence-level income (averaging annually about $1,000 per worker);
lack of education (averaging about fifth-grade level for adults); and
lack of special skills except in farm work.

They also share common problems. The only housing some families know is the series of temporary, makeshift, usually 1- or 2-room shelters they find in seasonal farm labor camps. Sometimes the safety of the water supply is questionable. Often the only means of human waste disposal is an unsanitary privy. Garbage and trash are likely to be strewn around the camp premises or on nearby dumps. Little or no provision is made for food preparation and storage.

Whether the environment is rural or urban, a slum setting populated by low-income, undereducated people is a fertile breeding ground for disease and accidental injury. Thus, the migrant farm laborer's family shares the health needs encountered among permanent residents living under similar deprived circumstances.

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An added handicap for the migrant is his frequent movement. This movement usually deprives him of residence status in any of his temporary work areas. Accordingly, he is ineligible for the medical and hospital care provisions made for other indigent persons.

His movement also hampers the establishment of communication between him and individuals or agencies which could potentially help him know where to turn in an emergency. Instead the migrant constantly encounters new communities with different types of emergency services, and different conditions for obtaining service. What he has learns in one community may be wholly inapplicable in another where an emergency occurs. So on the counts of information and contact, as well as on residence status, he is outside the range of most community effort which is directed toward helping people in need.

What does this situation mean to the migrant? To the community? To the community hospital? And where does the responsibility lie for planning, providing and financing services to protect and maintain the health of temporary as opposed to permanent community residents? Such questions have been tossed around for 20 years or longer.

Meaning to the Migrant

To the migrant, the situation typically means risk of disease and disability from avoidable causes, lack of care in many instances until an emergency develops, lack of follow-up for conditions requiring repeated medical attention, and failure to receive immunizations and other preventive services made available through organized community programs. Usually such programs fail to take migrants into account at the time planning is done.

Health conditions reported among migrant children are a

health care. They include serious upper respiratory infections, ear infections, impetigo, diarrheal disease, whooping cough, parasitic infestations, accidental injuries, and nutritional deficiencies. Among adults, upper respiratory infections, and accidents--including some resulting from acts of violence--, tooth decay, "back troubles," "stomach upsets," are frequently reported. In many cases diagnoses are nonspecific because time is lacking for more than a cursory examination and syptomatic treatment. In some requiring continued treatment over a period of time, failure to obtain needed follow-up care has led to such undesirable effects as permanent crippling.

The limited data available for migrants indicate low utilization of medical and dental services. For example, one of the seasonal farm labor health projects which received financial assistance from the Public Health Service during 1963 queried migrants who offered themselves for examination regarding their previous visits to a physician. More than one-third stated that they had never before visited a physician. Data are lacking by which this experience might be directly compared with that of other rural people. However, the National Health Survey found, for the period 1957-59, that the total rural population averaged 3.8 visits to a physician per person per year.

Another seasonal farm labor health project examined 596 persons 14 or more years old for dental defects during the 1963 season. Only 18 persons were without any defects whatever. Forty-two had no teeth and no dentures. The majority had never seen a dentist and seemed little concerned about dental needs.

In still another project area, four out of five among 313 migrant women of childbearing age reported having had one or more fetal deaths. About two-fifths of the women reporting fetal deaths had received no prenatal care, and about two-thirds had delivered at "home". "Home" in many of these cases was in

Studies of migrants' use of hospital care indicate that the cases that reach a hospital are usually emergencies. Among 63 deaths studied in a southern migrant-labor area during a 3-month period early in 1962, 25 persons were dead upon arrival at the hospital. The causes of death included heart-attacks, gun-shot wounds, poisoning, drowning, intoxication and violence, influenze, burns, prematurity, and pneumonia.

Another study of hospitalized migrant cases covered the crop seasons of a 3-year period in a northern area of heavy migrant impact. All of the 309 hospital admissions involving migrants were emergency cases. One-third resulted from assault, work accidents, auto accidents, and other types of accidents. One-fourth were divided about equally between childbirth and cases of diarrhea and dehydration, and poisoning. Of the 17 deaths recorded, one-fourth were from diarrhea and dehydration, and poisoning; another one-fourth were from accidents.

All the evidence suggests that hospitals admit migrants principally for emergency services. Few of the reported admissions are for elective medical or surgical procedures. Data from special studies of hospital experience support the findings of migrant health grant-assisted projects which provide outpatient services but as a rule have no special arrangements for hospital care. Hospital admissions reported by these projects are relatively few and are for such acute conditions as appendicitis, heart conditions, accidents resulting from violence or from motor vehicles, diarrhea and dehydration, pneumonia, complicated pregnancies, and similar conditions. Although some projects make a systematic effort to get women into the hospital for childbirth, others recognize the difficulty of obtaining hospital care for indigents who are not residents. They adapt to the situation by trying to help the mother prepare for safe delivery by a midwife at home, with follow-up care provided by public health nurses.

Meaning to the community

To the community, the situation presents a dilemma. On the one hand, the agricultural industry in the area may be heavily dependent on the availability of migrant labor. On the other hand, the temporary presence of workers and families usually presents a complex set of inter-related problems. Many communities have tended to sweep these problems "under the rug". Nevertheless, the problems persist.

Community attitudes toward migrants vary. Some show active concern for the people and their problems. Both public and voluntary agencies become heavily involved each crop season in projects to provide day care for the children of working parents, operate make-up summer schools to help migrant children reach the grade level for their age, set up thrift shops to sell used

clothing at a nominal price to needy migrant families, and help to obtain food to tide families over a period when work is poor or unavailable. They also set up various types of arrangements to provide medical care and preventive health services.

Even at best, however, the mobility of migrant workers and families makes their integration into the fabric of community life and services extremely difficult. And many communities have little desire to make the effort since local attitudes range from indifference to hostility.

Meaning to the community hospital

Finally, what does the situation mean to the community hospital? In the small rural hospital, the seasonal influx of migrants increases the demand for hospital care, especially for emergencies. The unpublished study in a northern work area already referred to showed that the hours between 7 o'clock in the evening and 1 o'clock in the morning had the heaviest load during each of three successive crop seasons.

The usual sources of information about patients are typically lacking for the migrant. He has no personal physician in the area and therefore no medical records are available. His lack of education, sometimes complicated by the fact that he habitually speaks Spanish and is limited in his ability to speak English, makes it difficult for hospital staff to obtain needed information from him.

His own funds are typically inadequate to pay a hospital bill. Hospital administrators may observe that migrants are getting "good pay" in the local area, or that they drive "good cars". The temporary employment and pay locally, however, must be averaged with periods of enforced unemployment when no work is available at other times and places. Calculated thus the annual income of migrant workers typically is at an indigent level.

The "good cars" some migrants drive may have been purchased with a small down payment during a period of temporary "affluence", and may be reclaimed if payments are not maintained. In some cases, on the other hand, the car may be actually owned by the migrant. When the alternative to driving his own automobile is jolting for many miles in an uncomfortable, reconditioned school bus owned by his crewleader, the migrant worker's purchase of a comfortable car with his first earnings may be fairly understandable, whether or not it can be considered wise.

Only in rare situations does a migrant have health insurance coverage to help meet hospital bills. If he has such coverage it is likely to be limited in scope and amount of benefits. The possibilities of extending group coverage to migrants are practically nil since most migrant "crews" have a rapid turnover in membership, and few function as crews throughout a year. Other administrative problems which interfere with possible efforts of voluntary health insurance carriers in extending coverage to migrants on either a group or an individual basis are related to their low and intermittent income, piece-rate basis of income payment which makes payroll deduction for premium collection purposes fairly impractical, and frequent movement from one employer and locality to another.

The migrant may have no real relationship to a local employer, if he happens to be employed at the time of hospital admission. The hospital may look to the crewleader, if the man belongs to a crew which has come from outside the local area. The worker's relationship with the crewleader may also be fairly tenuous and only recently established. Furthermore, the crewleader may have no feeling of responsibility for any bills a crew member may incur for hospital care. And the usual welfare sources for payment of hospital bills of indigent patients claim no responsibility for non-residents of the area.

In summary, the hospital is customarily left "holding the bag". The community shares reluctantly, but unavoidably, in meeting the cost of hospital bills left unpaid at the end of each crop season, usually by increasing the cost of care for local residents who are admitted to the hospital. And the care migrants receive is usually of an emergency type, not the kind that workers and families need to maintain good health.

The Migrant Health Act (PL 87-692)

The "no man's land" in which seasonal farm workers and families live as they move from crop to crop was recognized in legislation enacted by Congress in September 1962. The law enables the national government through the Public Health Service to share with State or local public or voluntary nonprofit groups in financing the cost of projects to improve migrants' health services or conditions.

Fifty-five projects assisted by migrant health project grants operated in 28 States during the 1964 crop season. The majority are sponsored by public agencies, but a wide range of public and voluntary groups are involved in nearly all, regardless of their sponsorship and immediate direction. The projects are planned and conducted by the community. Consultation and technical advice are available from the Public Health Service as well as financial aid.

The projects are focussed on meeting migrants' problems of obtaining health care in case of sickness or injury. These problems are real and understandable to the migrants served. Prevention of disease and promotion of health are added to this problem-solving approach.

Service schedules and arrangements are adjusted to the population group to be served. Thus, if labor camps are many miles from the nearest physicians' offices or hospital outpatient departments, family clinics are set up temporarily

in large labor camps or at other points that can be conveniently reached by the seasonal farm worker's family. The clinics are held at night or other times when people have time off from work. Unlike conventional public health clinics, they typically offer the kind of service to treat illness or injury that is provided by the general practitioner in his own office. Usually these services are supplemented by the visits of public health nurses to large camps or other points of labor concentration, the services of sanitarians who work with both camp owners and camp occupants to upgrade living conditions, and health education effort built into all aspects of project services.

The indigency of the typical migrant has been recognized in project development. However, the need for migrants to assume responsibility for meeting their own health problems is also recognized. The projects now in operation offer many opportunities for the migrant to take responsibility for learning and applying better homemaking and personal health practices. In some cases migrants themselves are involved in project operation as either paid or volunteer workers.

In limiting the project grant assistance offered by the Public Health Service to the financing of outpatient care, Congress indicated a feeling that this would meet the most crucial need. Based on existing evidence, in part supplied by hospitals prior to the bill's enactment, it was obvious that the emergency type of care hospitals were providing was often costly, and in some cases could have been prevented entirely had early outpatient care been readily accessible. Eliminating some of these cases and reducing the seriousness of others by early medical attention as part of a preventive health services program seemed to interested members of Congress the most reasonable approach to meeting migrants' health need.

Participation of community hospitals

A few community hospitals have participated in project operation through special arrangements for the use of their outpatient facilities and services. In some cases, where the hospital was within a short distance of migrant camps and could be readily reached, the mechanism for providing service is through migrant family clinics held in the hospital's outpatient facilities, usually scheduled at night. The hospital staff is usually reimbursed at an hourly or per session rate, and financing is also provided for laboratory tests and drugs at a prearranged unit amount, or at an average amount per clinic session.

In other projects, arrangements are made with hospital outpatient departments for "walk-ins" between migrant clinic sessions held at points of labor concentration. A predetermined all-inclusive rate or some other prearrangement is made for payment of the hospital for treatment of individual's payment. A means is also set up for establishing migrant status and thereby eligibility for payment for care from migrant funds.

In addition, some projects have arranged for provision of hospital inpatient care as part of the local contribution to the project. Thus, one State-wide project obtained a special fund from the State legislature for payment for general hospital care provided migrants. Unpaid bills for hospital care of migrants certified by project staff were prorated at the end of the crop season. About one-third of the total unpaid bills could be paid from the funds available. The amounts that were paid by migrants themselves were fairly minimal. Other sources of payment were not available.

In another State, the welfare department paid the cost of care for indigent migrants just as for indigent local residents. In still another, county welfare departments were reimbursed for payment of migrants' hospital bills by a

State-at-large fund if no other source of payment could be found. On a State-wide basis, a 1957 study determined that 1.1 percent of the seasonal farm migrants coming into the State became in need of some form of public assistance, usually hospital care. The agricultural economy in the area of the State which depends on migrants was valued at $1 billion, compared with an expenditure of less than $100,000 for the total costs of public assistance provided the 1.1 percent of the migrant population receiving temporary aid of some type. The total outlay for public assistance for all needy persons in the same period and the same area was more than $91 million.

In most migrant work areas, no public source of funds is readily available for payment of migrants' hospital bills. In one area, a grower's association levies an assessment against its members to help meet unpaid hospital bills at the end of the season. In others, local voluntary groups have raised funds for similar purposes. Most communities have continued as in the past, with hospitals providing care chiefly for emergency cases, seeking payment from any source where it can be found, and usually reluctantly ending by charging off the bills as "charity".

Some of the available evidence suggests, however, that at least some of the unpaid bills attributed to migrants may actually be chargeable to care of residents. Thus, in some farming areas it seems to be fairly usual for an unpaid hospital bill for an unskilled farm worker or member of his family to be charged off against "migrant hospital care" when in reality the family may have lived in the area for a number of years. On the other hand, migrants who receive hospital care may not be recognized as such, especially if they themselves pay their bills or some other source of funding is found.

In some teaching hospitals, the funds available for care of patients who are considered good teaching case material have been drawn upon for financing the in-patient care of at least a few domestic migrants.

Data on migrants' use of hospital care and on problems of hospital administrators in obtaining payment for inpatient care continue to be collected only sporadically and in a rather unsystematic way. From hospital admission forms properly filled out, it might be possible to trace back the records of persons who appeared to be migrants and arrive at some fairly adequate estimates of the number of migrants hospitalized, diagnosis at the time of admission, length of stay, payment made for inpatient care, sources of payment, and other pertinent data. Or, if interested individual hospitals or groups of hospitals could get together to agree upon some data recording and collecting system, it would be possible to obtain far more data than are now available on the actual number of migrants hospitalized, and the reasons why they require hospitalization. Such arrangements would yield useful data for planning projects that could strike at some of the most frequent causes of illness or injury requiring hospital care, as well as help to develop some reasonable basis for financing needed care.

The present information indicates a wide gap between need and use of hospital care by migrants. If the great majority of cases are emergencies, there is obviously a need that is not being met. This fact presents a challenge to other community agencies as well as hospitals, to determine the facts about the health needs of migrants, and to plan constructively to meet these needs. Such action would be in the long-run interests of the migrant, the community, and the community hospital.

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