Migrant Agricultural Workers and Health Care in the United States:

The Struggles and Successes of Washington State's Columbia Valley Community Health

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Table of Contents

Introduction

The results of the 2000 Census dramatically confirmed what prognosticators had already foreseen; the Hispanic population of the United States continues to grow at an astounding rate. Over the past ten years, this expansion has dwarfed that of the total populace, 57.8 percent to 13.1 percent. The years since the 1990 Census have seen Hispanic proliferation in all fifty states, with the largest jump, nearly 400 percent, occurring in North Carolina. Among states in the American southwest, still the most heavily Hispanic region in the country, Hispanics now make up 32.4 percent of the populace of California and 42.1 percent of that of New Mexico. At projected rates, non-Hispanic whites will become a minority[1] in the U.S. shortly after 2050. This rapid growth of the Latino[2] population in the U.S. gives rise to many questions about the future of America.

Throughout American history, the influx of outsiders has forged a double-edged sword. It has increased the celebrated ethnic and cultural diversity of America, while at the same time bringing about new social problems and tensions. These contrasting effects have engendered ambivalence in the attitudes of Americans toward the new population. The spirit of welcoming immigrants permeates American cultural mythology—from the concept of the Melting Pot to Emma Lazarus's famous inscription on the Statue of Liberty. Nevertheless, Americans' responses to waves of immigrants have varied over time and often have been quite hostile. The highly restrictive Immigration Act of 1924 seemingly rejected the notion that America was to be a nation of immigrants. More recently, legislation in California, including 1994's Proposition 187 which proposed "to expel the children of undocumented immigrants from schools and deny prenatal care to their mothers"[3] and Proposition 227 (dubbed "English for children" and passed

[1] Davis, Mike. *Magical Urbanism: Latinos Reinvent the US City.* Verso, London, New York. 2000. Page 7.
[2] For the purposes of this thesis, the terms Hispanic and Latino will be used interchangeably.
[3] Davis, 67

in June 1998) which prohibited teachers from using Spanish in the classroom[4], revealed a resurgence of anti-minority attitudes. The conflicts that have flared in California, where the major growth of Hispanics has preceded that of the rest of the country, provide a window into the future of America.

This nation's record for providing aid to those poor who come to its shores demonstrates an ideological conflict. In debates about social welfare, compassion for poor newcomers clashes with nativist attitudes and the peculiarly American ideal of the self-made man. Most often, the individualistic attitude that places blame for poverty squarely on the poor themselves has dominated, with the result that America remains far behind other developed countries in providing social benefits for the destitute. Still, Americans demonstrate some willingness to support programs that assist the underserved.

The immigration of Mexican agricultural workers to the Pacific Northwest and the evolution of health care institutions to provide for their needs offers insight into the themes of immigration, growth of ethnic minorities, and care for the poor. This thesis first examines how, when, and why this minority population came to the Northwest. It next details the medical difficulties which migrants have experienced, and it then proceeds to explain how both the government and citizens of the region reacted to the newfound presence of Hispanic farmworkers. As in the case of California, the cultural interaction examined in this study, mired in inevitable social conflict, provides insight into the cultural fusion that continues to occur in America.

Government and private efforts to provide health care to migrant Mexican agricultural laborers in the Pacific Northwest provides the backdrop of this paper. The seasonal nature of farmwork, characterized by high employment during the harvest followed by a substantially

[4] Ibid, 122

reduced workforce in the off-season, makes the seasonal arrival of migrants essential to the success of the farming industry. Yet the rigors of the work, the stress and uncertainty of temporary employment, the cultural differences between Hispanics and white Americans, and the poverty of the agricultural laborers contribute to the poor health of Mexican migrants.

Since the mid twentieth century, Mexicans have migrated in ever increasing numbers to the Wenatchee Valley of North Central Washington, an area known for its tree fruit production. During the past 50 years, they have grown from comprising a small portion of the population that came for the harvest and left during the winter months, to settling in the area permanently and becoming a major component of the region's populace. (The 2000 Census found a 140.6 percent increase in the numbers of Hispanics in North Central Washington since 1990, driving the overall Hispanic population to 22.2 percent of the region).[5] Yet the majority remain poor and underserved. A mutual dependence binds agricultural laborers and local citizens, the majority of whom are white. The economy of North Central Washington relies heavily on the labor of Hispanic farmworkers. Conversely, farmworkers depend on the help of local citizens and the government to meet their needs for social services.

Beginning in 1969, the federal government teamed up with residents of North Central Washington to provide health care for the region's poor, agricultural worker population. Over time, this effort expanded to include other low-income individuals in the service area. Throughout, variations in federal economic policy have significantly affected the project. The uniquely American reluctance to support governmental intervention in health care has necessitated considerable local effort to supplement federal funding to aid the poor. The changes in policy and ideology exhibited on the federal and local level in the late twentieth century facilitated the formation and success of a Migrant Health Project based in Wenatchee. The

growth and fruition of the project reveals that through federal and local cooperation, Americans can help provide for the needs of poor immigrants upon whom the nation has always relied.

[5] *Wenatchee World.* March 26, 2001. Maher, Stephen. "Area Joins nation in Hispanic Explosion." 3.

1. Mexican Immigration to the Pacific Northwest

Mexican citizens have migrated to the United States since the early 1900s, searching for jobs as well as living and working conditions better than those in their homeland. Lacking other skills and opportunities, many have resorted to migrant and seasonal agricultural work. Economic swings and wars have greatly affected levels of immigration. Although often overlooked, the northwestern states have been major recipients of Hispanic migrant labor. These laborers who ventured from southern climes to the Pacific Northwest have confronted conditions considerably different than those in Mexico and the American Southwest. These include new types of farms, a colder climate, a greater distance from Mexico, and, until recently, the lack of a Spanish-speaking community.

1900-1920s

The first discernible phase of Mexican immigration in the twentieth century spanned from 1910 to 1920. While some immigration predated this period, no clear pattern existed. A liberal American immigration policy, poor conditions in Mexico, and recruitment by the growing agricultural and railroad industries in the United States prompted this first movement.

With the completion of the Northern Transcontinental Railroad in 1893 and the growth of irrigation projects, the Northwest expanded agriculturally. Growers realized that they could grow a wide variety of crops in Washington and Oregon. Expanded agricultural production resulted in a serious shortage of farm labor. The sparseness of the population in the Pacific Northwest, combined with the seasonal and arduous nature of the work, made finding local laborers difficult. With a short window in which produce could be harvested and put on the market for the highest value, the labor-intensive crops grown in the Northwest required large

numbers of workers for short periods of time. The fact that in 1935 farmers in Central Washington's Yakima Valley employed sixty-six times more workers at the September peak than they did during the winter demonstrates the cyclical nature of employment.[6] Northwest growers responded by advertising through handbills and word of mouth to recruit seasonal migrant workers. Many of these were Mexicans, a number of whom had already crossed the border into the Southwest United States.

The volatile political and economic climate in Mexico helped to push Mexicans north into America. The Diaz dictatorship (1876-1911), the Revolution of 1910, and rural poverty all contributed to Mexicans' fleeing to the United States. Mexico's Civil War (1911-1920) spurred nearly one million Mexicans to move to the United States. The lack of any marked improvement after the Revolution prompted continued immigration. As a result, more Mexicans came north of the border in the 1920s than in the decade of Mexican civil war.

Developments in the United States also contributed to widespread Mexican migration. The Immigration Act of 1917 instituted a literacy and head tax requirement for Mexican immigrants. However, Secretary of Labor William Bauchop Wilson, responding to a wartime shortage of workers, granted an exemption to western sugar beet farmers, allowing them to recruit Mexican labor without following the provisions of the 1917 Immigration Act. Further, the National Origins Act of 1924, which established a quota system to regulate immigration, did not limit the entry of natives of Western Hemisphere countries. Thus, no quotas on Mexican emigrants existed. Farmers used this open-border policy to bring thousands of Mexican workers into the United States. Many of these people moved to the Northwest, with the greatest number farming beet fields in Idaho, but with others harvesting crops in Washington and Oregon.

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[6] Erasmo Gamboa, *Mexican Labor and World War II: Braceros in the Pacific Northwest, 1942-1947* (Austin, TX: University of Texas Press, 1990), 4.

Unskilled immigrants also began working in industries related to agriculture, including the railroads and irrigation projects. Railroad jobs offered a permanency which agriculture did not. Accordingly, Mexican railroad workers became some of the first Mexicans to settle in the Northwest.

Immigration during the Great Depression

The Depression of the 1930s curtailed both legal and illegal Mexican immigration. The 1929 economic crash hit the Northwest farming economy hard. Jobs in agriculture disappeared, eliminating the need for Mexican laborers. The State Department began to enforce literacy, head tax, and visa requirements, thereby decreasing legal immigration. Additionally, immigration officials sought to reduce illegal crossings. In 1930, federal and local governments began deporting illegal Mexican immigrants, both to provide more jobs for unemployed U.S. citizens and to avoid the cost of providing for impoverished immigrants.

By 1936, however, price supports, new marketing strategies, and tariff protection led to the recovery of prices for certain Northwest crops. Farmers and growers adjusted the amounts and types of crops which they produced. With the recovery of agriculture and unemployment levels still high, farmwork often provided the only available non-government funded jobs. Still, the jobless frequently preferred the relief rolls or seeking jobs with the Federal Emergency Relief Administration, Civil Works Administration, or the Works Progress Administration. Seasonal work proved strenuous, and farm wages remained less than those paid for factory work or federally funded relief jobs. For example, in 1939, farmworkers in Washington earned on average $2.60 per day, whereas those working on the state's federally funded road construction

projects earned $6.29.[7] Consequently, even with high levels of unemployment, the local labor force in the agricultural regions of the Northwest did not meet the demand for springtime and harvesting workers.

Although the Mexican farm labor force in California declined 30 percent during the Depression, Mexicans remained a ready source of labor in the western United States. The New Deal offered very little to seasonal migratory laborers, and wretched conditions in Mexican communities in the Southwest during the Depression induced the workers to head to Northwest farms. Amongst farmers, sugar beet growers, the majority of whom resided in Idaho, recruited the most Hispanic laborers to the Northwest, though producers of other crops also took on Mexican laborers. While white workers often viewed the large Mexican migration with disdain, Mexicans took jobs that many whites would not.

Although thousands of Mexicans came to the Northwest seeking seasonal work, few took up permanent residence in the region because of a lack of off-season employment, poor winter housing, the expiration of their work contracts, and restrictive federal and state relief policies. States in the Northwest made continuous and long-term residency a prerequisite to the receipt of relief. They did so, at least in part, to prevent migrant workers from becoming a social burden, knowing that the migrants never stayed long enough to qualify for aid. While the New Deal charged the Farm Security Administration (FSA) with the responsibility of alleviating the plight of the rural poor, the FSA for the most part ignored the needs of Hispanic migrants. Instead, it focused on white migrants from Missouri, Kansas, and the Dakotas who had moved to the Northwest, primarily between 1935 and 1937. The FSA rationalized its decision to omit Mexican migrants from rehabilitation efforts (resettlement, loans, and grants) by arguing that

[7] Gamboa, 11.

they were unskilled and were not forced into migration by the Depression as were their white migrant counterparts.[8] The only FSA efforts that benefited Mexican migrants were a few mobile camps where they could receive food and health care. Nevertheless, despite the terrible conditions during the Depression, Mexicans continued to come to the Northwest. Historian Erasmo Gamboa explains:

> All told, the decade of the Depression did little to alter the migration patterns of Mexican people to the Pacific Northwest. On the surface, it would appear that the general unemployment, the end of Mexican immigration to the United States, and the influx of many uprooted Midwesterners to the Northwest were reasons enough why Mexicans would not continue to be recruited to the northwestern states. Yet, paradoxically and in contrast to the 1920s, Mexican migratory workers came in greater numbers. This apparent contradiction of recruiting workers during high unemployment and shrinking job opportunities made possible the continued presence of Mexicans in the region. As before, the region's agricultural industry needed field workers; Mexicans were sought out because they were available, could be paid cheap wages, and would accept the laborious jobs that others turned down.[9]

World War II Bracero Program—Importation of Mexican Agricultural Workers

Beginning in 1941, the need for increased wartime agricultural production and the exodus of workers from agriculture into industry created a serious farm labor shortage in the Northwest. Furthermore, Mexican and white migrant labor did not come north for the harvest, in part because California faced its own agricultural labor shortage and thus tried to prevent workers from leaving. The transfer of workers into war industry positions in Seattle and Portland exacerbated this agricultural worker shortfall.

In both 1941 and 1942, farm labor shortages forced Northwest communities to take drastic measures. Local schools closed to allow students to help with the harvest. Certain communities closed stores and recreational facilities to encourage people to work in the fields.

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[8] Gamboa, 17.
[9] Ibid, 20.

Wenatchee Valley (Washington) orchardist James Arneil recalled the practice of "send[ing] busses to the Seattle jails and pick[ing] up busloads from the drunk tanks and also busloads from the Canadian Indian reservations for labor to help with the harvests."[10] Some large ranchers traveled to Mexico offering work and housing.[11] Certain areas resorted to relocating Japanese Americans from internment camps. However, this effort precipitated a backlash because of wartime anti-Japanese attitudes.

The rapidly escalating demand for farm produce during the war intensified the labor shortage. In 1941, the federal government lifted Depression-era crop controls, and large irrigation projects made more land available for cultivation. Meanwhile, influential individuals across the nation began to take notice of the worker shortages. President Franklin Roosevelt, realizing the magnitude of the problem, granted draft deferments to certain farmworkers.[12] The federal government responded to the labor crisis by developing its basic wartime farm labor policy. Government organizations such as the FSA, the U.S. Department of Agriculture (USDA), and the USDA's subsidiary War Food Administration (WFA) became involved in developing labor contracts and transporting workers to areas of need. This administrative program became public law 45 (PL-45). Backing off its self-reliant stance, agriculture came to expect the help of the federal government in procuring labor, although it wanted the government to ignore the social and economic conditions of field workers.

Commencing in 1941 in the Southwest and increasing as labor shortages worsened, farmers began calling for the importation of Mexican workers. The federal government initially hesitated to accommodate this request. Memories of the failure of the World War I Bracero program and the FSA's efforts during the Depression to improve the wretched conditions of farm

[10] James Arneil, Wenatchee fruit grower. Electronic Mail correspondence with author, 24 January 2001.
[11] Ronald Patnode, Catholic priest in North Central Washington. Telephone interview by author, 21 March 2001.

laborers and remove Mexicans, coupled with concerns about the impact of anti-Mexican sentiment, at first stalled any effective government response. Soon, however, the farm labor shortage became too pressing, and the U.S. and Mexican governments negotiated an agreement whereby the U.S. government paid to transport contract workers from Mexico to work in agricultural jobs. North Texas State University history professor Ellis Hawley summarizes the Bracero Program: "Under an executive agreement in 1942, followed by supplementary legislation in 1943, the federal government, acting originally through the Farm Security Administration and later through the Extension Service and the War Food Administration, proceeded to recruit Mexican workers, bring them to the United States, and supply them to farm employers."[13] The Office of Labor within the USDA's War Food Administration implemented the Mexican Farm Labor Program (MFLP), which came to be known as the Bracero (referring to arms, *brazos*, that is helping hands) program.[14] The Bracero contracts guaranteed the Mexicans wages for no less than 75 percent of the duration of their contract (contracts could not exceed six months) and mandated adequate housing and sanitary conditions. From October of 1942 until the year's end, the government certified 4,189 Mexicans to work in the United States. While farmers objected to the government's implementing rules concerning the treatment of workers, they quickly realized that they could sidestep provisions included in the workers' contracts. Furthermore, they understood that without Mexican laborers, no matter what efforts they employed, they simply could not harvest all their crops.

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[12] Gamboa, 31.
[13] Ellis Hawley, "The Politics of the Mexican Labor Issue, 1950-1965," *Agricultural History* 15 no. 3. (July 1966): 158.
[14] Gamboa, 41.

Braceros in the United States

The need to maximize agricultural production during a time of a shrinking local labor pool led to the 1943 agreement to import Mexican workers. Under that agreement, farmers organized into farm labor associations (FLA). Each FLA made a request for a certain number of braceros based on the needs of its members, then doled out the laborers to accommodate those needs. This system proved advantageous because most farms required only a small number of intermittently employed workers. The Bracero program grew to the point that in the second half of the 1950s the U.S. government issued about 430,000 Bracero visas per year.[15] Nevertheless, this did not accommodate the farmers' demands. The government did not always supply as many workers as farmers requested, and this prompted an increase in illegal immigration during and after World War II.

The Bracero program did not allow for the entry of any Mexican who sought work in the United States. Program organizers screened Mexicans based upon their experience in agriculture and put them through health and physical examinations, which included chest X-rays and tests for venereal disease.[16] The majority of those Mexicans who journeyed to Mexico City for screening hailed from towns and villages of Mexico's Central Plateau. Coming from rural and underdeveloped regions, most were uneducated and illiterate and thus did not understand the terms of their contracts. Once chosen, busses and trains transported them to their designated locations.

Braceros imported into the Pacific Northwest experienced especially difficult circumstances. They arrived unprepared for the cold spring climate. They were put to work the day after they arrived, and the growers, who often disregarded the treatment and sanitation

[15] Douglass S. Massey and Zai Liang, "The long-term consequences of a temporary worker program: The US Bracero experience," *Population Research and Policy Review* 8 (1989): 204.

provisions of the Bracero contracts, exercised near complete control over them. Additionally, employers relegated Braceros to the most difficult and worst paying tasks. Laws prohibited Braceros from working outside the fields, so they remained locked in undesirable jobs with little opportunity to improve. These harsh conditions took a toll on the workers. Gamboa writes, "In spite of the fact that the men were selected in Mexico for their good health, they soon developed illnesses, such as appendicitis, tuberculosis, arthritis, jaundice, or meningitis, and suffered serious accidents while in the Pacific Northwest."[17] Lead poisoning from the sprays used in orchard work became another occupational hazard for Braceros.

Despite harsh conditions, many Mexican migrants worked extremely hard and proved exceptionally productive. Growers throughout the Northwest praised the work of the Braceros in newspapers and farm journals. This praise was in part a genuine commendation of the quality of their work, but it was also a means of silencing opposition to the Bracero program in hopes of making it a permanent institution. The fact that growers often preferred Mexican Braceros to other workers precipitated some backlash in a Northwest society which had yet to accept the presence of the Mexicans in their communities.

Repercussions of the Bracero Program

Although the Bracero program did not end nationwide until 1964, 1947 saw its termination in the Northwest. Yet, despite its "temporary" designation, the effects of the guestworker program outlived the program. Douglass Massey and Zai Liang note these repercussions:

> The Bracero Program, in the course of its history imported some 4.5 million Mexican workers into the United States, making it the largest temporary worker

[16] Gamboa, 51.
[17] Ibid, 69.

> program in US history. At its height in the late 1950's, the Bracero Program imported over 400,000 workers per year. In the long run, however, the Bracero Program was not temporary, and several observers have argued that it ultimately encouraged a larger and more permanent migration to the United States.[18]

Mexicans did not stop migrating once the government program ended and labor recruitment stopped. They used their experiences in the United States and the contacts that they had developed to continue to return, both legally and illegally. Additionally, migrants drew family and friends into this itinerant life. Studies show that being related to a guestworker reduced the costs and risks of migration. Massey and Liang assert, "In a very real way, the Bracero Program of the 1940s and 1950s established the foundations for large-scale Mexican immigration to the United States during the 1970s and 1980s."[19] Immigration grew rapidly from 1960, when 32,000 legal immigrants entered the United States, to 1980, when that number reached 100,000.[20] From 1964 to 1988, approximately 1.4 million Mexicans arrived in the United States as permanent legal immigrants and at least 1.5 million entered illegally.[21]

Repeatedly visiting a distant area to work, particularly when accompanied by friends and relatives, increases the likelihood of permanent settlement in that location. Massey and Liang point out that "guestworker programs have three long-run consequences: they alter migrant motivations to increase the probability of making additional trips; they lead to the spread of migratory behavior through family and friendship networks; and they ultimately generate high probabilities of settlement."[22] Migrant settlement and the subsequent influx of family and friends resulted in the creation of new ethnic communities in agricultural regions of the United

[18] Massey and Liang, 200.
[19] Ibid, 201.
[20] Ibid, 204.
[21] Ibid, 204.
[22] Ibid, 206.

States. These predominately poor communities created social problems that had to be addressed at both local and federal levels.

Migration to the Wenatchee Valley

An understanding of twentieth century Mexican migration to the Northwest proves essential to comprehending the roots of the Hispanic population of the Wenatchee Valley. This region, famous for its production of tree fruit, lies in Chelan and Douglas Counties in North Central Washington at the eastern edge of the Cascade Mountain Range. The influx of Hispanics into the valley, followed by settlement, conforms to the pattern of migration described by Massey. Braceros accounted for a portion of the farmworkers in the area during World War II. However, Mexicans did not begin to populate the area in significant numbers until the mid-1970s according to Wenatchee physician Dr. Mark Shipman.[23] The development of the Mexican influence in Chelan and Douglas Counties trailed that of nearby Yakima County, an area that specialized in corn, sugar beets, hops, and potatoes during this era. Until the mid-1970s, Hispanics did not begin working extensively with tree fruit and so constituted a minority of the farmworkers in the Wenatchee Valley. Prior to this, white migrants, many from Oklahoma and Arkansas made up most of the agricultural workforce. Today, however, Hispanic residents constitute over 16 percent of the region's 93,000 people.[24] This number does not include the thousands of migrant and seasonal laborers who work in the area's orchards each year.

Mexican migrant workers who arrive in the Wenatchee Valley and other agricultural regions looking for jobs confront major obstacles in the quest for income and security. In recent years, many Hispanics have worked their way up within the agricultural hierarchy to positions as

[23] Marc Shipman, M.D., Wenatchee physician. Personal interview by author, January 2001.

orchard managers, foremen, and, in a few cases, as owner-growers. Even today, however, limited education, low agricultural wages, a lack of a steady year-round labor market, and the language barrier make life difficult for migrant Hispanics.

[24] Columbia Valley Community Health Grant, 2000-2001. Submitted to the Bureau of Primary Health Care (December 3, 1999): 16.

2. Health of Migrant/Seasonal Workers

Characteristics of Agricultural Labor

At present, an estimated three to five million farmworkers toil in American fields. People from many different ethnic groups make up this population, but Hispanics constitute the majority. American agriculture relies heavily on these workers, who come in two principal types, migrant and seasonal. The Migrant Health Program of the United States Department of Health and Human Services defines a migratory agricultural worker as "an individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last 24 months, and who established for the purpose of such employment a temporary abode."[25] However, as Juan Palerm, a professor of Anthropology at the University of California, Santa Barbara, observes, "not all farm workers are migrant. Many have settled *permanently* with their families in small rural towns and communities located in those regions subjected to agricultural intensification where farm employment is more abundant and regular."[26] These are labeled seasonal agricultural workers. The numbers of migrant and seasonal laborers in a given region depends on factors such as type of crops and availability of off-season employment.

Migrant and seasonal agricultural workers share much in common. In fact, historians and policy-makers often include seasonal farmworkers in the broad category of migrant labor. Programs designed to help migrants often target seasonal workers as well. Even though they work hard and the demand for their services remains high, many such agricultural laborers continue to live in poverty. The National Advisory Council on Migrant Health reported in 1995 that "the average annual migrant farmworker family income is substantially lower than the

[25] Philip L. Martin, *Harvest of Confusion: Migrant Workers in U.S. Agriculture* (San Francisco: Westview Press, 1989), 170.

national poverty threshold."[27] The lifestyle of the destitute farmworker often perpetuates itself. The lack of education and absence of other work experience impedes any vocational change. Low pay forces each family member, including young children, to work. This makes it difficult, if not impossible, for children to attend school, thereby keeping them in the farmwork cycle. Indeed, a 1995 study revealed that almost half of the nation's migrant farmworkers have less than a ninth-grade education.[28] Elva Trevino Hart's *Barefoot Heart*, a story about the author's rise from a migrant family to success in computer science and literature,[29] reveals the considerable barriers that the children of farmworkers face in trying to break this cycle.

Migrant and seasonal farmworkers face myriad obstacles. Poor working, housing, and sanitation conditions frequently predominate. Long hours of grueling labor are the norm. Pay remains sporadic because of the seasonal nature of agricultural work, characterized by long hours during the harvest followed by inactivity. Migrant families must travel long distances during the summer months to stay employed. Sonia Sandhaus, a nurse and scholar of migrant health, writes, "The average migrant farmworker spends approximately six months per year doing seasonal work (for which he or she earns $5,000, less than half of the U.S. poverty threshold), eight weeks doing nonagricultural work, eight weeks on the road, and ten weeks unemployed."[30] Their itinerancy precludes continuous enrollment of their children in school, and because of residency requirements, receipt of welfare. Experienced migrants learn how to avail themselves of food stamps and other social services, but the uninitiated, lacking knowledge of the ins and outs of the system, must often do without.

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[26] Juan Vincente Palerm, "Cross-cultural Medicine a Decade Later: A Season in the Life of a Migrant Farm Worker in California," *The Western Journal of Medicine* (September 1992): 364.
[27] "Losing Ground: The Condition of Farmworkers in America," Recommendations of the National Advisory Council on Migrant Health, (September 1995): 7.
[28] Ibid, 7.
[29] Elva Trevino-Hart, *Barefoot Heart: Stories of a Migrant Child* (Tempe, Arizona: Bilingual Press, 1999).
[30] Sonia Sandhaus, "Migrant Health: A Harvest of Poverty," *American Journal of Nursing* 98 (September 1998): 52.

Migrant Health

The lifestyle of itinerant farmworkers wreaks havoc upon their health. Statistics point out a major gulf between the health of farmworkers and the rest of the population. The following facts illustrate the alarming state of migrants' health:

> • The infant mortality rate among migrating laborers is 25 times higher than the national average. Their life expectancy is 49 years, compared to the national average of 75 years. The rate of parasitic infection is 11 to 59 times higher than that in the general population, and malnutrition is higher than in any other subpopulation in the country. Deaths from influenza, pneumonia, and tuberculosis are 25% higher.[31] (1998)
> • In 1969, the Migrant Health Program compared a sampling of medical conditions among the patients reported by selected migrant health projects throughout the United States with a sampling of medical conditions among patients in private physicians' offices. Infective and parasitic diseases, diseases of the respiratory system, and diseases of the digestive system were from two to five times as large a proportion of the conditions seen among migrants compared with the general population. Tuberculosis was seen 17 times, venereal disease 18 times, and infestations with worms 35 times as often among migrants.[32] (1988)
> • Up to 78 percent of all farm workers—in contrast to two or three percent of the general public—suffer from parasitic infection.[33] (1994)
> • The death rates for farm workers from influenza and pneumonia are 20 percent and 200 percent higher, respectively, than the national average.[34] (1994)

A high incidence of diseases that are rare or absent in other segments of the population plagues migrant farm laborers. These include respiratory, digestive, and infectious diseases, parasitic infestations, diarrheal disease, severe ear infections, skin infections, and nutritional deficiencies. In Daniel Rothenberg's *With These Hands*, a compilation of stories told by people involved with migrant farmworkers, Dr. Ed Zuroweste, the medical director of a community health center in Pennsylvania, discusses challenges which he faces in treating migrant workers:

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[31] Sandhaus, 52.
[32] Helen L. Johnston, *Health for the Nation's Harvesters* (Farmington Hills, Michigan: National Migrant Worker Council, Inc., 1985), 94.

> Farmworkers exhibit the type of health status that one sees in the Third World. We see a lot of infectious diseases because of poor sanitation, poor nutrition, and exposure. Whenever you have a population that lives in poverty, with poor sanitation and poor access to health care, then you have a public health problem. Farmworkers are very susceptible to diseases that are out there—tuberculosis, cholera, leprosy—things that we haven't thought about much in recent years. Since farmworkers' access to health care is very limited, they often present in a more advanced stage, which makes them difficult to treat. It never ceases to amaze me how advanced farmworkers' medical problems are.[35]

The dangers inherent in farmwork play a major role in the low standard of health of agricultural laborers. Farmworkers have the highest work-related injury and mortality rate in the nation.[36] Their work exposes them to the elements, agricultural chemicals, poor water, inadequate sewage systems, substandard housing, and stoop labor.[37] A study by the National Advisory Council on Migrant Health linked high rates of communicable disease to a lack of the basic public health necessities, such as access to potable water and toilet facilities.[38] Accidents, which occur frequently in farmwork, compound the danger. Child workers remain especially susceptible to mishaps involving farm machinery. Traveling long distances in old cars to and from work increases the incidence of automobile accidents for migrants. Additionally, the stress of farmwork and the constant worry about how to get the next paycheck degrade mental health among the farmworker population. Depressed workers often turn to drugs and alcohol, further worsening their health.

Pesticide exposure likewise poses serious health problems, both chronic and acute. Farmworker Ezequiel Marfín reports:

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[33] Isabel Valle, *Fields of Toil: A Migrant Family's Journey* (Pullman, Washington: Washington State University Press, 1994), 59.
[34] Ibid, 59.
[35] Daniel Rothenberg, *With These Hands: The Hidden World of Migrant Farmworkers Today* (New York: Harcourt Brace & Company, 1998), 226.
[36] "Losing Ground," 3.
[37] Ibid, 27.
[38] "Losing Ground," 28.

> The chemicals are affecting the community a lot, and there are no studies that have been done over a long period of time. I've been a field worker and I've worked with chemicals. And they produce long-term allergies, and they cause colds that last two or three years to get rid of. We believe [it is] because of the chemicals...when I go to the places where they have used chemicals, right away I break out. And so I have been contaminated.[39]

Farmers depend on pesticides to grow the high-quality produce that consumers demand. However, allowing workers into the fields too soon after spraying and failing to provide suitable sources of water for drinking and bathing promote large-scale pesticide-related problems. The Environmental Protection Agency (EPA) estimates that 300,000 farmworkers suffer acute illnesses and injuries as a result of pesticide exposure each year.[40] Often, workers do not realize that pesticides cause the rashes, diarrhea, and skin infections to which they have grown accustomed. Lead poisoning poses another health threat to those working in the fields.

A lack of access to health care compounds the workers' plight. Many simply cannot afford to visit a doctor. A 1981 General Accounting Office (GAO) study, "Problems in the Structure and Management of the Migrant Health Program," reported that "most officials at 15 health facilities we visited where migrants, seasonal farmworkers, and the rural poor were all served said these groups have essentially the same health care needs."[41] Other studies, however, indicate that farmworkers have greater health care needs than non-agricultural workers in the same income bracket. Even though migrant farm laborers require medical help as much as or more than others of like means, many barriers stand between these workers and the health care which they need.

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[39] "Losing Ground", 29. From Eziquiel Morfin Testimony before the National Advisory Council on Migrant Health (1992).
[40] Ibid, 29.
[41] "Problems in the Structure and Management of the Migrant Health Program," General Accounting Office Migrant Health Study, HRD-81-92 (May 8, 1981): 12.

Barriers to Quality Health Care

Farmworkers' lack of access to health care stems from many causes. Many lack the funds and health insurance necessary to secure treatment. In addition, much agricultural work occurs in rural areas where clinics and doctors are scarce. Even when facilities exist, migrants often remain unable or reluctant to use them. Some lack transportation from their place of residence to a health clinic. Maria Elena Martinez, a migrant worker, whose family the *Walla Walla (WA) Union-Bulletin* featured in a year-long series of articles, explains another problem: "Well, Raul [Maria's husband] won't go to the doctor if he gets sick, but that's because he doesn't want to miss one day's work."[42] Indeed, many agricultural laborers worry that they will lose work time or their job if they miss a day or even a few hours of work while seeking care. Furthermore, illegal immigrants working in agriculture often fear that visiting a clinic will result in their deportation.

Even when farmworkers decide to seek care, problems can occur. Language and cultural barriers impede the doctor-patient relationship, diagnosis, and explanations of treatments. Dr. Meyer, a Wenatchee physician, tells of once having to treat a Hispanic patient through the translation of the woman's six-year-old daughter. Furthermore, agricultural workers often do not visit a health care provider until treatable health problems have progressed to serious conditions. Once they receive initial treatment for chronic ailments, migrants often do not return for the necessary follow-up care until their condition has deteriorated to its initial state.

Many factors stand in the way of migrants' controlling their access to medical help. Most lack the income necessary to purchase health insurance, and few employers provide it to them. Furthermore, many do not have the education to know how to protect their own health, and migrants have little say over their often-dangerous employment conditions—safety, housing,

sanitation, low pay, etc. Although laws have changed recently, for many years workmen's compensation benefits did not cover migrants. Forced to move constantly in pursuit of work, migrants cannot establish continuity with a physician or clinic and usually do not carry their medical records with them. This constant mobility also inhibits study, program development, and assessment of conditions of migrant health.

Moreover, the reluctance of Americans to support government involvement in health care has hurt migrant and seasonal laborers. While many citizens endorse the abstract notion of helping the destitute, the fear that this will lead to complete government control of health care paralyzes effective action. Unlike other developed countries, the United States has yet to enact a national health care system. Twentieth-century American politics has witnessed five separate failures of reformers to legislate national health insurance: the Progressive era, the New Deal, the Truman administration, the early 1970s, and the early 1990s under President Clinton. In his article *The Politics of Universal Health Insurance: Lessons from the Past*, Yale professor Theodore Marmor argues that, despite widespread public support, a national health plan has failed because entrenched interests, such as the American Medical Association, have skillfully manipulated the deepest fears of Americans to protect their own interests.[43] He provides an example to illustrate this point: during the 1950s ideological criticism linked national health insurance with socialism and communism. Marmor also maintains that political battles over the type of health plan to support have repeatedly prevented the enactment of national health insurance.

The relative invisibility of migrant communities exacerbates the problem of the lack of support for government efforts, as people remain unaware of the plight of migrant workers.

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[42] Valle, 17.

Further, locals express worries about migrant disease and discriminate against them. Finally, some Americans oppose social services that benefit migrants for fear that the benefits will cause the itinerants to stay in the community.

Americans, however, have not stood completely oblivious, unsympathetic, and inactive in the face of the migrant health problem. Rather, in times when the inadequacies and horrors associated with migrant health care have come to light, some have responded by attempting to improve conditions with new programs. As a result, although problems still exist with health care for the poor, publicity about the need has led to change for the better.

Exposure of Migrant Problem

For much of the 20th century in America, the plight of the migrant worker remained largely unseen and ignored. The labor laws that protected workers in other industries did not apply to agriculture. A National Advisory Council study on migrant health proposed an explanation for this discrepancy:

> The evolution of worker protection arose from the industrial movement in the United States. The regulation of age and working hours for children, the reduction of dangers created by equipment or closely confined working areas, ventilation of sweatshops, and unionization were all important achievements during the Industrial Revolution. In contrast, the small family farm, as a work place, was viewed as a mecca of fresh air and "God's green earth." But working conditions for farmworkers have always been brutal, including working from dawn to dark in damp fields and orchards, stoop labor, long hours in wet clothing, and exposure to the elements.[44]

Ignorance regarding the harsh conditions endured by migrant agricultural workers prevailed. However, two key events prompted public outcry and government-sponsored programs to aid

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[43] Theodore R. Marmor, "The Politics of Universal Health Insurance: Lessons from the Past?", *Journal of Interdisciplinary History* (Spring, 1996): 672.
[44] "Losing Ground," 28.

migrants: John Steinbeck's *The Grapes of Wrath* and CBS's 1960 Edward R. Murrow production, *Harvest of Shame*.

Steinbeck's 1939 novel exposed the wretched conditions suffered by migrants who moved west to escape the Dust Bowl. Soon thereafter, in 1942, the United States Senate Committee on Education and Labor (the La Follette Committee) issued a report which concluded that "the economic and social plight of California's agricultural labor is miserable beyond belief." The report cited low annual earnings, poor housing, and lack of job security, and it called for federal legislation to protect the economic and civil liberties of migrant farmworkers.[45] During the late 1930s and early 1940s, the New Deal's Farm Security Administration (FSA) built Farm Security Camps to provide housing, referrals to physicians or hospitals, and basic health care services in areas of major farm labor demand.[46] By 1946, the program, then under the auspices of the Department of Agriculture, provided health care to over 100,000 workers. However, Congress withdrew funding following World War II, as it did for all other programs considered wartime emergency measures. Some federal efforts to provide health care to migrants ended after the New Deal; others were terminated after World War II; and the public quickly lost interest in the plight of the migrant population. Nevertheless, the needs remained.

Murrow's *Harvest of Shame*, which aired on Thanksgiving Day in 1960, marked a turning point in attitudes toward migrant farmworkers. This documentary featured an interview with Secretary of Labor James Paul Mitchell, conversations with migrant families, and footage of migrants both working and on the road. Murrow poignantly demonstrated the depth of migrant depravation and despair. Among the most alarming facts, Murrow reported: the average migrant worked 136 days per year yet often could not meet expenses; migrants possessed no

[45] Martin, 5-6.
[46] "Losing Ground," 35.

voice in the legislative process; and the United States spent more money on migratory wildlife than on the education of migrant children. Murrow's report provoked a public outcry over the exploitation of migrants, and it helped to muster support for government programs to address the problems.

Government Involvement in Migrant and Seasonal Health

Attitudes toward migrant workers began to change in the 1960s. During those years, the Democratic and Republican party platforms both included statements dealing with migrants. In *Harvest of Confusion*, author Philip Martin notes:

> The Democrats pledged "to assure migrant labor, perhaps the most underprivileged of all, of a comprehensive program to bring them not only decent wages but also an adequate standard of health, housing, social security protection, education, and welfare services." The Republicans pledged action along "these constructive lines: improvement of job opportunities and working conditions for migratory farmworkers."[47]

Additionally, both the Senate and the House of Representatives created Subcommittees on Migratory Labor to study the issue and to propose legislation to assist agricultural migrants. Martin details some of these developments:

> In the mid-1960s the bracero program came under sustained attack and was ended, Cesar Chavez began his campaign to organize California farmworkers into the United Farm Workers union, and the federal government initiated programs to provide educational and health service for migrant farmworkers and their children. In the mid-1960s, agricultural economists predicted that a wave of mechanization would eliminate thousands of farm jobs, so "migrant farmworker" became an occupation which required federal assistance to escape.[48]

This last prediction proved false. Mechanization never uprooted significant numbers of migrant farm laborers.

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[47] U.S. Senate, 1961, p. x , Martin, 6-7.
[48] Martin, 7.

The War on Poverty programs of the 1960s dealing with migrant workers were premised upon the vague generalization that most of the "millions" of migrants were either black families from Florida or Hispanics from Texas and California who packed their possessions and moved north each year. Daniel Rothenberg details the federal efforts of the 1960s:

> The 1960s' War on Poverty created a series of social programs specifically designed to improve the lives of migrant farmworkers and their families. Farmworkers' poverty, isolation, and their constant mobility were recognized as obstacles to accessing social services and key problems for migrant children, who rarely finished school. The problems of farmworkers were also understood as a federal responsibility, since state governments were seen as unlikely to spend money on transient workers with limited ties to local communities. The laws established four key programs: Migrant Health, Migrant Education, Migrant Head Start, and the migrant provisions of the Job Training Partnership Act (JTPA), all of which continue to operate.
>
> Migrant Education and Migrant Head Start are designed to help farmworker children succeed in school. Migrant Health allocates funds to serve farmworkers' health needs, often providing outreach services to labor camps and working to coordinate care for workers who move from one place to another.[49]

Migrant assistance programs of this era did not allocate any of their limited funds to conducting studies to determine the identity and mobility patterns of migrants. Poor funding and an inadequate understanding of America's migrant laborers hindered such programs. Still, they set positive precedents, and they have improved significantly since their inception.

During the 1970s, federal assistance programs, to preserve their funding and to determine which states most needed financial assistance, began to commission studies of migrants.[50] However, most such studies failed to adopt and follow a uniform methodology. Migrant assistance programs, attempting to ascertain the number of migrants, could not get accurate counts because the Bureau of the Census and the Department of Labor utilized significantly different definitions and methods. Unable to rely on the numbers proposed by these two

[49] Rothenberg, 225
[50] Martin, 8.

agencies, migrant programs conducted their own studies, which also used varying definitions and methods.

In the 1980s, during the Reagan administration, the plight of the migrant receded to a lower-profile public issue.[51] Assistance programs cut back on migrant studies because the federal government made clear that little chance existed for increased funding for migrant assistance. Additionally, the quality of statistical data deteriorated as increasing numbers of unregistered illegal aliens crossed the border, becoming a more significant component of the migrant workforce.

Commentators disagree about the effect of migrant assistance programs and about whether the migrants' status improved or deteriorated with such programs operational. Martin's *Harvest of Confusion*, published in 1989, asserts that by the late 1980s, the numbers of the stereotypical migrant *family* had decreased. A different migrant replaced them—extremely poor, single immigrant men, such as ones from southern Mexico and Guatemala, as well as better paid semi-skilled and professional migrant men. Martin concludes that the "declining number of family migrants is a tribute to the success of assistance programs which gave migrants and their children the option of nonfarm jobs."[52] However, others challenge the notion that the migrant condition has improved significantly. Dr. Zuroweste argues:

> I challenge anybody to tell me that the health status of farmworkers has improved significantly in the last thirty years. I've been involved with migrant health for fifteen years. I went into it thinking that we could make a difference and improve farmworkers' health. I have yet to see that happen. Migrant Health funding is still low. What we have so far are Band-Aid programs that reach maybe fifteen percent of the farmworker population.[53]

[51] Martin, 8.
[52] Ibid, 9.
[53] Rothenberg, 227-228.

Notwithstanding such disagreement, most concede that of the many efforts to benefit migrant and seasonal workers, the funding of approximately 130 federally subsidized migrant health centers, located in designated high-impact areas, has proved one of the most successful. The first of these clinics gained funding in 1961. While numerous centers closed due to the slashing of welfare programs in the 1980s, many have persevered. These clinics have been unable to reach the entire population—some studies show them accommodating as little as 15 percent of the target population[54]—yet they have met particular success in some areas. One such clinic is Columbia Valley Community Health in Wenatchee, Washington, which has weathered periods of greater and lesser federal government funding to successfully provide local migrant workers with vital health care.

[54] "Losing Ground," 10.

3. Founding of Columbia Valley Community Health

Wenatchee Valley

Washington State ranks as the nation's largest producer of apples and also a major grower of cherries and pears. The Wenatchee Valley, which sits in the eastern foothills of the Cascade Mountains in the center of the state, produces, in addition to other commercial fruit crops, nearly half of Washington's apples. The floor of the valley rests 600 feet above sea level, but mountains that reach peak elevations of 6,000 feet border it. Irrigation of the valley's rich, volcanic soil allows farmers to overcome Wenatchee's arid climate—one which provides an annual average of only nine inches of precipitation and approximately 300 days of sunshine—to grow high-quality produce. The construction of the Highline Canal in 1903 marked the beginning of a long period of agricultural development which has culminated in the valley's becoming a leading fruit-producing region.

Cold winter temperatures limit the growing season to the six months from April to September. Since Washington produces all of its agricultural goods during this time, the demand for agricultural workers remains high for this peak period. As cold temperatures return, however, the agricultural worker market diminishes significantly. In 1966, the employment of migrant farmworkers in Washington varied from a low of 1,500 in February to a high of almost 25,000 in September.[55] A 1967 study by the Consulting Services Corporation of Seattle documented that Washington's full-time agricultural workforce lacked the numbers to meet the

[55] "Migrant Farmworkers in the State of Washington, Volume II, Economic and Social Characteristics of Migrant Agricultural Workers in Washington State," (Seattle, Washington: Consulting Services Corporation, May 1, 1967): iii.

high demand for labor during the harvest. It went on to explain that Washington agriculture depended upon seasonal workers to harvest the crops.[56]

The study, prepared for the Office of Economic Opportunity in Washington, D.C., revealed much about the migrant agricultural workforce in Washington in the 1950s and early 1960s. Until the late 1960s, Anglo migrants outnumbered Latin American migrants in Washington, 49 percent to 41 percent. This statistic also proved true in the Wenatchee Valley, where large numbers of the State's migrants found employment. In 1966, Chelan County, of which Wenatchee is the county seat, employed the second largest number of migrant workers in the state.[57]

Significant differences existed between Anglo and Latin American migrants. The largest percentage of Latin American migrants wintered in Texas and traveled north in March. These individuals worked primarily in the fields picking berries and doing other stoop labor tasks, traveled with a family, and preferred to be paid by the hour. In contrast, Anglos usually traveled alone, preferred to be paid a piece-rate, and worked in tree fruit harvests.[58] Since tree fruit production makes up the vast majority of agriculture in the Wenatchee Valley, this would indicate that the majority of agricultural workers in Wenatchee before the 1970s were Anglos. Indeed, interviews with several Wenatchee area growers who operated in the 1960s confirms that until the 1970s, Anglos dominated the agricultural workforce.

The late 1960s and the 1970s saw the numbers of Hispanic migrants in Wenatchee Valley agriculture grow dramatically. Their presence created new problems for the people of North Central Washington. Like Anglo migrants before them, Hispanics earned little money. In 1965, half of the migrant families earned $1,150 or less per year working in seasonal agriculture.

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[56] "Migrant Farmworkers in the State of Washington," 1.
[57] Ibid, 2.

Studies estimated total annual family income at about $2,300.[59] While most migrant mothers (92 percent) went to the hospital for childbirth, the majority of migrants could not afford health insurance and medical care in non-emergency situations. For example, in one large-scale study, nearly three-fourths of the sample adults and one-fourth of the sample children had received no preventive immunization.[60] The most commonly reported ailments, gastrointestinal and respiratory illnesses, stemmed from common conditions of migrants: poor nutrition, poor sanitation, contact with chemicals, and close contact with large groups in the fields. Perhaps no surer indication of the dire migrant health care situation exists than life expectancy. On average, migrants can expect to live fifteen years less that the American average (55.2 years versus 70.2 years).[61] The language barrier, according to the study, erected another barrier between non-Anglo migrants and effective delivery of health care services. The migrants had difficulty explaining their symptoms to doctors and nurses. They also feared and did not understand the specific medical practices used by physicians.[62] In addition, Latin Americans relied heavily on culturally based home remedies and medicines and thus at times demonstrated reluctance to avail themselves of modern medical services. These problems persist for poor Latinos.

During the early years of Hispanic migration, no significant Spanish-speaking community existed in Wenatchee year-round. As a result, Hispanic workers in Wenatchee lacked a community bond with, and guidance from, people of their own ethnic and cultural background who knew the area and its institutions. This exacerbated the difficulty of finding medical care providers and obtaining aid.

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[58] "Migrant Farmworkers in the State of Washington," 27.
[59] Ibid, 13.
[60] Ibid, vi.
[61] Ibid, vii.
[62] Ibid, 45.

Yet the mid-1970s saw the demographics of the agricultural workforce in Wenatchee begin to change substantially. After spending several years working as migrants in the area, many Hispanics had developed ties and begun to settle permanently. Year-round agricultural jobs, which included not only summer and early fall harvesting but also off-season pruning, planting, irrigating, hoeing, and fruit packing, allowed former migrants to remain in the area full-time.

As the ethnic composition of the agricultural workforce changed, so too did people's attitudes regarding the influx of Hispanics into the valley. Ray Taylor, a longtime leader in the Wenatchee medical community, reported that when Hispanics first started arriving, natives responded with the attitude that they should come, do their work, and leave.[63] In the 1960s, farmers showed reluctance to hiring Hispanics, doing so only out of necessity. However, as some Hispanic workers began to have success and stay in Wenatchee, natives began to realize their worth as good workers and that their influx into the area would not stop. Growers came to welcome the increase of Hispanic agricultural workers. Longtime Wenatchee orchardist Jim Wade recalled the coming of the Mexicans and their effect on the workforce: "In the early 1960s, when the first Mexicans came to Wenatchee, they all came for the harvest, then went home. They did not become the majority of the workers until the early 1980s. Most Hispanics are good people with good families. They are hard workers, better than the [Anglo migrants] before them."[64] Based on a fear of migrant disease, the good will of some citizens, the need to attract agricultural migrants, and the realization that the Hispanic influx was irreversible, some Wenatchee residents began to set up health, housing, and other social services to care for the new

[63] Ray Taylor, Wenatchee resident and former Chelan-Douglas Medical Society President, telephone interview by author, December 2000.
[64] Jim Wade, Wenatchee fruit grower, Telephone interview by author, February 2001.

population. This local, grass-roots effort fostered the birth of the Migrant Health Project in Wenatchee.

Efforts before CVCH

Prior to the 1969 founding of the North Central Washington Migrant Health Project, indigent migrants seeking care had no alternatives. They had to rely upon Wenatchee's physicians to donate their time and services. Lacking enough money to purchase health insurance or to pay for care directly, migrants received treatment only in emergency situations. Physicians received compensation for treating those who were on welfare, but they could not afford to treat too many welfare patients. In 1969, the Chelan-Douglas County Health District received federal funds, which it used to provide medical care for migrants and their families. To allocate services, the Health District set up a migrant workers health project. The *Wenatchee World* reported about this project: "migrant health services were provided at a medical-dental clinic held in the East Wenatchee Medical Center every Wednesday night. A weekly dental clinic was held in Chelan. The clinics were staffed by a physician, his nurse, a volunteer medical social worker, two volunteer baby sitters, and two public health nurses.... In day care centers, the medical department staff tried to instruct migrants in ordinary health measures—dealing with lice, how to clean baby bottles, and even how to brush teeth."[65] Additionally, three nurses and three community aides, who worked for the Health District, divided into teams. The *Wenatchee World* reported that a nurse and an aide worked together as a team in three locations, Chelan-Manson, Wenatchee, and Cashmere. The teams provided nursing services to preschool children in the Migrant Day Care Centers, worked during the evening at medical and dental clinics, and

[65] *Wenatchee World.* 22 April 1971: p. 4

made referrals to physicians and dentists.[66] Health District workers focused on health education, stressing cleanliness, nutrition, dental care, family planning, and general health counseling. In the first year of the project's operation, 35 volunteer doctors and dentists provided medical and dental care to 239 migrants in Chelan and Douglas Counties.

Soon after the beginning of the Chelan-Douglas County Health District, Wenatchee residents began searching for a way to improve the system. Those involved set up a Chelan-Douglas Comprehensive Health Planning Council. In June of 1970, a committee assigned to study migrant health problems presented five general recommendations:

1. Neglects of good water, adequate toilet facilities and housing should be corrected. Lack of adequate staffing makes it difficult for the Chelan-Douglas Health District sanitarians to cover all the migrant labor camps.
2. Concern about possible health sanitation conditions surrounding the jails was expressed.
3. Some type of permanent "Friendship Center" to house migrants, who come here to help with the harvest, should be established because many of these persons have no place to live until they find a job.
4. Explore the possibilities of a more adequate park system to accommodate migrants because now many camp along roadsides or streams.
5. Some enforcement should be started to deter spraying of pesticides which today sometimes is allowed to drift onto workers in an area.[67]

These recommendations manifest a feeling of responsibility for and a desire to improve the conditions of agricultural laborers.

Problems emerged with the Health District's migrant health program. Former Chelan-Douglas Medical Society president Ray Taylor explained that Medicare, a program started in 1965 by the Johnson administration, paid only part of the bill for the low-income people served by the migrant program. The Health District could not subsidize the rest. Its annual $26,000 grant from the United States Public Health Service proved insufficient to pay for the extensive

[66] *Wenatchee World.* 16 November 1969.
[67] *Wenatchee World.* 24 June 1970: p. 8

health needs of the migrant population.[68] Additionally, the medical and dental clinic's being only open one night per week precluded many from utilizing its services.

The 1970 medical-dental budget of $9,039 paid for medical visits for 110 individual patients, 60 dental care visits, 108 night medical clinic visitors, 105 night dental clinic visits, and 166 prescriptions for medicine.[69] While this miniscule budget could provide for only a fraction of the target population, it still helped. Then, in 1971, the Chelan-Douglas health board, after only two years of conducting its migrant health program, refused to request federal funds to continue operating in 1972. In justifying their decision, officials cited excessive local administrative costs and abuses in which care was provided to people who were not working for growers. Affected community members responded angrily to the end of the program. Orchardist Don Paton noted that "fruit growers depended heavily upon migrants being attracted into the area. Growers in Cashmere Valley [10 miles away from Wenatchee] expressed concern about the loss of the migrant health services."[70] Dr. Griffith Quimby "said use of area hospital emergency rooms had decreased considerably while the migrant health services program was in effect. He said that the hospitals will now have to absorb the costs because the migrants are going to start showing back up again at emergency doors of hospitals, with no funds to pay for their care"[71], reported the *Wenatchee World.* Dr. Wayne Zook, the president of the Chelan-Douglas County Medical Association in 1971, criticized the ending of the program as an evasion of an issue that had to be addressed and would not disappear. Zook commented: "These people [the migrants] are going to be here. They're going to have to be taken care of. It's just a

[68] Taylor interview, December 2000.
[69] *Wenatchee World.* 20 April 1971: p. 1
[70] Ibid.
[71] Ibid.

question of who does it. If the migrant health program doesn't do it, then the hospitals and doctors will have to do it on their own."[72]

Throughout the community, citizens decried the decision to disregard their "responsibility" to help the area's farmworker population. However, the migrant health program did not have to be scrapped altogether. Another local agency could take over, sponsor the program, and continue to receive federal funding. In this void, local migrant health advocates stepped up to continue the efforts to provide care to farmworkers.

Founding of the North Central Washington Migrant Health Project

Margaret Moran, a Wenatchee nurse and one of the members of the 1970 committee assigned to study migrant health problems, spearheaded an effort to improve the quality of care available to agricultural workers in the Wenatchee Valley. Moran recruited to Wenatchee a group of social workers who had started a health center in nearby Othello. This group included Jim Tiffany, a man who went on to become Executive Director of the Migrant Health Project in the 1980s. On January 11, 1972, Moran and twenty-three other health care professionals, government representatives, and concerned citizens voted unanimously to incorporate as a non-profit organization and apply for a federal grant.[73] They named the corporation the North Central Washington Migrant Health Project. On April 1, 1972, the Project received its first federal grant of $125,000.

In the Project's early days, volunteers held outreach screening clinics in the orchards and along the roads of Chelan, Douglas, Grant, and Okanogan Counties. Night clinics took place in churches, the hospital basement, offices, and wherever else volunteers could find temporary

[72] *Wenatchee World.* 22 April 1971: p. 4
[73] CVCH Grant: 18.

space. The Project enlisted local doctors to work in the night clinics. Mary Murphy Hall, a former residence hall for nursing students in Wenatchee, became the first real home for the night clinics. Short on funding and facilities, the Project used any community resources that it could to accomplish its mission.

Federal Government Aid to Migrants in the 1960s and 1970s

While certain Wenatchee residents worked hard to provide health care to poor agricultural workers who remained so necessary to the area's economy, the Migrant Health Project relied heavily on grants from the federal government. Were it not for increases in federal appropriations for migrant and community health centers, the Project could not function. However, the federal aid that proved so critical to the success of the Project was slow to develop.

Prior to the September 25, 1962, passage of the Migrant Health Act, conditions for farmworkers went almost unregulated by federal law. The Act, signed by President John F. Kennedy, authorized the delivery of primary and supplemental health services to farmworkers. A National Advisory Council on Migrant Health report explained that "the Migrant Health Act was devised to make health care services accessible to migrant farmworkers and their families by helping states and local communities adapt their existing health care system to meet the unique needs of this population."[74] Federal organizers hoped that contributed funds from local government and voluntary sources would supplement the small initial appropriation of $3 million. Helen Johnston summarizes:

> The group [participants at an interstate migratory labor meeting called by Washington Governor Albert Rosselini in 1960] rejected the concept of a federally financed and operated health program treating migrants as a group of federal beneficiaries. Instead they believed that the primary responsibility rested with the community where migrants were employed and the role of the federal

[74] "Losing Ground," 35.

agency was to help through the provision of special project grants and supporting consultation, information, and other services.[75]

In Wenatchee, this vision of community leadership materialized as local residents helped to fund and administer the migrant health center.

The federal Migrant Health Program's first year saw administrators approve 52 organizations for support. Early on, the assistance remained limited. A 1967 report by the Senate Subcommittee on Migratory Labor concluded that "service coverage remains weak in many of the areas where projects are now receiving grant assistance. Three-fifths of the counties identified as migrant home-base or work areas are still untouched."[76] Federal appropriations for the first ten years continued to be insufficient. Moreover, even as the ceiling for authorized funding increased, actual appropriations lagged behind the authorized amount. In fact, in the first year, Congress appropriated only $750,000 of the authorized $3 million.[77]

In general, government has responded slowly to the needs of migrants, and laws protecting migrants have been difficult to enforce. Johnston notes that since the 1940s, "Many groups have recommended the extension to farmworkers of laws relating to wages and hours, collective bargaining, protection against child labor, regulation of the interstate transportation of workers with overnight way stations provided along routes involving more than one day's travel, and safety and workmen's compensation provisions."[78] While farmworkers now receive many of these protections, laws protecting agricultural workers have always lagged behind those benefiting laborers in other industries. A strong farm lobby has effectively prevented the passage of legislation that would greatly improve the lives of farmworkers. At work here seems to be primarily economic considerations rather than the desire on the part of the farmers to

[75] Johnston, 137.
[76] "Losing Ground," 35.
[77] Johnston, 151.

preserve the poor working conditions of the laborers. In the volatile agricultural industry, where unexpected weather variations can wipe out a full season's crop, growers must keep costs as low as possible. Enforcement can be sporadic, and farmers perceive, rightly or wrongly, that strict adherence to all governmental regulations can cripple their operations. Wenatchee orchardist Jim Wade asserted: "We cannot afford to build housing for all workers at the level mandated by the government. Standards for migrant housing are better than those for motels."[79] Hence, farmers must often face the choice of complying with difficult and underenforced standards or ignoring some to preserve their business.

Early government efforts and the establishment of local health clinics in the 1960s and early 1970s were only the beginning. Over time, federal and local government officials could evaluate these efforts from a policy perspective, while farmworkers learned about and came to trust the migrant and community health centers. The late 1970s and 1980s were a tumultuous time for migrant health at the federal level and at the local level in Wenatchee as the government forced health centers to improve efficiency by withdrawing funding from those that did not comply with federal guidelines and regulations.

[78] Johnston, 112.
[79] Wade interview, February 2001.

4. CVCH from the Late 1970s through the 1980s

It took many years for the North Central Washington Migrant Health Project to become a respected, well-known, efficient, and necessary component of Wenatchee's medical community. Farmworkers first had to become aware of and comfortable with the services provided by the clinic. Correspondingly, those who operated the clinic had to work out the Project administration problems, primarily involving funding and community relations. Despite its tumultuous beginnings, the end of the 1980s saw the Project's achieving a good measure of acceptance in the community.

Turmoil of the Late 1970s

Wenatchee World newspaper articles from the late 1970s report that several problems plagued the Project. Most of these surfaced in 1977. The newspaper notes that migrant families complained about delays and humiliation at the Project's Wenatchee site when they sought help. This prompted some migrants to pay extra money to visit private physicians. Those who could not afford this had no choice but to face degradation at the clinic or to seek no care at all.

Internal fighting, firings, and resignations at the Project caused delays in treating patients.[80] In 1976, the Project's physician, Dr. Raymond Bunker, resigned. Despite a year of searching, by the summer of 1978 the Project remained unable to find a replacement. Without its own physician, the Project had to settle for a visiting doctor from Seattle (a 2 1/2 hour drive away) working at the clinic once a week. On days when the Seattle-based physician was not present, migrants who entered the clinic needing urgent care were referred to local doctors. The Project paid for these referrals, but this resulted in a major financial drain. Critics likewise

[80] *Wenatchee World.* 28 June 1977: p. 3.

claimed that the Project devoted too much money to administration and not enough to medical care. They pointed out that, in 1977, 17 of 22 employees were administrators, receptionists, secretaries, and outreach workers (who traveled around to advise migrants about the Project).[81]

Facing an annual influx of approximately 17,000 migrant agricultural workers, lacking medical personnel, and weathering quarrels between medical staff and non-medical administrators, the Migrant Health Project was in poor shape.[82] The disarray of the Wenatchee Project prompted Okanogan County to request federal funds for its own migrant health project. Okanogan received these funds and broke away from North Central Washington Migrant Health. Grant County tried to break away as well, but it did not receive funding and therefore had to remain affiliated with Wenatchee.

The large migration of farmworkers posed a further problem for the community. County health officials expressed a fear that the lack of a complete screening and treatment program made diseases carried by migrants a threat to other migrants, their families, other agricultural workers, and the rest of the community's population.[83] Summing up the Project's many problems, in 1977 Wenatchee's Dr. Charles Connor declared: "There's been a lot of criticism about how [the Project] operates. The thing really isn't working."[84]

In the past, however, Project directors had demonstrated a willingness to change the operations to adapt to the community's health needs. For example, in 1973, the Project's policy board extended Migrant Health's medical services to cover processing and packing plant employees who derived most of their annual income from seasonal farmwork. In short, the board recognized the needs of the growing community of seasonal farmworkers in the

[81] *Wenatchee World.* 28 June 1977: p. 4.
[82] *Wenatchee World.* 29 June 1977: p. 2.
[83] Ibid: p. 1.
[84] *Wenatchee World.* 30 June 1977: p. 10.

Wenatchee Valley.[85] That ability to adapt to changing circumstances would prove critical in 1977, when the Project made a key change that would reverse its downward spiral.

Migrant Health under Castañeda

In 1977, the Migrant Health Project hired Guillermo Castañeda as executive director. Castañeda had managed the Toppenish Migrant Health Clinic for three years before moving to Wenatchee. He arrived to find a troubled North Central Washington Migrant Health Project. The lack of a medical staff had led to delays in treating migrants or referring them to other medical facilities.[86] Therefore, organizing a medical staff so that low-income individuals could be treated at Project facilities became one of Castañeda's first objectives. He developed other goals as well. Castañeda sought to put more outreach workers into the fields to talk to the farmworkers to find out their needs and concerns. These people explained the services available at the clinics and sometimes gave preliminary health screenings right in the fields.[87] He also met with Health District officials to eliminate any duplication of services offered in the Wenatchee Valley or Moses Lake.

Soon after his arrival, Castañeda began making changes that improved the Migrant Health Project. He arranged for a visiting doctor from nearby Cle Elum to come to Wenatchee three times a week and another from the University of Washington to come once per week. This allowed Migrant Health to care for more patients itself. The agency completely pulled out of Okanogan County, leaving migrant care in that area to its new federally funded program. This saved money for the Wenatchee and Moses Lake clinics. Later, Castañeda hired Dr. Joe Sandoval, a former migrant worker, as the new full-time Project physician. This enabled the

[85] *Wenatchee World.* 20 May 1973: p. 3.
[86] Ibid.

Project to meet the needs of the ever-increasing number of migrant families who chose to remain in North Central Washington to do pruning and other off-season orchard work. With these changes, the number of clients at the Project's clinic increased by 50 percent between 1977 and 1978.[88] Aid for seasonal farmworkers meshed with Castañeda's goal to provide care for the rural poor as well as for migrants. Finally, Castañeda worked with the County Health Departments and local physicians, who had criticized the Project in the past, to improve relations. Nevertheless, Castañeda acknowledged that "we still have a lot of work to do in that area."[89]

During these years, the Migrant Health Project received funding from several different sources. In 1979, approximately half of the budget, $579,000, came from the federal department of Health, Education, and Welfare (the precursor to Health and Human Services). Federal funding also provided for 10 to 15 CETA (Comprehensive Employment and Training Act) employees, some VISTA (Volunteers in Service to America) workers, and some physicians from the National Health Services Corps, a program used to encourage doctors to work in migrant and community health centers by subsidizing their medical education. State and local organizations also contributed. The Washington State Department of Social and Health Services provided $25,000 for the Women, Infants, and Children (WIC) nutritional program. The State contributed additional funds, including $23,000 to set up a summer migrant day-care facility in nearby Cashmere. Finally, the clinic received about $71,000 in direct payments from patients who could afford to pay for their care.[90]

The late 1970s saw Hispanic migrants continue to pour into the area, with many electing to stay permanently. By the spring of 1979, the clinic served 25 to 30 patients per day, a difficult

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[87] *Wenatchee World.* 23 August 1977: p. 16.
[88] *Wenatchee World.* 15 March 1978: p. 6.
[89] Ibid.
[90] *Wenatchee World.* 23 November 1978: p. 2

task given its inadequate facilities and only three medical personnel—one full-time physician and two nurse practitioners. As more people, both migrants and orchardists, learned about the clinic, the numbers of patients steadily increased. Castañeda accurately foresaw the continued increase in patients, drawn especially from the growing numbers of seasonal workers who maintained a residence in Wenatchee full-time. In March of 1979 Castañeda noted, "We served more patients this winter than we had in the peak of the season last year. We're expecting even more this season."[91] At the end of 1979, Castañeda stepped down as executive director after three years of service. In 1980, the board replaced him with Jim Tiffany, one of the Project's founders in 1972 and the man who would lead the Project through the tumultuous early years of the 1980s.

Government Cutbacks in the 1980s

In his five years as executive director, Tiffany encountered many obstacles. Most of these dealt with funding. The scaling back of welfare programs that began under Jimmy Carter intensified during the Reagan years. When Reagan took office in 1981, high interest rates, a sustained period of inflation, and heavy unemployment plagued the country. To revive the economy, Reagan's advisors planned three steps: a 10 percent tax reduction, a federal hiring freeze, and eligibility tightening in several health and welfare programs, including food stamps and Medicaid.[92] Reagan's efforts to cap welfare costs achieved their goal; adjusted for inflation, spending for welfare programs climbed no higher in fiscal 1984 than in 1980 and, excluding the rapidly rising cost of Medicaid, sunk 5 percent lower.[93] The Migrant Health Program suffered from these cuts. In the 1970's, its budget grew 284 percent, from $14 million to $39.7 million.

[91] *Wenatchee World.* 27 March 1979: p. 3.
[92] "Awaiting Reagan's Economic Medicine," *Industry Week* (January 12, 1981): 17.

Under Reagan in the 1980s, the budget increased by only 5.5 percent, from $43.223 million to $45.6 million.[94] In his 1987 book, *The Mean Season*, Fred Block explains the rationale for welfare cuts: "Over the last decade, the welfare state has become the target of a concerted ideological attack. From the expanding network of conservative think tanks and foundations on up to the president himself, the same themes are reiterated: that social welfare measures are a drag on the economy, an incentive to immorality, and a cruel hoax on the needy themselves."[95] The measures enacted by the Reagan administration greatly impacted Migrant Health. They made it increasingly difficult for migrants, who already had problems qualifying for federal welfare programs even before the tightening of eligibility standards.

Responding to government pressure to decrease costs, Tiffany immediately set to work reducing the Project's budget. He eliminated $250,000 from the $1.2 million 1980 fiscal budget.[96] At the same time as the budget cuts, the board actually increased the maximum subsidy for patients from 75 percent to 90 percent, thereby decreasing the financial burden on the patients, while forcing Migrant Health to scavenge for funds. These changes earned the Migrant Health Project high marks from government agencies.

The budget reduction did not solve all the agency's problems. In the spring of 1981, for reasons that he refused to make public, Tiffany terminated Wenatchee's medical director, Dr. Bruce Tracy. This drew the ire of Tracy and the Wenatchee medical community. Moreover, Tiffany could not afford to hire another physician. The Project saw too few patients to receive federal funding for a second staff physician: the Project treated 650 patients monthly, while federal regulations required a minimum of 875 per month in order to garner a government

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[93] "Why There's No Welfare Fat Left to Trim," *Business Week* (March 26, 1984): 81.
[94] Migrant Health Program budget information obtained from Bureau of Primary Health Care employee Helen Kavanagh, May, 2001.

subsidy for two doctors.[97] This left the Project with one physician to serve each month's 650 patients, 97 percent of whom qualified as low-income and 85 percent of whom had no welfare or insurance.[98]

Funding problems worried Project directors as they entered 1983. Tiffany expected a 12 to 50 percent funding cut from the federal Public Health Service and the state Department of Social and Health Services due to federal and state budget trimming.[99] Additionally, Grant County doctors and dentists protested the continued funding of North Central Washington Migrant Health in Wenatchee and Moses Lake. As reasons for their objection, they cited lax administration, waste of tax monies, and competition with private physicians for patients.[100] Tiffany countered these accusations, noting that even though the Project may compete with private health care facilities, the government funds paid for the health care of people who would otherwise not receive care at all.

Funding cuts forced project administrators to make choices about what types of care to emphasize. According to the *Wenatchee World*, "The clinics spent 8 percent more in 1982 than 1981 on primary medical care but spent 25 percent less on nutrition and preventive care and 36 percent less on social services and outreach work."[101] Tiffany commented, "At a time of diminishing federal resources, we have maintained our commitment to primary health services, while reluctantly reducing our efforts in the areas of prevention, education and social services."[102] As government funds decreased, the Project turned to requesting more money from

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[95] Fred Block and others, eds., *The Mean Season: The Attack on the Welfare State* (New York: Pantheon Books, 1987), ix.
[96] *Wenatchee World.* 19 March 1981: p. 2
[97] *Wenatchee World.* 12 May 1981.
[98] Minutes from Membership Meeting, Chelan-Douglas County Medical Society, 2 March 1982: p. 3.
[99] *Wenatchee World.* 11 December 1981: p. 2.
[100] Ibid.
[101] *Wenatchee World.* 10 February 1983: p. 14.
[102] Ibid.

patients. With a 1982 federal grant of $511,669 that was 26 percent smaller than the previous year's grant, the Project adjusted its sliding scale fee plan and increased the fees collected from clinic users from 15 percent of the total bill to 83 percent.[103]

The support that the Project eventually gained from the Chelan-Douglas Medical Society, which had criticized North Central Washington Migrant Health in the past, proved crucial to the continuation of the Project. Throughout his term as director, Tiffany worked hard to improve relations with local physicians. The greatest threat to this relationship, and to the continuation of the Project, occurred over the issue of competition. The government pressed Migrant Health to be competitive by charging patients more money and serving more than just migrants and the very poor. In fact, as the *Wenatchee World* reported, the "Central Office [of the Public Health Service's Region 10, based in Seattle] was not simply encouraging Centers to be competitive, but was actually making funds available to selected CHCs [Community Health Centers] to 'improve their competitive position.'"[104] However, Project employees believed competition directly conflicted with the founding principles of migrant and community health centers. Tiffany asserted, "We do not exist to maximize profits at the expense of local private providers, on whom our patients must depend for referral consultations and follow-up care."[105] Similarly, the Project's Board members felt that "cooperation, not competition, was essential for good patient care in our community."[106] Due to budget cuts, the Project at this time depended on the cooperation of local physicians, and Tiffany held that competition would damage this relationship. In his 1985 letter to the Northwest Regional Primary Care association, he recounted:

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[103] *Wenatchee World.* 10 February 1983: p. 14.
[104] Jim Tiffany, Letter to Jayne Leet, North Central Washington Migrant Health Project, 30 October 1985.
[105] Ibid.
[106] Ibid.

> When I became Executive Director here in 1980, many of our patients needing specialty consultations were either doing without, going to the Emergency Room, or making the 150-mile trip to Seattle. The local Medical Society was extremely antagonistic, and local physicians were not seeing our patients. At this time we have local physicians on our Board of Directors, we enjoy the enthusiastic support of the Medical Society, and our patients get seen locally. Any talk of "competition" would destroy the balance we have worked hard to achieve here.[107]

Tiffany explained that local physicians opposed governmental funding for a competing health center on a philosophical level.[108] Wenatchee physician and former Migrant Health Board member Marc Shipman agreed:

> Here in Wenatchee traditionally and all throughout the years all the doctors kind of do their part and take care of welfare patients and regular patients. Everybody here shoulders their responsibility. Now when an agency comes along and says we are federally funded and we'll take care of this segment of society, you can understand the medical community looking a bit worried about a federally funded agency who's going to take over our patients. What's going to stop that from continuing to grow?[109]

Physicians objected to the 1981 switch of Migrant Health from a free clinic to one that charged users with a sliding fee scale. They worried that government funding for farmworker health care could transform into a federally subsidized national health care system. However, Tiffany's hard work assuring local physicians that the Project would not compete with but rather would supplement their efforts earned the support of the Chelan-Douglas Medical Society. In 1982, the Society drafted a letter of support for Migrant Health:

> We feel that the project is a necessary part of our community health system. We do not feel that it is a competition to the private sector, but rather is a mechanism whereby those migrants in our area, and less fortunate among our non-migrant population, can receive necessary health care by competent providers. It would be difficult for those of us in the private sector to absorb the patient care responsibilities currently carried out by the Community Health Center... The Wenatchee Community Health Center, then, is felt to be a necessary and efficient

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[107] Tiffany letter to Leet.
[108] Jim Tiffany, former Migrant Health Project Executive Director, personal interview by author, January 2001.
[109] Shipman interview, January 2001.

part of our health care scheme, and we suggest that they deserve continued monetary support from governmental agencies at least at current levels.[110]

From 1983 to 1985, the regional branch of the Department of Health and Human Services (HHS) heavily scrutinized North Central Washington Migrant Health. Representatives of Region 10 of HHS reviewed it dozens of times. While none of these investigations uncovered major problems, Migrant Health received numerous threats that its funding would face cuts and the Project eliminated. At one point, Region 10 placed Migrant Health on "Exceptional Grantee" status, the last step before defunding, and searched for other Health Centers to take over the Project's grant. In dire straits, the Project publicized the problems that it was experiencing with the government. The outpouring of community support for the Project proved a key factor in pressuring the government to continue funding. Despite all the conflicts and threats, the Project never lost funding, and it continued to grow throughout the difficult years of the 1980s.

[110] Letter of support for Wenatchee Community Health Project, Chelan-Douglas County Medical Society, 2 November 1982.

5. CVCH in the 1990s

Since the late 1980s, many positive changes have occurred at Columbia Valley Community Health (CVCH), the name adopted in 1990 by the Board of Directors of the North Central Washington Migrant Health Project. CVCH hired more physicians, instituted new programs, and added on-site dental services. At the same time, the Hispanic population of the Wenatchee Valley has expanded rapidly in the past ten years. Throughout, CVCH has continued to focus on care for underserved farmworkers, while attempting to reach out to other low-income members of the community as well. The Center's mission statement (adopted in 1994) reflects this commitment: "It is the mission of Columbia Valley Community Health to protect, improve, and promote the quality of life of all human beings by providing the highest quality medical, dental, nutrition, counseling, and related services possible, especially to those who are most vulnerable or can least afford such services."

Community Demographics and Target Population

Currently, Hispanics comprise a much larger proportion of the population of Wenatchee than they did in the 1960s and 1970s. A great number of these Hispanics are migrant and seasonal farmworkers. Of the 93,000 people in Chelan and Douglas Counties, 80 percent are white, 16 percent (15,200) are Hispanic, and 3 percent are American Indian, Alaskan Natives, Asian/Pacific, and black.[111] This population data does not include a total of 48,110 migrant farmworkers in the two counties, of which 95 percent are Hispanic. Including these migrants brings the overall Hispanic population to 45 percent.[112] Indicative of the large growth of the region's population and its increasingly Hispanic character, since 1990 the overall population of

[111] CVCH Grant.

Chelan and Douglas Counties has increased by about 32 percent, while the Hispanic population has grown by 75 percent in the last five years alone.[113]

The poor predominate among this expanding population. Those below the poverty level in 1999 numbered 15.3 percent.[114] Amazingly, migrants below the poverty level totaled 93 percent. Including them raises the number of officially poor within Chelan and Douglas counties to 54 percent. Although fruit-related employment, unlike much agricultural work done by Hispanics in other areas, can take place year-round—fruit work includes plowing, pruning, irrigating, picking, and packing—unemployment levels still fluctuate widely. Unemployment in Chelan and Douglas Counties oscillates from a low of 5.5 percent during the harvest to 11.1 percent in the off-season. The poverty of the region results in a lack of financing for medical care among the poor. According to the Department of Social and Health Services, in 1998, 14.8 percent of the Chelan-Douglas population (15,091) received Medicaid. Additionally, 26 percent went uninsured and only 35 percent had private insurance.

CVCH works hard to serve the area's impoverished citizens. Based on 1998 UDS figures, CVCH administers to an 89 percent Hispanic and 11 percent white patient population. The significance of this statistic becomes striking when one recalls that whites outnumber Hispanics in the service area. Of the patients, 73 percent fell below the 100 percent poverty level, compared to 15.3 percent in the community at large, and 98.7 percent were at or below the 200 percent poverty level. Finally, 47 percent of CVCH's patients receive Medicaid, 39 percent come uninsured, and only 8 percent have private insurance.

CVCH serves a relatively small portion of the migrant and seasonal farmworker population. According to the 2000-2001 grant proposal, about 3 percent (1,686) of the 48,110

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[112] CVCH Grant.
[113] Ibid.

migrant farmworkers and 4 percent (3,503) of the 75,919 seasonal farmworkers use the Center's services each year. This does not mean that less than 5 percent of these people have access to the services. It simply indicates that a relatively small number become sick, need medical attention, and come to the Center for care. The grant explains the health problems experienced by those patients who do use CVCH:

> Through experience our physicians have found that the problems and need that bring families to the clinic are often the result of social "dis-ease." Issues related to social condition, poverty and low education are a major factor in the well being of our families. Hispanic mothers comprise 30-35% of the births in our counties; the average education level of these mothers is 7.6 years. Infectious disease, hypertension, diabetes, pesticide exposure, dental disease, behavioral health problems, and work related injuries are only some of the health issues faced by our clientele.[115]

As noted, barriers often limit the care received by poor agricultural workers. These limitations vary from region to region. In Wenatchee, geography constitutes a major barrier. About 40 percent of the service area's population live outside of the Greater Wenatchee Area—approximately 25 to 60 miles from the clinic site.[116] This makes accessing CVCH's clinic services difficult for many poor workers who lack the time and transportation to visit the clinic.

Clinic Structure and Community Relations

During the Clinton presidency, funding for welfare programs that benefited Hispanics increased. From 1992 to 2001, under the leadership of Clinton, the budget for the Migrant Health Program, which had increased moderately under President Bush, rose by 55 percent, from $57.4 million to $89 million. Greater government efforts to help Hispanics likely played a role in the 1996 election in which Latino support for Clinton rose to 72 percent from 60 percent in

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[114] CVCH Grant.
[115] Ibid.
[116] Ibid.

1992.[117] Armed with increased government funding beginning in the 1990s, CVCH now operates with seven full-time physicians, two physician assistants, and a nurse practitioner. Due in large part to the cooperation of these medical personnel and other community health resources, the state of farmworkers' health in the Wenatchee Valley has improved. Asked to generalize about the state of health of the average migrant or seasonal farmworker seen at CVCH, Medical Director Malcolm Butler responded:

> The young people who migrate north from Mexico are the best and the brightest. Like all migrants throughout time, they are the ones who dream of a better life and have the ambition to go out and get it.... Now, having said that, we do see the ravages of poverty, mostly alcohol abuse, depression, and squalor. I have never seen a malnourished child. I have seen a few malnourished alcoholics. We see very few pesticide exposures, or industrial accidents. Mostly we see healthy workers who live a long way away from home, are paranoid about the INS, and suffer from a lot of depression, anxiety, and loneliness.[118]

Hence, from Butler's portrayal, it appears that the health of farmworkers currently in the CVCH service area is significantly better than that of agricultural workers in other areas.

Much of the success of CVCH stems from carefully cultivated relationships with local agencies that provide services needed by the Center's patients. CVCH maintains formal and informal agreements with agencies including Children and Family Services, Wenatchee Food Bank, The Salvation Army, Catholic Family Services, The Center for Alcohol and Drug Treatment, Migrant Headstart, and a Farmer's Market that accepts WIC vouchers. Additionally, CVCH sustains a strong relationship with Central Washington Hospital, a large health center in Wenatchee, enabling its physicians to admit patients at the hospital for care beyond the scope of that offered at CVCH. Finally, CVCH works alongside the Chelan-Douglas Health District in improving public health.

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[117] Dana Milbank, "The Deputy," *The New Republic* (July 20 & 27): 11.
[118] Malcolm Butler, M.D., Columbia Valley Community Health Medical Director, personal interview by author, January 2001.

Through these relationships, it is evident that CVCH, known as "La Clinica Chiquita" by its Hispanic patients, devotes itself to helping its patients in any possible way, both in and out of the Center. For this reason and for its bilingual and culturally sensitive services, patients like CVCH. In fact, many of its patients can afford to go elsewhere but prefer CVCH. In describing why patients choose CVCH, Dr. Butler explained:

> They come for all sorts of reasons. Many come because they do not have access anywhere else. Many (those with Medicaid) can choose to go elsewhere but continue to utilize our clinic (60 percent of our patients have Medicaid). I suspect that they stick with us because we are bilingual/bicultural, and respect them in a very personal way. Some people come to us because they are mad at the other clinics in town who refused to see them when they fell on hard times, and they found that we are willing to see them regardless of their financial status. We have worked hard to make the clinic a dignified modern facility where anyone can feel comfortable. We are now competing successfully for insured clients, even though they have almost unlimited options. I hope that regardless of why people initially discovered us, they stick with us because we care, we practice top-flight medicine, and we care more about our relationship with them than about the type of car they drive.[119]

Hence, the Center has become well respected throughout the community, and agencies and employers in Chelan and Douglas Counties often refer underserved citizens to CVCH.

Community Support

As part of the grant application process, the Public Health Service requires health centers to submit letters of support. CVCH had no trouble collecting letters from noteworthy individuals, such as State Representative Linda Evans Parlette, Migrant Health State Supervisor Mike Taylor, Central Washington Hospital's John T. Evans, and Department of Social and Health Services administrator John F. Lein. These letters acknowledged different aspects of CVCH that contribute to the Health Center's success, including cultural understanding, cooperation, and its mission to care for the underserved. In her letter, the Chelan-Douglas Health

District's Pat Loddewig commended CVCH for its cooperation with the district and the vital role CVCH serves: "Your clinic has been cooperative in meeting the needs of our clients for primary care. We have found your providers to be helpful in meeting the primary care needs of our clients....Columbia Valley Community Health meets a critical need within our community by providing culturally sensitive health services to low-income families."[120] State supervisor Taylor agreed, noting the vital importance of CVCH to a region characterized by an "increasing population of low income migrant families."[121] Central Washington Hospital's Evans likewise lauded CVCH:

> As health care reform has become a reality in Washington State, your physicians have joined with others in organizing the community and establishing the relationships necessary to pass the benefits of reform on to the citizens we serve. You have participated in a way that reflects your personal commitment to the health of our independent physicians and hospital institution.... Community citizens would simply not be served, and those served not as well, without your organization and its focus on patient need.[122]

Jim Tiffany, the former executive director of the Migrant Health Project and current publisher of the Wenatchee-based Spanish newspaper *El Mundo*, wrote that the readers of the paper uniformly appreciate the services offered by the Health Center. Finally, John Lein's letter touched on the two basic themes which underlie CVCH's success, need and cooperation. He wrote: "CVCH is important because yours is the only medical provider that accepts clients regardless of their ability to pay. Many individuals would be without basic and necessary health services without your organization.... The relationship between our agencies is healthy. We have experienced a sense of cooperation and partnership for many years."[123] Since its turbulent

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[119] Malcolm Butler, M.D. interview.
[120] CVCH Grant.
[121] Ibid.
[122] Ibid.
[123] Ibid.

early years and the funding crunch of the 1980s, CVCH has improved immensely both in the services it offers and in the support it receives from the community.

Recent Development and Flores's Legacy

On February 28, 2001, Ben Flores, the CVCH executive director for the past nine years, resigned to take over as chief of the Migrant Health Branch of the Bureau of Primary Care (part of the department of HHS) in Bethesda, Maryland. In his new position, Flores will oversee 125 migrant health programs nationwide, administering $70 million in grants for health care services to more than 500,000 migrant farmworkers and their families.[124] Prior to taking over in Wenatchee, Flores earned a medical degree in Mexico City and a master's degree in public health administration from Loma Linda University in southern California. Flores proceeded to head community health clinics in Texas and California for nearly ten years before coming to CVCH.

Employees at CVCH and citizens throughout the community expressed sorrow at losing Flores, while praising his accomplishments. The *Wenatchee World* quoted Dr. Butler, the medical director: "'I think Ben has brought a great deal of stability to the organization and a great deal of dignity to the organization, and also to the clients we serve.' Though sorry to lose him, Butler said, 'we're very excited. It's a great honor for him to assume a post like this. It's also a great honor for us.'"[125] During Flores's term as executive director, CVCH's staff of doctors, dentists, physician assistants, and nurse practitioners grew from six to 14, while its budget expanded from $2.5 million to more than $6.5 million. CVCH used this money to serve 14,500 people in 2000. Flores's most visible accomplishment remains the 1991 consolidation of

[124] *Wenatchee World.* 28 February 2001.
[125] Ibid.

medical, dental, pharmacy, X-ray, lab, and administrative services into one 40,000-square-foot facility which Flores purchased from a private clinic in Wenatchee. Associates noted that the facility, which differs markedly from other community health centers, which often occupy rented, run-down buildings, aided Flores in fostering "the professionalism that has helped to attract and keep quality staff."[126] Flores played a key role in improving CVCH to its present state and setting it in a good position to prosper in the future. Doug Head, president of the CVCH board of directors, stated, "If we have to lose Ben to a national-level position, this is a good time for it, the organization has never been stronger in its 30-year history."[127]

The promotion of Flores from Wenatchee's CVCH to the national position heading the Migrant Branch of the Bureau of Primary Health Care demonstrates the connections between federal and local efforts in migrant and community health in the United States. Flores will use his practical experience running health centers in Texas, California, and Washington to improve federal undertakings to better health care for the underserved. This close relationship between federal and local efforts has played a major role in past attempts to improve care and will continue to do so in the future.

[126] *Wenatchee World.* 28 February 2001.
[127] Ibid.

Conclusion

The struggles and successes of Columbia Valley Community Health, together with the federal and local reactions to Mexican immigration, reveal much about the attitudes and beliefs of Americans. Changing opinions about the presence of Hispanics in the Wenatchee Valley, ranging from early hostility to more recent acceptance, demonstrate the capacity of Americans to accommodate individuals hailing from foreign cultures. Speaking generally about CVCH, Jim Tiffany observed, "The history of our health center shows the maturing of a community in terms of diversity.... It was a difficult adjustment that North Central Washington went through and I think it is the same kind of adjustment that any community goes through with [the coming of] a new and different group."[128] Tiffany noted that the conservative Republican character of Eastern Washington makes residents apprehensive about government programs targeted toward poor Hispanics. The demographic and cultural changes beginning in the 1960s contributed to the general reluctance to support government welfare and prompted some to write letters to the newspapers charging Mexicans with cheating the system by getting free health care. Several letters angrily called for Hispanics to return to Mexico. However, at present, according to Tiffany, "the community has matured; it has realized that diversity is going to be a part of our national identity." As evidence, Tiffany cited the City of Wenatchee's recent engagement in a major project to set up a social service center for Latino people in South Wenatchee "that would have been absolutely unheard of just ten years ago."[129] This same pattern of initial hostility toward immigrants followed by a later melding of the two converging cultures has manifested itself repeatedly throughout American history.

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[128] Tiffany interview, January 2001.
[129] Ibid.

The challenges faced by the Migrant Health Project in providing health care to farmworkers, ranging from overcoming cultural and language barriers to paying for the medical expenses of the uninsured, reveal the barriers faced by poor migrants. Hispanic agricultural laborers work hard to survive, but aid from the government and from local citizens proves essential. As a result, problems occur due to the typically American reluctance to support government-sponsored social welfare programs, especially those dealing with health care.

Yet CVCH's story teaches that Americans do not oppose all forms of governmental aid for the poor. In time, if federal programs prove both successful and necessary, Americans will rally behind them, motivated by both self-interest and compassion. The migrants' vital role in the economy makes caring for them beneficial for all involved. Coupling compassion of local citizens with funding from the federal government can significantly improve the wretched conditions endured by America's poor. Still, much work remains in the effort to bring the care of all migrants up to a minimally acceptable level.

The future of migrant health care is in flux. The threat of abrogating the Public Health Service's Community and Migrant Health Center program has disappeared. Now, those knowledgeable in the field express the desire for increased federal appropriations. Greater funding will allow for better financed health centers, more extensive migrant health research, portable Medicaid coverage for migrants as they travel from state to state, and an increased emphasis on health care for Hispanics. Yet the government must exercise prudence in its spending. Expenditures at a level perceived by the populace to be excessive may provoke an undesirable backlash. The United States already spends 15 percent of its gross domestic product on health care ($1.4 trillion). Immigrants make up one-fourth of the 45 million uninsured people in the United States. Extending Medicare coverage to uninsured immigrants would require

substantial additional expenditure (a report by the Center for Immigration Studies concluded that funding Medicare coverage for just 7.4 million immigrants would cost $30 billion a year.)[130]

Dr. Butler, the CVCH Medical Director, hopes for a long-term solution: "I think that anyone who has devoted themselves to serving the underserved has to hope that this country will eventually outlaw the inequities in our health care system by moving to a single-payer [plan]. In our circles, there is unanimous acceptance that [this] is the only long-term fix for our dreadful system."[131] A government funded, single-payer plan does not appear imminent in the United States. While nine out of ten Americans believe that the health care system in the U.S. needs reform,[132] entrenched interests, including the American Medical Association and private health insurance providers, coupled with an American government that promotes conflict thereby limiting rapid change, renders the immediate enactment of a national health system in the near future unlikely. Many suggest that such a reform will not occur until the present health system reaches the brink of total collapse. Even though the sought-after single-payer plan is not imminent, recent developments show promise. On March 8, 2001, a major strawberry producer in California signed a contract with the United Farm Workers that, among other provisions, subsidizes the health coverage of farmworkers.[133] Also, the Mexican and U.S. governments are working on a plan to provide binational coverage for Mexican migrants on American soil. This would allow the Mexican government to shoulder a portion of the expense of health care for the millions of uninsured Mexican farmworkers in the United States.[134]

Subsidizing health care for Hispanic migrant workers constitutes just one of the social dilemmas caused by the Latino population in the United States that grew by nearly 60 percent in

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[130] *The Dallas Morning News.* 7 March 2001.
[131] Malcolm Butler, M.D. interview.
[132] Marmor, 671.
[133] *The New York Times.* 9 March 2001.

the past ten years. Many other changes, both positive and negative, will occur as this population continues to grow. To examine the social dynamic at play in the fusion of the traditional American and the Hispanic cultures is to look into the future of the United States. The growing importance of Spanish language and culture in the 1980s and 1990s, discussed by Román de la Campa in the introduction to his book *Magical Urbanism,*[135] will only continue to expand throughout America. While in the past Latinos have remained relatively invisible in the press, in popular culture, and in cultural studies, a thorough examination of America's future necessitates an examination of the effects of Hispanics on the United States. The history of Hispanics in the Pacific Northwest yields clues about the newfound social issues stemming from Latino immigration and the resulting cultural fusion.

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[134] *The Dallas Morning News.* 7 March 2001.
[135] Davis, xvi.

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