Migrant Health Policy: History, Analysis, and Challenge

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Migrant agricultural workers are a vital and often overlooked population whose health can affect that of U.S. inhabitants in general. The nature of the farm worker population, however, places this group at a disadvantage in formation of policy to promote its interests. Following World War II, government agency "infighting" prevented the emergence of a coherent policy for farm worker health. Improvements were made during the socially active 1960s, but these have been eroded as immigrants are increasingly distrusted in U.S. society. This article briefly traces the history of migrant farm worker health policy in the United States, applies a model for policy analysis, reviews farm worker health policy research, and proposes a plan of action to advance health policy for this population.

Migrant farm workers have been harvesting American crops for generations. At first, they were native born: displaced former slaves and sharecroppers doing the work they knew. During the dustbowl years, farmers who had lost their farms looked for work wherever crops were ripening. The domestic labor shortage during World War II (1941 to 1945) prompted the development of the Bracero program in 1943 to import farm workers from Mexico. This program, the result of an agreement between Mexican and U.S. governments, established a guest worker program in which thousands of Mexican workers were brought into the United States at the beginning of each agricultural season and returned to Mexico at the end of the season. Although the Bracero program was terminated in 1964, the majority of U.S. migratory farm worker labor force continues to be foreign born, primarily from Mexico (Mines, Gabbard, & Steirman, 1997). Multiple social, environmental, and access issues undermine the health of this population, and although it is a vital public health and economic concern, farm worker health is often overlooked by practicing nurses and policy makers alike.

Health is important to each individual, and the health of others is a matter of humanitarianism. More pragmatically, it is in the interest of the nation's public health to prevent and treat infectious disease among people who move frequently from one area to another. The health of workers

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who are hand picking, processing, and packing fresh fruits and vegetables consumed in the United States also has the potential to affect consumers' health. From a purely economic motive, healthy workers are more productive, thereby benefiting employers. In spite of these arguments for a strong and inclusive farm worker health policy, this population has lagged behind other disadvantaged groups in securing access to essential health care services.

One reason for this is the fact that to be effective, any approach to migrant health must include social determinants of health, such as housing, work conditions, transportation, sanitation, water supply, and education. Thus, the issues involved are complex and extend beyond the delivery of health services to farm worker populations. This article will review the history of U.S. farm worker health policy, apply a model for analysis, review migrant health policy research to date, and suggest a trajectory for future action to improve this population's health.

FEDERAL LEGISLATION

The nature of the migrant farm worker population places it at a distinct disadvantage when it comes to policy formation to promote its interests. Even when the majority of migrant farm workers were born in the United States, their mobility, poor education, and marginal status precluded the development of a political presence. Historically, until the success of Cesar Chavez and the United Farm Workers in the 1960s and 1970s, farm workers depended on outside groups and individuals to champion their causes. However, this only partially explains the difficulty that has been experienced in the formation of policy for migrant farm workers.

History

Understanding the status of current legislation regarding migrant farm workers requires an historical perspective. During the 1930s, agricultural interests had successfully lobbied to have farm workers specifically excluded from the Fair Labor Standards Act of 1938 (Effland, 1991; Sakala, 1987). During World War II, emergency legislation had been passed to permit the importation of farm labor from Mexico. Once the wartime labor shortage ended, debate emerged between growers, who wanted a ready source of compliant labor, and labor advocates, who opposed importation of foreign workers to increase the workforce and decrease wages. Although the U.S. Department of Labor was given control over farm labor issues in postwar legislative restructuring, the U.S. Department of Agriculture persisted in introducing farm labor legislation. "The critical question for farmworkers as they entered the post-war period was whether farmworker advocates or farm employers would establish control of farm labor issues after the war" (Effland, 1991, p. 11).

During the next few decades, numerous committees and commissions were formed to study migrant laborer issues and make recommendations to the various administrations (see Table 1). Throughout this period, the emergence of a clear policy direction was prevented by the persistent power struggle between the U.S. Department of Agriculture, representing employers, and the U.S. Department of Labor, representing farm workers (Effland, 1991). Attempts at policy change initiated primarily within the executive branch of government aimed at assisting states in solving migrant problems and were incremental in nature.

The Bracero program was pivotal to discussions of migrant farm worker issues after World War II. This binational agreement allowed Mexican workers temporary admission to the United States for the purpose of agricultural work. Studies demonstrated that this virtually unlimited supply of labor drove down the earning potential of domestic farm workers while preventing any hope of organizing to improve their situation (a right denied them in New Deal legislation). Farm worker advocates recognized that economic disenfranchisement was integral to workers' problems and focused a great deal of energy on persuading Congress to eliminate this program. Nevertheless, the Bracero program was not eliminated until 1964, and a similar program importing workers from Mexico and the West Indies (the H2A worker program, named for the type of visa issued to the workers) continues on the East Coast to the present day (Rothenberg, 1998).

TABLE 1: Committees and Commissions Formed to Study Migrant Issues Between World War II and the Emergence of Current Migrant Health Policy

Year	*Initiator*	*Name*	*Recommendations*
1947	President Truman	Federal Interagency Committee	Removal of state residency requirements for health, education, and welfare assistance Federal grants-in-aid to help states in providing those services to migrants Need for increased public awareness of migrant problems to support necessary legislation Education of employers, communities, and migrants to promote more efficient recruitment and smoother integration of migrants into local areas Areas with needs for seasonal agricultural labor should diversify industries to assist in eliminating need for migration
1950	President Truman	President's Commission on Migratory Labor	Low work standards and conditions of employment in agriculture result in dependence on underprivileged at home and abroad to supply work force Jobs offering a decent living might result in domestic workers willing to provide a dependable agricultural labor supply Federal policy has resulted in procuring foreign labor, which has resulted in perpetuation of obsolete and backward conditions Federal role should be as coordinator of efforts by all concerned groups
1953 to 1960	President Eisenhower	Interdepartmental Committee on Migratory Labor	Identified more than 500 studies during past 50 years "There was no need for future study on the total migratory labor problem, but [that] an action program should be instituted at once" (Effland, 1991, p. 61) Established model codes for safe transportation of migrant workers Established model codes for farm labor camp housing standards State migratory labor committees established in 28 states A new set of studies and surveys undertaken to provide more information on migrants and their needs
1966	President Johnson	Task Force on Migratory and Other Farm Workers	Called for expanded research program to determine the nature of the farm labor force and the effects of technological change on that labor force Recommended coverage of farm labor under federal collective bargaining, social security, and unemployment insurance laws Recommended continued funding of education, health, housing, and other social services for migrants Recommended development of a more comprehensive system of service delivery to migrants Recommended improved efficiency in recruitment and employment of interstate migrants

SOURCE: Effland (1991).

Beginning in 1959, the shift began within the United States toward a more liberal, activist point of view. At the same time, the legislative branch of government began to take an interest in migrant issues, and a Senate Subcommittee on Migratory Labor (1959 to 1968) was formed. This congressional subcommittee was highly influential in the legislative success farm worker programs had during the 1960s (Effland, 1991).

Congressional reformers wanted to reduce Mexican immigration, regulate farm labor contractors, and eliminate child labor in the fields. However, they became convinced that it would be easier to provide services for farm workers, especially migrants, than to confront the political difficulties of the agricultural industry (Taylor, Martin, & Fix, 1997). They therefore focused on federally mandated and controlled programs providing such services for farm workers. The first of these was the Migrant Health Act (1962), which provided for grants to states, local governments, and nonprofit agencies for clinics and visiting health services for migrant families (Effland, 1991). The fact that the Migrant Health Act was passed with broad bipartisan support from both Houses of Congress illustrates the change that was taking place in the country as a whole. In 1964, 2 years later, the migrant education and migrant Head Start programs were formed as part of the "war on poverty's" key legislation, the Economic Opportunity Act. These two programs were designed both to provide alternatives to field work for the youngest migrants and to improve the chance they would have the educational background to qualify for other forms of employment when they were older. The Migrant Health, Migrant Education, and Migrant Head Start Acts continue to be the backbone of migrant health policy in the United States today.

Recent Legislation

Other laws since the 1960s have also had a significant impact on the health of migrant farm workers. The Immigration Reform and Control Act of 1986 had one provision in particular that dramatically changed the environment in which migrants live and work: the special agricultural worker legalization program. Based on the premise that about 350,000 people would be eligible, this statute permitted farm workers who could provide evidence of at least 90 days of farm work in the preceding year (1985 to 1986) to legally enter the United States to petition for legal residency. In anticipation of increased border enforcement, this law was designed to provide legal documentation for farm workers who had formed relationships with employers over time, also reducing growers' anxiety over possible labor shortages. Lawmakers were surprised when almost 1.3 million applications were received, thus tripling the number of legalizations performed (Martin & Martin, 1994). Not only was this program vastly more popular than anticipated, but also the new legally documented immigrants then settled permanently in the United States, forming the basis for networks with Mexican towns and promoting further immigration (Martin & Martin, 1994; Taylor et al., 1997).

Worldwide, the existence of networks has been identified as a key element in promoting legal and illegal immigration (Population Reference Bureau, 1996). In addition, there is evidence that the combination of networks and the heightened surveillance at the Mexican border has resulted in undocumented immigrants remaining in the United States once they have successfully made the trip (McDonnell, 1997). The increased numbers of immigrants following the special agricultural worker legalization program again translated into lower wages and poorer working conditions for domestic farm workers (Taylor et al., 1997).

Another recent law that has had dramatic effects on migrant farm workers is the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (or welfare reform) (Taylor et al., 1997). Provisions of this law bar most legally documented noncitizens from receiving food stamps and give individual states discretion to bar legally documented noncitizens from receiving Medicaid. Most documented immigrants are barred from any federal means-tested assistance program for 5 years or until they naturalize. Although migrant farm workers are not mentioned in this law, the implications are staggering. In their home base area, unless there is a designated migrant health center nearby, this population does not have access to the programs intended to form their safety net. The argument can be made that it would be in the best interest of legal resident farm

workers to become citizens, thus providing them with the potential for a voice in government. In reality, language barriers and the networks established following the Immigration Reform and Control Act of 1986 noted previously prevent most farm workers from being able to apply for citizenship. To date, the migrant health program may still provide health care to farmworkers regardless of their citizenship status.

THEORETICAL MODEL

The group theory model of policy analysis posits that groups with common interests gather to press their demands on government. The influence of a group is determined by the number of people involved, the wealth of the group, the overall strength of the group, and its internal cohesion (Dye, 1998). Policy focus can be conceptualized as a fulcrum maintaining balance between opposing groups with different amounts of influence or "weight." Policy shift occurs when the relative influence of the groups changes.

Group theory can be used in the analysis of migrant health policy during the past 50 years. After World War II, farm worker causes were advocated by relatively isolated volunteer and religious organizations and by the Secretary of Labor. Farm workers themselves were not organized and had virtually no influence in the policy arena. Although they initiated commissions and panels to study farm worker issues (see Table 1), neither President Truman nor President Eisenhower intervened to have the recommendations of those panels (such as improving working conditions and establishing minimum labor standards) translated into policy (Effland, 1991). The group opposing progressive farm worker policies was composed of such well-organized and well-funded groups as the National Grange, the American Farm Bureau Federation, the National Canners' Association, and the Western Growers' Association in combination with the Agriculture Department. During this time, policy clearly favored agricultural growers. Figure 1 illustrates the focus of migrant policy during this period.

During the 1960s, however, farm worker advocates increased their influence in several ways. One of the major tactics was to attach migrant worker issues to the Civil Rights Movement. Once

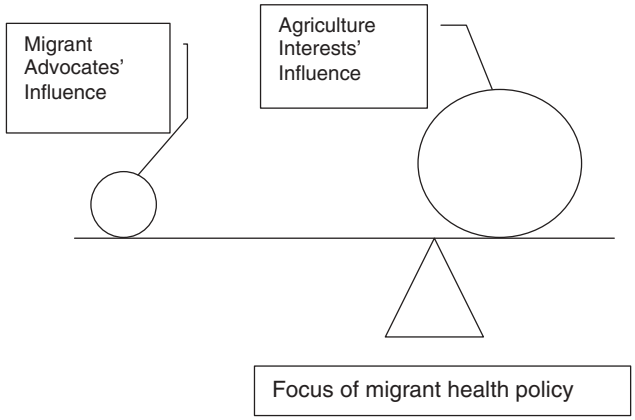

Figure 1: From the 1950s to the Early 1960s, Policy Favored Growers
SOURCE: Dye (1998).

the Bracero program ended, a second contributor to increased influence was the organization of farm laborers into the United Farm Workers by Cesar Chavez. Under Chavez's leadership, the United Farm Workers Union was able to negotiate significant improvements in wages and working conditions, especially in California, in the late 1960s. During this time, the Senate established the Subcommittee on Migratory Labor, and both Presidents John F. Kennedy and Lyndon Baines Johnson pushed farm worker issues legislatively. According to group theory analysis (see Figure 2), it should be no surprise that the policy shift occurred in favor of migrant farm workers.

In recent years, however, especially following the influx of immigrants resulting from the special agricultural worker provision in the Immigration Reform and Control Act (1986), migrant farm workers are increasingly being viewed by the public less as a minority population in need of government protection and more as undocumented immigrants (regardless of their legal status; Shanks, 2001). Many U.S. citizens fear that farm workers are in the United States to collect social benefits and take jobs away from "legitimate" workers, and there is an increasing distrust of immigrants of all kinds. The influence and power of the 1960s has been eroded. Because of an apparent policy shift, migrant workers today are socially regarded as "deviants" or "dependents" (Schneider & Ingram, 1997), and policy has again

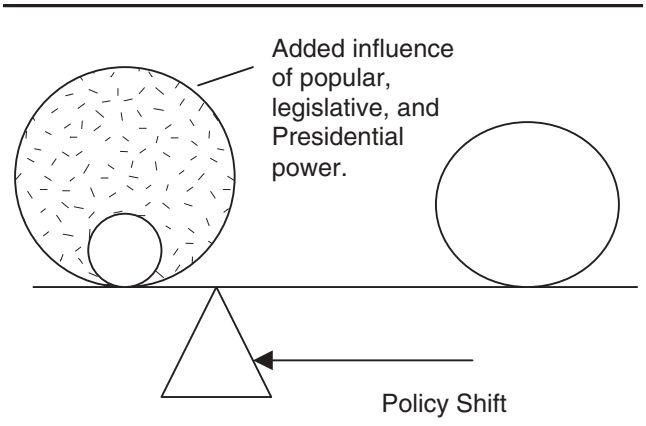

Figure 2: Increased Influence of Farm Worker Advocacy Groups in the Mid 1960s Translated Into Policy Shift
SOURCE: Dye (1998).

realigned itself more with the "family farmer" for whom the public has a great deal of sympathy.

MIGRANT HEALTH POLICY RESEARCH

It must be noted that all research in this area is hindered by the fact that there is no consensus on the total number of migrants working in the United States. This lack of a denominator for statistical analyses is a result of seasonal fluctuations, farm workers' wariness of government agencies (on the part of both documented and undocumented workers; Rust, 1990), and informal hiring practices (Massey, Durand, & Malone, 2002). Furthermore, the definition of migrant farm worker differs by federal program. The migrant health program requires that a family have been migratory for agricultural employment within the past 2 years; migrant education includes the past 5 years. Employment in poultry- or livestock-related jobs qualifies farm workers for migrant education programs but not migrant health programs (Martin & Martin, 1994). Seasonal farm workers are included in some studies but not in others (Rust, 1990), further complicating the issue.

Operating within these limitations, the Bureau of Primary Health Care (1999) reports that migrant and community health centers serve about 600,000 migrant and seasonal farm workers each year (from its overall estimate of 1.5 million migrants and 2.5 million seasonal farm workers). It is believed that the Migrant Health Program may serve only about 13% of its target population due to access issues (Slesinger, 1992).

Access and barriers to care have been the focus of several studies. Direct access issues such as proximity to migrant health centers, transportation, and convenience of hours have been cited (Perilla, Wilson, Wold, & Spencer, 1998; Slesinger, 1992; White-Means, 1992). Whereas migrant health centers are usually located in home base areas and communities where there are high concentrations of migrant farm workers during the season, often, geographic access is difficult. Some crops with short harvests will employ farm workers for only a few weeks per year, making the establishment of a center in that area unfeasible. Paradoxically, although this is a mobile population, most migrants depend on transportation provided by crew leaders or others, which may not be available for individual clinic visits. The absence of specialized services such as dental and eye care at health centers has also been cited as a deterrent (Perilla et al., 1998). Finally, health centers tend to have clinic hours during the day; unless farm workers are too ill to work, the financial incentive to prioritize work over health care is strong.

Lack of health insurance (Bollini & Siem, 1995; White-Means, 1992) and questionable legal status (Gellert, 1993; Guttmacher, 1984; Rust, 1990) have been cited as additional barriers to the use of available health care. With the advent of welfare reform, even legally documented immigrants may believe they are not eligible for services, although clinics funded under migrant health legislation may provide care regardless of legal status.

Some authors have described discrimination, either overt or covert, and language barriers as impediments to migrants' access to health care (McVea, 1997; Slesinger, 1992; Slesinger & Ofstead, 1996; Uniken Venema, Garretsen, & Van Der Mass, 1995). Resentment from permanent community residents, manifesting itself in subtle and blatant ways, is not uncommon (Rothenberg, 1998). When health care providers deal with individuals from different cultures for only a few weeks each year, they are unlikely to become conversant in those cultures. Professional translators may be costly or unavailable in these settings.

The long-term effects of migrant health policy can be difficult to measure because of the transient nature of the population. Migrant workers enter the workforce and "settle out" regularly, so even longitudinal studies would not necessarily evaluate the impact of migrant health policy.

Several authors have studied health status, and findings have consistently shown that the health of migrant workers is poorer than would be expected for the population's age and work level. A widely accepted health indicator, perinatal outcomes, has been reported as poorer than the national average for women attending migrant health centers (Dever, 1991; Rust, 1990).

Despite the "healthy migrant effect," that is, the fact that the population is self-selected for its ability to work (Bollini & Siem, 1995), chronic conditions are common reasons for seeking health care (Dever, 1991) and are often in more advanced stages or poorer control when care is sought (Slesinger, 1992). Furthermore, the ability to manage chronic conditions requiring lifestyle changes involving mealtimes, rest periods, and work hours is severely hampered by the lack of control farm workers have over their daily lives.

Acute conditions such as dermatitis and infections are similarly common (Dever, 1991). Although some infectious disease among migrant farm workers, such as the rubella outbreak in North Carolina in 1997, is the result of the exposure of unimmunized foreign-born populations, much is considered "relocated" communicable disease from countries of origin (Gellert, 1993). Tuberculosis, a significant disease for migrant health workers, is primarily a relocated disease, although farm worker housing conditions would be conducive to the spread of the disease.

Workplace hazards, specifically pesticide exposure and plant-specific illness such as tobacco sickness, are additional threats to the health of migrant farm workers (Dever, 1991; Perilla et al., 1998; Rust, 1990; Slesinger, 1992). Lack of education concerning these dangers and poorly enforced EPA regulations are often cited as responsible.

The impact of the provisions of the Immigration Reform and Control Act of 1986 has been studied with some of the most compelling research on the status of this population. Taylor et al. (1997) built on the earlier work of economists Martin and Martin (1994) when they studied migrant communities in Central California. They indicated that the late 1960s and early 1970s was an era of respectable incomes for farm workers, which was related to the termination of the Bracero program and the bargaining power of Cesar Chavez's United Farm Workers. These authors concluded that the only way to improve the lives of farm workers was to limit immigration at the U.S-Mexico border.

Finally, the impact of the 1996 welfare reform law, which was up for reauthorization in 2002, should be addressed. Based on multiple regression analysis, Taylor et al. (1997) concluded, "Farm employment stimulates immigration into rural towns. Both farm employment and immigration significantly increase poverty. Rising poverty, in turn, increases welfare demands. Controlling for poverty incidence, however, immigrants are significantly less likely than natives to receive welfare income" (p. 36). Passel and Clark (1998), reporting on their research with immigrants in New York State, recorded the taxes paid by documented immigrants (29.1% of income) and undocumented aliens (15.4% of income). Although this study sample was not composed of farm workers, it highlights the issue that taxes are withheld from farm worker paychecks. Few migrants and very few workers with false documents will file for the tax refunds due them. This, therefore, places them in the position of paying taxes and falling below the poverty line but being unable to use programs supported by those taxes.

CONCLUSION

Bollini and Siem (1995) described nations as falling into two categories regarding their policies toward immigrants: those that make special efforts to accommodate and incorporate the new individuals and families and those that believe the newcomers should make use of existing resources to become part of their new country. In many ways, migrant health policy in the United States today reflects this dichotomy as well, except that the country cannot seem to decide how we are to view migrant farm workers. Are they the epitome of the working poor, with working conditions and schedules and cultural and language differences

that need to be accommodated? Are they "human cogs" in the agricultural wheel, easily replaced by others as disadvantaged as they? Are they guests whom we have invited to work at employment we choose not to do and to whom we owe basic livelihood and health services?

Because of the classic standoff between the U.S. Department of Agriculture and the U.S. Department of Labor, no comprehensive policy for this population has been articulated. What is clear, using the group theory of policy analysis, is that farm worker advocates must regain influence and therefore power if they are to positively affect policy for this group. In the 1960s and 1970s, real gains were made when the people of the United States joined together to end social inequities they believed were inconsistent with their views of democracy. Although ordinary citizens have little economic cause for resentment of farm workers, the complacency generated by affluence provides many Americans today little incentive to look toward the greater social good. If we, as a nation, cannot improve the situation of those who feed us because it is the right thing to do, then we must do it out of self-interest. A health conscious middle class should demand conditions that permit healthy farm workers to produce and gather their food.

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