Medical Utilization Patterns of Hispanic Migrant Farmworkers in Wisconsin

DORIS P. SLESINGER, PhD
ELEANOR CAUTLEY, BA

OBTAINING HEALTH DATA ON HIGHLY MOBILE POPULATIONS such as migrant workers is difficult. Some researchers have tried to circumvent the difficulty by examining medical records from migrant or other health clinics (*1*); others have examined the health behavior of workers when they have returned to their home States (*2,3*), where they may not have the problems encountered while migrating. Officials of the National Center for Health Statistics (*4*) and users of the Center's data (*5*) have noted the difficulty of obtaining information on migrant workers through the National Health Interview Survey because of its sample design and the necessity for those surveyed to live in established households. Both sets of authors suggest that in-depth local surveys are the way to address the needs of such small and unusual populations.

We report here the results of a survey of migrant agricultural workers in Wisconsin that revealed their patterns of medical utilization while working in the receiving State. The information presented is based on a representative sample of workers rather than on a sample of medical records. The preventive components and the illness components of medical care are discussed separately because previous research (*6*) has shown that utilization patterns for the two components differ.

We hypothesized that a number of characteristics of migrant workers might influence their use of health care services, namely, age, sex, education, and proficiency in Spanish or English. From previous research on medical utilization, we hypothesized that older, female, and better educated workers would report more use of medical services (*7–9*). In addition, we anticipated that those who spoke English would also be more likely to obtain medical care.

Study Methods

A 10 percent stratified random sample of migrant agricultural workers age 16 or older was surveyed in Wis-

Dr. Slesinger is an associate professor and Ms. Cautley is a research specialist, Department of Rural Sociology, University of Wisconsin-Madison. *The illustrations were drawn by Fernando Hernandez. An earlier version of this paper was presented at the Hispanic Health Services Research Conference in Albuquerque, N.Mex., September 6, 1979.* *The work described was supported by (a) United Migrant Opportunity Services, Inc., Milwaukee, Wis., (b) University of Wisconsin-Extension; (c) the University of Wisconsin-Madison through the College of Agricultural and Life Sciences, Rural Development Act—Title V—funds, the research committee of the Graduate School, the Institute for Research for Poverty, and a Center for Demography and Ecology grant from the Center for Population Research (National Institute for Child Health and Human Development No. HD 058–76); and (d) the Wisconsin Division of Health, Bureau of Community Health.*

Tearsheet requests to Dr. Doris P. Slesinger, Department of Rural Sociology, University of Wisconsin-Madison, 1450 Linden Drive, Madison, Wis. 53706.

consin in the summer of 1978 (*10*). The definition of "migrant worker" used for the survey is one set forth in Wisconsin statutes (ch. 17, laws of 1977):

> . . . any person who temporarily leaves a principal place of residence outside of this state and comes to this state for not more than 10 months in a year to accept seasonal employment in the planting, cultivating, harvesting, handling, drying, packing, packaging, processing, freezing, grading, or storing of fruits and vegetables; in nursery work; in sod farming; or in Christmas tree cultivation or harvesting.

The names of migrant workers were obtained from lists provided by every employer of migrants known to the Job Service of the Bureau of Migrant Services, Wisconsin Department of Industry, Labor, and Human Relations. This agency is required to have a complete registry of all employers who hire migrant workers. To obtain further information about farms that employed small numbers of migrant workers, additional contacts were made with the Job Service's regional area supervisors, who knew the local areas well.

After each employer of migrant workers was contacted, every 10th name was selected from the lists of migrant workers that the employers supplied, beginning with a random start. If an employer had fewer than 10 migrant workers, a special listing sheet was used, containing 10 lines and a preselected random number, so that as names of workers were listed, the sampled person could be identified. The intention was to contact employers at a time when each of them was employing a peak number of workers; however, it was not always possible to follow this procedure because of scheduling problems and limited staff size.

A total of 408 workers were selected, representing about 4,080 migrant workers who were in Wisconsin for the 1978 planting and harvest season. Bilingual (English-Spanish) interviewers were hired and trained by the staff. Interview schedules were printed in both English and Spanish, and the respondent decided in which language the interview should be conducted. Interviewing began in early July and ended the last day of September.

Of the 408 persons selected, interviews were held with 262, resulting in a response rate of 64 percent. Eight of the 408 refused to be interviewed, and 138 moved within the few days between the time their names were selected and the time of the interviews. Some of these workers left Wisconsin in late August so that their children would be in Texas by the first day of the school year; others were missed because the migrant housing camps closed rapidly once harvesting was completed.

Because we knew the places of employment of all 146 workers in the selected sample who were not interviewed, we were able to use a weighting procedure to attain a more complete representation of the selected sample for our analysis than the unweighted number of the 262 workers actually interviewed afforded. The procedure was based on the assumption that the workers not interviewed were similar to those working in the same county who were interviewed. That is, the family and demographic characteristics of workers picking cucumbers in one county whom we were unable to interview would likely be similar to those of other workers in that county whom we did interview. Each sampled worker was classified by the county in which he or she worked, and then each completed interview was weighted by a factor (called a "noninterview adjustment factor") that inflated the number of completed interviews in a county to the total number of workers sampled in that county. This weighting procedure is similar to one that the Bureau of the Census uses in its monthly Current Population Survey, a procedure described in detail in a technical publication on the design and methodology of the Current Population Survey (*11*).

We determined the weighting factor for each county by dividing the number of workers sampled in each county by the number of workers interviewed in that county. The weighting factor was 1.0 in 12 counties, between 1.1 and 2.0 in 12 counties, and between 2.1 and 3.0 in 7 counties.

When we compared the demographic characteristics of the total unweighted sample with the characteristics of the weighted sample, differences in age, sex, education, and language proficiency varied no more than 3 percent. However, 43 percent of the unweighted sample of workers, compared with 51 percent of the weighted sample, were employed in harvesting field crops. This difference was anticipated since many of the missing workers had left the State toward the end of the harvest season, as previously mentioned.

All analyses presented in this paper are based on the weighted data, which we believe better represent the original sample of migrant workers, and therefore also better represent the population of all Wisconsin migrant workers. However, all statistical tests performed are based on the unweighted number of respondents, a procedure that is statistically conservative.

This paper is based on responses from Hispanic migrants only, but they represented 92 percent of the total sample of migrant workers. Thus, the data presented are based on 241 interviews, or a weighted sample of 378 workers. Eighty-one percent of the interviews were conducted in Spanish, 12 percent in English, and 5 percent in both languages; the language used in 2 percent of the interviews was not ascertained.

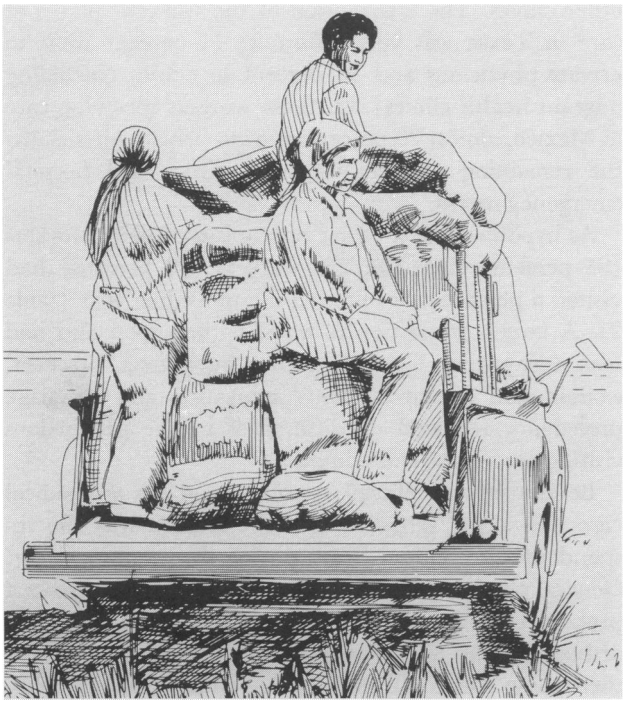
Description of Migrant Workers

Some migrant workers arrived in Wisconsin in early April 1978 and some stayed until December, but the majority arrived in June and July, staying for about 4 months. Early seasonal workers were employed in nurseries and sod farms, but the majority of migrants who worked in the fields harvested various vegetable crops, mainly cucumbers for pickles. Late season fieldwork consisted mainly of cultivating and harvesting Christmas trees. Cannery work reached its peak in August with the canning of peas, corn, green beans, beets, and other vegetables. About half the migrants who came to Wisconsin worked in the fields; the other half, in canneries.

About 60 percent of the workers were male. The workers' ages were fairly evenly distributed among the various age groups, with approximately one-fifth in each of the following categories: 16–19, 20–29, 30–39, 40–49, and 50 or older. The oldest worker interviewed was 67.

About one of five workers came to Wisconsin as a "single" worker, that is, he or she migrated alone—without other family members. Almost three of four single workers were males. On the average, these single workers were older than workers accompanied by family members; 40 percent of the single workers were 50 or older, compared with 15 percent of the workers with families. About two of three workers were married, and about two-thirds of the households included children under 18 years of age.

Equal proportions of men and women worked in canneries, whereas a larger proportion of men were employed in fieldwork. Half of the fieldworkers were under 30 years of age. Cannery workers tended to be older; 29 percent were 50 or older, compared with 13 percent of the fieldworkers.



Education was linked strongly to age; the older the migrant worker, the more likely that he or she had received little formal schooling. Three of 10 Hispanic migrant workers had completed fewer than 5 years of schooling (the conventional definition of functional illiteracy used by the Federal Government). Not one worker 45 or older had completed eighth grade. More than 70 percent of both the men and women had completed only 8 or fewer years of school, a proportion that contrasts sharply with the 30 percent for nonmigrant farm laborers in Wisconsin (*12*).

The workers were asked what language they spoke most often (primary language) and whether they also spoke another language (secondary language). For 90 percent of the Hispanic workers, Spanish was their primary language; only 4 percent identified English as primary. Just over half of the Hispanic workers were able to speak both English and Spanish, whereas 45 percent spoke only Spanish. There is a clear correspondence between age and English proficiency: 83 percent of the workers 16–24 were able to speak English, contrasted with only 24 percent of those 50 or older.

Total family income in 1977, as reported by the workers, ranged from less than $1,000 to more than $15,000. About one of four families had one wage earner, one of four families had two wage earners, and the remaining families had three to nine wage earners. The average family income was just under $6,000, a figure slightly below the 1976 poverty level standards published by the Bureau of the Census (*13*) for the same average family size (5.4 members) with a male head.

About 35 percent of the families had income from wages only; 29 percent had a combination of wages plus Federal transfer payments (for example, unemployment compensation, workmen's compensation, social security, veteran's benefits, or disability payments); 23 percent had income from wages, transfer payments, and loans; and the remainder had income from various other combinations, including public welfare assistance. Wages were the only source of income for a larger proportion of fieldworkers than cannery workers (42 percent versus 29 percent), whereas a larger proportion of cannery workers received wages plus Federal transfer payments (37 percent versus 18 percent).

Results

Perceived health status. Workers were asked to evaluate their health status by answering the following question: In general, would you say that your health is excellent, good, fair, or poor? One of three workers

Table 1. Percentages of migrant workers who perceived their health status as excellent, good, fair, and poor, by age, sex, educational attainment, and language proficiency

Perceived health status	Total workers (N = 378) [1]	Age		Sex		Education [2]		Language [2]	
		Less than 30 (N = 158)	30 and over (N = 220)	Male (N = 228)	Female (N = 150)	Less than 5 years (N = 113)	5 years or more (N = 257)	Spanish only (N = 168)	Spanish + English (N = 202)
Excellent	16.5	25.9	9.8	17.7	14.8	7.7	21.0	8.4	23.2
Good	47.2	51.2	44.2	50.4	42.2	41.5	50.2	45.7	49.8
Fair	33.0	22.9	40.3	29.9	37.7	45.1	26.4	42.3	23.9
Poor	2.8	0.0	4.9	1.2	5.3	4.2	2.4	2.6	3.1
No answer	0.5	0.0	0.8	0.8	0.0	1.5	0.0	1.0	0.0

[1] Weighted number of respondents. [2] Total number of respondents is less than 378 because of missing data.

perceived his or her health to be fair or poor (table 1). If the migrants' perceived health status is compared with that of persons in the 1976 National Health Interview Survey earning annually less than $5,000, it is noteworthy that only 17 percent of the migrants believed that they were in excellent health in contrast to 32 percent of low income persons in the national population (*14*). Also, as shown in table 1, those migrants who were older, who were female, had less education, and who spoke only Spanish considered their health to be worse than others. Two of these variables, educational attainment and language proficiency, reflect the strong correlation of perceived health with age. That is, those least proficient in English and with the lowest educational levels were also the oldest workers.

Respondents were read a list of 24 common medical conditions that have been used in many health surveys and asked if each condition bothered them "very much," "some," or "not at all." Since, on the average, only 2 percent of the migrants mentioned any condition that bothered them "very much," we combined the first two response categories. The 10 conditions that ranked foremost, along with the percentages of workers bothered "very much" or "some" by them, were as follows:

10 medical conditions most frequently mentioned	*Total respondents (N = 378)*	*Males (N = 228)*	*Females (N = 150)*
Headaches	32.5	22.7	47.3
Eye trouble	31.7	23.5	44.1
Backache	26.7	23.9	30.9
Tooth or gum trouble	25.9	21.2	32.9
Nervousness	19.6	11.9	31.4
Irritability	17.6	13.7	23.5
Trouble sleeping	16.1	10.0	25.3
Coughing	14.0	11.6	17.6
Stomach pains	13.6	7.2	23.4
Low spirits	10.5	3.9	20.7

In most health surveys, women report more health problems than men, especially in the area of mental distress. The female migrant workers also consistently regarded themselves as afflicted with troublesome conditions to a greater extent than males.

Medical utilization patterns. Fifty-seven percent of the Hispanic migrants had received medical care in the year before the interview. This proportion is well below the 76 percent reported by persons with family incomes below $5,000 in a national survey (*15a*) and also below the 65 percent reported by Hispanics in five southwestern States (*16*). Of the migrant workers who had received care during the preceding year, 37 percent received that care in Wisconsin, 37 percent in Texas, 15 percent in Mexico, and 11 percent in other places, including Florida.

Of the workers who had received care in Wisconsin, more than half received it from a federally funded migrant health clinic (La Clinica de los Campesinos), one-fifth from private physicians, and one-seventh from other clinics. The distribution of the workers' places of care in Texas was very different: 44 percent went to private physicians and 38 percent to clinics (including migrant health clinics). Of those workers receiving care in Mexico, almost 70 percent went to private physicians; the remaining workers went to clinics and hospital emergency rooms.

As hypothesized, a larger proportion of older workers (64 percent) than younger workers (48 percent) had visited a physician or clinic in the preceding year (table 2). A larger proportion of women than men also had seen a physician. Contrary to our hypotheses, however, examination of the migrants' education and language proficiency revealed no differences in the proportions visiting physicians and clinics.

Besides showing the effects of sex and age on medical care utilization, table 2 shows the reasons why the respondents had obtained care during the preceding year. General physical examinations accounted for the greatest proportion of the physician or clinic visits (21 percent); orthopedic and musculoskeletal problems followed; and then came minor illnesses or infections such as colds,

Table 2. Percentages of migrant workers who had visited a physician or clinic during the preceding year for various reasons, by age and sex

Reason for visit	Total workers (N = 216)	Age		Sex	
		Less than 30 (N = 75)	30 and over (N = 141)	Male (N = 124)	Female (N = 92)
Percentage that visited physician or clinic	57.0	47.5	63.8	53.4	62.4
Probability		< 0.025		Not significant	
Checkup, general examination	20.9	24.1	19.1	18.4	23.5
Orthopedic or musculoskeletal problem	12.5	1.3	18.4	16.8	5.3
Minor illness or infection	8.8	16.0	5.0	8.8	9.6
Skin problem	8.3	8.0	8.5	12.8	2.1
Gastrointestinal or digestive problem	7.9	1.3	11.3	8.0	7.4
Genitourinary or reproductive condition	6.9	10.7	5.0	1.6	13.8
Mental or emotional problem	4.6	5.3	4.3	2.4	7.4
Eye problem	4.2	4.0	4.3	6.4	2.1
Diabetes	3.7	1.3	5.0	0.8	7.4
Cardiovascular problem	3.2	0.0	5.0	4.0	2.1
Respiratory problem	2.8	1.3	3.5	4.0	1.1
Injury	2.8	8.0	0.0	2.4	4.3
Surgery	2.3	6.7	0.0	3.2	1.1
Other	9.7	8.0	10.6	10.4	9.6
No answer	1.4	4.0	0.0	0.0	3.2

NOTE: All percentages are based on weighted numbers of respondents.

skin disorders, and gastrointestinal and digestive conditions. These reasons for visits contrast sharply with those identified in the National Ambulatory Medical Care Survey of office visits (*17*), in which diseases of the respiratory and circulatory system were the second and third most prevalent reasons for visits, after preventive medical procedures and examinations. The frequency with which migrants saw physicians for orthopedic, muscular, and skin conditions was no doubt related to the kind of work they did.

The reasons for seeking care differed sharply by age. Larger proportions of workers under 30 than over 30 reported seeking care for minor illnesses, whereas the older workers were more likely to seek care for orthopedic, gastrointestinal, and digestive problems. Men sought care more often for orthopedic and skin problems, whereas women reported more visits due to genitourinary and reproductive system conditions.

Nine percent of the workers reported spending at least 1 day in the hospital during the preceding year. This percentage varied by sex; 16 percent of the women and 5 percent of the men reported some hospitalization. The reasons most frequently cited by women for staying in the hospital overnight were pregnancy and birth-related conditions. Apart from these conditions, the most frequently cited reason for both men and women was minor surgery, mainly removal of the appendix.

According to calculations by Andersen and associates (*16*), Hispanics are hospitalized at about the same rate as other groups (11 percent per year). The percentage in our study was slightly lower, a difference that may be explained by sampling variation or by the age range of the migrant respondents (few were over 65 years of age and none were under age 16).

Preventive medical care. We investigated three kinds of preventive medical care: a general physical examination when there were no signs of illness, a dental visit, and a vision checkup. Table 3 shows the characteristics of migrant workers who never at any time had these three types of preventive care.

First, and particularly striking, is the relatively large proportion of workers (30 percent) who had never obtained a routine physical examination. Only 28 percent of the migrants had obtained a physical examination within the preceding year, a low percentage compared with the 70 percent reported for the general population of Wisconsin (*18*), but about the same as that reported for a national sample of persons with an elementary school education (*7*).

Only one characteristic, age, was related in the hypothesized direction to this kind of preventive care: a significantly larger proportion of workers under 30 (43 percent) compared with those 30 and older (22 percent) had never had a routine physical examination. Both sex and education were related in the opposite direction to that posed in our hypotheses: higher proportions of women than men and of the better educated workers than the less educated had never received a general physical examination.

Table 3. Percentage of migrant workers who had never used three selected preventive medicine measures, by age, sex, educational attainment, and language proficiency

Measures never used	Total workers (N = 378)[1]	Age		Sex		Education		Language	
		Less than 30 (N = 158)	30 and over (N = 220)	Male (N = 228)	Female (N = 150)	Less than 5 years (N = 113)	5 years or more (N = 257)	Spanish only (N = 168)	Spanish + English (N = 202)
Routine physical examination	30.3	41.8	22.0	24.8	38.6	22.0	33.9	26.7	33.6
Probability[2]		< 0.001		< 0.005		< 0.05		N.S.	
Visit to dentist	24.7	29.2	24.3	32.9	16.3	25.7	26.6	30.7	22.9
Probability[2]		N.S.		< 0.01		< 0.01		N.S.	
Vision check	35.5	41.8	33.1	37.7	35.2	41.0	34.4	44.3	30.5
Probability[2]		N.S.		N.S.		N.S.		< 0.005	

[1] Weighted number of respondents.
[2] Probability is determined from difference of proportions, 1-tailed t-test, based on unweighted numbers.
NOTE: N.S. = not significant. All percentages are based on weighted number of respondents.

Dental care. Table 3 also shows that 25 percent of the workers had never visited a dentist. This proportion is much larger than in other groups. For example, in a national survey, 16 percent of persons in families with incomes less than $5,000 had never seen a dentist (*15b*). About 25 percent of the migrant workers had seen a dentist within the preceding 12 months, as compared with approximately half of Wisconsin residents (*18*) or of a national sample of Americans 17–64 years (*19*). Our survey results are similar to those of Andersen and colleagues (*16*), who noted that 31 percent of the Spanish-heritage population in the Southwest had seen a dentist in the preceding year, compared with about 50 percent of the national population.

Proximity of the migrants' work camp to the Wisconsin migrant dental clinic seemed to influence the migrants' use of dental care in Wisconsin. Twenty-six percent of the workers living in the clinic catchment area received dental care, whereas only 11 percent of those outside the catchment area got care. Of the migrants who did receive dental care in Wisconsin, 70 percent received that care at La Clinica de los Campesinos.

The proportion of men who had never visited a dentist (33 percent) differed significantly from the proportion of women (16 percent); likewise, the proportion of persons who spoke only Spanish who had never visited a dentist (31 percent) differed significantly from the proportion of bilingual persons (23 percent). Both of these relationships were in the hypothesized direction.

Vision care. Thirty-one percent of the migrant workers reported wearing eyeglasses at least some of the time, although a considerable proportion of the sampled workers (36 percent) had never had their vision checked. In a national survey, only 11 percent of persons 3 years and older in families with incomes less than $5,000 had never had an eye examination (*20*). All of the statistics for vision care supported our hypotheses; the only statistically significant difference appeared when language proficiency was analyzed. Forty-four percent of the monolingual Spanish speakers never had a vision check compared with 30 percent of the bilingual Spanish speakers. A greater proportion of workers in the La Clinica de los Campesinos catchment area had received vision checks than migrant workers in outlying areas (64 percent versus 53 percent).

Method of payment. Each respondent was asked, "How do you pay your medical bills here in Wisconsin?" About 23 percent said that they never had received care in Wisconsin. The distribution of methods of payment among the remaining 292 workers was as follows:

Method of payment	*Percent of workers*
Migrant health funds only or migrant health funds plus out of pocket	38.4
Health insurance only or health insurance plus out of pocket	19.5
Medicaid only or Medicaid plus out of pocket	14.4
Out of pocket only	18.5
Other combinations	9.2

The largest segment of migrants (38 percent) used the migrant health clinics for their care, where most of their bills were paid with Federal migrant health funds. Smaller proportions used private health insurance and Medicaid. However, almost one of five workers used no means of paying medical bills except his or her own funds.

Seventy-nine percent mentioned only one method of payment; 20 percent mentioned two methods (with 11

percent of these mentioning the out-of-pocket method); 2 percent mentioned three methods of payment.

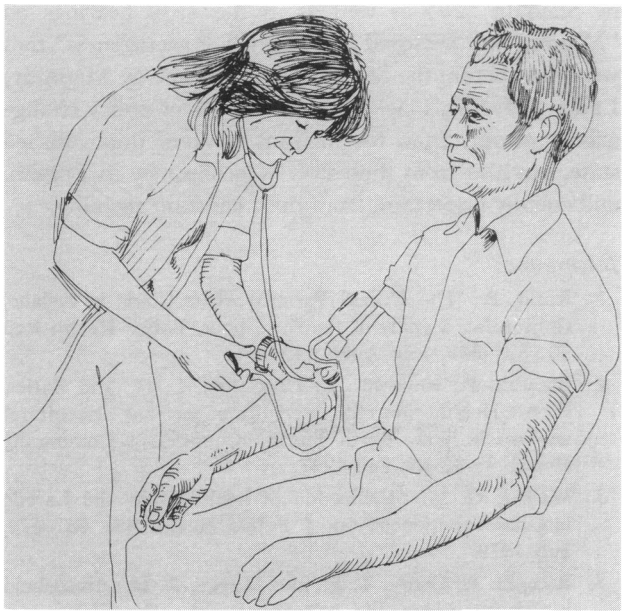
We examined the method of payment for those workers who reported a physician visit, physical examination, or vision checkup in the preceding year and found that the distribution of payment methods was similar for all three items. For dental care, however, a larger proportion of bills were paid out of pocket.

Migrants who had private health insurance were more likely to work in a cannery and to be "single" workers (that is, alone in Wisconsin), whereas migrant health funds were more likely to be used by workers with families, especially those in fieldwork. By far, the largest group paying bills with out-of-pocket funds consisted of fieldworkers who were single. Medicaid recipients were more likely than others to have visited a dentist and to have had their vision checked. However, only 15 percent of the workers paid their medical expenses with Medicaid.

Discussion

As Kopstein wrote, "utilization trends cannot be used to determine the extent to which health needs are being met" (*15c*), and that is certainly true for migrant workers. The fact that the self-perceived health status of migrant workers, even of younger migrants, is much lower than that of other populations, combined with their low medical utilization patterns, clearly indicates that migrants are a medically underserved population.

Our study led to the formulation of a series of recommendations related to the medical utilization patterns and the medical needs of migrant workers and their families. These recommendations evolved from a discussion between the research staff and the project's advisory committee, which had been formed during the planning stage of the study. The advisory committee consisted of representatives from La Clinica de los Campesinos, from the Job Service of the Bureau of Migrant Services, and from two migrant worker service organizations (one of these representatives had been a migrant worker), as well as a Hispanic mental health worker, a Mexican-American employed by the Wisconsin Bureau of Health Statistics, and a University of Wisconsin sociologist familiar with Chicano studies. Although our survey was restricted to Wisconsin, we believe that these recommendations may well have application to other States and implications for national policy as well.



Preventive care includes blood pressure checks

The survey data showed that migrants receive much less preventive care than other groups in the United States. This includes dental care, vision care, general physical examinations, and also, in the case of women—although not reported here (*10*)—pelvic examinations, Papanicolaou tests, and early prenatal care. Since this lower level of preventive care holds especially for those under 30, it indicates a need for health providers and planners to expand their efforts to improve utilization of preventive care services.

To improve utilization, we need to improve access to health services. Migrants who had heard of or used the federally funded migrant health clinic La Clinica de los Campesinos perceived fewer barriers to seeking care and reported greater use of services. Those living in La Clinica's catchment area also did not express as many concerns about a lack of night and weekend clinic hours or transportation difficulties and language problems as did migrant workers living elsewhere in the State (*10*).

Efforts should be made to adapt existing health care facilities to migrant needs. A network of year-round health care providers exists in the State that could serve the migrant community. It includes private practitioners in rural areas, some group practices, and some clinics associated with intermediate size hospitals. With the numbers of migratory workers in Wisconsin declining each year, funding for specialized services devoted solely to migrant health needs will no doubt continue to decline. One of La Clinica's two out-stations was discontinued in 1978 because of the decreasing numbers of migrants in the area, and at this point no other facility has taken its place. Bleiweis and associates (*2*), after studying migrant health utilization patterns in Florida, also have suggested that greater use be made of existing services.

We know some of the conditions that make it more likely that a health clinic will be used by migrants. Two important ones are the availability of night and weekend clinic hours and the presence of Spanish-speaking

health professionals or paraprofessionals (*10*). If such personnel are not available, the migrants should have access to community workers who can translate and interpret medical information in Spanish and English. In addition, private practitioners should consider adding bilingual physician assistants or nurse practitioners for the summer months to share the additional workload when the migrants are in the State. One possible source of bilingual paraprofessionals might be southern Texas, where the demand for health services may decrease during the period that the migrants are away.

Of course, any existing Hispanic health service should be made available to migrant workers. In Wisconsin, all of these facilities are located in cities, not farm areas, and although they serve Spanish-speaking residents, migrants seldom use them. We suggest that these facilities be publicized within migrant communities and that their staffs be expanded to cover the increased patient load during the harvest season.

Attention also should be directed to improving the financial arrangements for paying for migrants' medical care. Fewer than one of five workers in our survey reported that Medicaid helped pay his or her medical bills. There are several barriers to use of Medicaid by migrant workers. Because the Medicaid program is administered at the county level, State policies are implemented in different ways by various counties. For example, Federal regulations state that a migrant worker's annual income is to be used in determining eligibility, but some counties continue to multiply the worker's current monthly income by 12 to estimate annual income. This method is clearly inappropriate since most migrants remain in Wisconsin for no more than 4 months, during which they earn their major income for the entire year. In addition, most counties are not adequately staffed during the migrant season to handle applications for Medicaid from Spanish-speaking workers, office hours are not adjusted to accommodate people who usually work 6 days a week, and generally staff time is not available for visits to the homes or workplaces of the migrants.

A recommendation we would make directed at national policy is that the Federal Government classify migrant workers as being categorically eligible for Title 19 funds throughout the United States. Such a classification would solve many problems. The migrants could then receive medical care in any State, and some consistency in coverage and benefits would be achieved. Repeated certification would not be necessary. This is how the WIC (Women, Infants and Children) Nutrition Program of the Department of Agriculture is organized. Many migrant women have commented favorably on this program and have shown by their utilization how much they like it. A recommendation of similar intent was made in October 1979 by the National Advisory Council on Migrant Health of the Department of Health, Education, and Welfare (now DHHS, the Department of Health and Human Services), namely, ". . . that consideration be given to legislative or regulatory changes to make interstate migrants eligible for standard Medicaid benefits at the Federal level" (*21*). A step in this direction was taken in July 1979, when the definition of State residency for persons applying for Aid to Families with Dependent Children and for Medicaid applicants was expanded to include migrant and itinerant workers who enter a State with a job commitment or to seek employment (*22*).

Lastly, migrants need to be involved in health planning if they are to have their needs properly represented. However, most public hearings for health planning in local areas are held in late winter or early spring, when migrant groups are usually not present in the State. Ideally, the migrant groups should be represented on local health planning boards when their numbers so warrant. Health systems agencies or local planning boards should schedule special meetings in the summer, allowing migrants an opportunity to represent their needs. If such scheduling is not feasible, Hispanic community groups such as United Migrant Opportunity Services and La Raza Unida should act as advocates to present migrants' needs before local boards and committees. This input is especially needed when mental health services are planned, because local communities are instrumental in planning these services.

To conclude, the migrant workers' relative lack of political and economic power has been well described by Shenkin (*23*) as well as in the 1970 hearings on "Migrant and Seasonal Farmworker Powerlessness" that were held before the Senate Subcommittee on Migratory Labor (*24*). This lack of power to affect policy change arises not only from the migrant workers' impoverished state, but also from their lack of proficiency in English, and equally important, from their constant mobility.

References

1. Rudd, P.: The United Farm Workers Clinic in Delano, California: a study of the rural poor. Public Health Rep 90: 331–339, July–August 1975.
2. Bleiweis, P., Reynolds, R. C., Cohen, L. D., and Butler, N. A.: Health care characteristics of migrant agricultural workers in three north Florida Counties. J Community Health 3: 32–43, Fall 1977.
3. Walker, G. M.: Utilization of health care: the Laredo migrant experience. Am J Public Health 69: 667–672, July 1979.
4. Rice, D. P., Drury, T. F., and Mugge, R. H.: Household health interviews and minority health: the NCHS perspective. Med Care 18: 327–335, March 1980.

5. Salber, E. J., and Beza, A. G.: The health interview survey and minority health. Med Care 18: 319–326, March 1980.
6. Hoppe, S. K., and Heller, P. L.: Alienation, familism and the utilization of health services by Mexican Americans. J Health Soc Behav 16: 304–314, September 1975.
7. National Center for Health Statistics: Physician visits: volume and interval since last visit, United States 1975. Data from the Health Interview Survey, Series 10, No. 128, April 1979.
8. Bullough, B.: Poverty, ethnic identity and preventive health care. J Health Soc Behav 13: 347–359, December 1972.
9. Greene, L. W.: Status identity and preventive health behavior. Pacific Health Education Reports, No. 1. School of Public Health, University of California, Berkeley, 1970.
10. Slesinger, D. P.: Health needs of migrant workers in Wisconsin. Department of Rural Sociology, University of Wisconsin-Extension, Madison, July 1979.
11. U.S. Bureau of the Census: The current population survey: design and methodology. Technical Paper 40. U.S. Government Printing Office, Washington, D.C., January 1978, pp. 56–58.
12. U.S. Bureau of the Census: 1970 census of population; characteristics of the population: Wisconsin. U.S. Government Printing Office, Washington, D.C., 1970, vol. 1, pt. 51.
13. U.S. Bureau of the Census: Characteristics of the population below the poverty level: 1976. Current Population Reports, Series P–60, No. 115. U.S. Government Printing Office, Washington, D.C., 1978.
14. National Center for Health Statistics: Health, United States, 1978. DHEW Publication No. (PHS) 78–1232. Department of Health, Education, and Welfare, Hyattsville, Md., December 1978.
15. National Center for Health Statistics: Health, United States, 1979. Department of Health, Education, and Welfare, Hyattsville, Md., 1980: (*a*) p. 133, (*b*) p. 137 (*c*) p. 127.
16. Andersen, R., et al.: Access to medical care among the Hispanic population of the Southwestern United States. J Health Soc Behav 22: 78–89, March, 1981.
17. National Center for Health Statistics: Ambulatory medical care rendered in physicians' offices: United States, 1975. Advance Data from Vital and Health Statistics, Oct. 12, 1977, vol. 12.
18. Southeastern Wisconsin Health Systems Agency: 1977 Wisconsin Health Status Survey. Milwaukee, 1978, vols. 1 and 2.
19. National Center for Health Statistics: Current Estimates from the Health Interview Survey: United States 1978. Data from the Health Interview Survey, Series 10, No. 130, November 1979. Department of Health, Education, and Welfare, Hyattsville, Md.
20. National Center for Health Statistics: Use of selected medical procedures associated with preventive care: United States 1973. Data from the Health Interview Survey, Series 10, No. 110, March 1977.
21. Bureau of Community Health Services: Minutes of National Advisory Council on Migrant Health meeting, Washington, D.C., October 15–18, 1979. Health Services Administration, Rockville, Md.
22. Coverage and conditions of eligibility in financial assistance programs; residency. Agency: Social Security Administration, HEW. Federal Register, vol. 44, No. 138, pp. 41459–41460, July 17, 1979.
23. Shenkin, B. N.: Health care for migrant workers: policies & politics. Ballinger Publishing Company, Cambridge, Mass., 1974.
24. U.S. Senate, Subcommittee on Migratory Labor of the Comimttee on Labor and Public Welfare: Hearings on "Migrant and Seasonal Farmworker Powerlessness." 91st Congress, 1st and 2d sessions. U.S. Government Printing Office, Washington, D.C., 1970.

SYNOPSIS

SLESINGER, DORIS P. (University of Wisconsin), and CAUTLEY, ELEANOR: *Medical utilization patterns of Hispanic migrant farmworkers in Wisconsin. Public Health Reports, Vol. 96, May–June 1981, pp. 255–263.*

In a survey conducted in 1978 of a 10 percent stratified random sample of Wisconsin migrant agricultural workers, the self-perceived health status and the medical utilization patterns of the Hispanic workers in the sample (92 percent of the total group) were examined.

Based on prior research with national populations, it was hypothesized that older, female, better educated, and English-speaking workers would have higher utilization levels. Utilization was measured by four variables: a physician or clinic visit in the preceding year and ever having had a general physical examination, a dental visit, or a vision checkup.

The survey results, based on unverified self-reported data, indicated that in general the use by migrant workers of health services, especially preventive care, was low compared with other populations. Some of the hypotheses that were tested were confirmed by the survey data: older workers were more likely to have visited a physician in the preceding year and to have had a routine physical examination; women were more likely to have seen a physician in the preceding year and to have had a dental visit; workers who spoke English as well as Spanish (usually the younger workers) were more likely to have been to a dentist and to have had a vision checkup. Educational attainment was not related to any of the utilization measures.

Besides the demographic factors related to medical utilization, the survey revealed barriers to care related to time, distance, language, and money. Access to a migrant health clinic and the availability of Medicaid were related to dentist visits and vision checkups. Thirty-eight percent of the migrants had used migrant health clinics; only 14 percent had used Medicaid to pay medical bills; about one in five had no means of payment except his or her own funds.