The Migrant and the Rest of Us

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PUBLIC HEALTH workers, private physicians, and other local community residents are likely to have varied impressions of migrants depending on the angle from which they are viewed. The sanitarian sees the crowded housing of migrants with its lack of proper provision for sewage and garbage disposal and its water supply that may be polluted. The public health nurse who visits labor camps as part of her routine at the peak of the crop season sees cases of diarrhea, impetigo, malnutrition, and ear infections. The local physician and the hospital administrator see only people who come in an emergency when a serious accident or illness makes them seek medical care. Migrants may have few resources of their own for meeting an emergency. Nonresidence makes them ineligible for local welfare aid, and so some of their bills remain unpaid at the end of every crop season. The average person in a community is likely to view the migrant worker as a necessary part of the local economy, but potentially an economic burden if he stays beyond the season when he is needed. This same average person may fear the migrant as a potential disease carrier.

Only by putting all these views together can the migrant health problem be seen in its totality. For the Nation, the exact dimensions of the problem are poorly defined. Twenty years ago a national health survey showed more frequent illness and longer-term disability among individuals and families on the move than among permanent residents. There is little evidence that the relative health status of the two groups has changed greatly in the last 20 years. Diarrheal disease continues to be common among migrant children. Outbreaks of typhoid and diphtheria continue to occur sporadically in migrant camps. All indications are that migrant children are probably less likely to be immunized against preventable diseases than resident children. Too often mothers fail to obtain prenatal care that will help to assure the health of both mother and child. Poor diets are common.

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Number of People Involved

The national estimate of the number of migrants is approximately 1.25 million. Of these, nearly one-half million are foreign workers, chiefly from Mexico. These aliens are single men working under contract, with guarantees of work for stipulated periods of time. They are physically screened before they enter the country. Health insurance protection is given them under the terms of their contract. Housing for them must meet minimum requirements before they are assigned to an employer. When their contracts are fulfilled, the workers return to their own countries.

The tightening of our border patrol has nearly eliminated the wetbacks, illegal entrants, who formerly crossed the Mexican border in droves at harvest time.

Many workers are accompanied by family dependents.

The remaining three-fourths of a million in the agricultural migrant population are workers and their dependents who come chiefly from the southern border States. Texas is the largest single supply State and the greatest demand State. Unlike the foreign workers with contracts, these domestic agricultural workers, who are United States citizens, seldom work under contract. Few have health insurance protection, and standards for their housing are likely to be minimal.

While the domestic migrant works in sugar beets, cherries, potatoes, cotton, or beans, his pay may be relatively good. But periods of employment are balanced by periods of unemployment when the weather is bad, crops are poor, or work not available between crop seasons. Working time is also lost when workers are traveling from job to job. Most domestic migrant families lead a hand-to-mouth existence with an annual income of not more than $2,000 even when several members of the family work. The average cash income of the male migratory farm worker, according to a 1954 national sample survey, was $1,160. This includes income from both farm and nonfarm sources.

Economic Background

Seasonal work in agriculture requires a mobile labor force. As American agriculture has become bigger and more industrialized, machines have reduced the total number of man-hours of work required to produce the Nation's food and fiber. But some operations have not yet been mechanized nor for them does mechanization appear to be possible. Thus, for the greater part of a year, a relatively small labor force may be able to carry on the work of many crop areas. For a few short weeks or months, however, this labor force must be greatly expanded or the rest of the year's work will be lost. Some local workers can be recruited for short periods, but in many areas, the local labor supply must be supplemented by outside workers.

Available work changes with the seasons.

Family "housing" in a makeshift camp.

In the early spring the vegetable pickers are stooping over the fields in Florida, the Lower Rio Grande Valley, and southern Arizona and California picking the fresh carrots, beans, spinach, peas, celery, and lettuce that we serve on our dinner tables. These workers are chiefly southern Negroes, Puerto Ricans, Indians of the southwest, Spanish-Americans, including both domestic workers and Mexican nationals, and Anglo-Saxons from low-income farming areas in the south.

By the middle of the summer some of these same people are doing the same kind of work in New York State, Michigan, Montana, Colorado, Idaho, Washington, Oregon, and other northern States. At the end of the crop season, they will head south again in trucks, buses, and cars.

Impact on Local Health Resources

As stated earlier, the total number of domestic migrants is estimated at about three quarters of a million. A map of their movement, however, makes it clear that this figure is not a true measure of the size of the problem (*1*). It has been said that the number might well be multiplied by the number of times people move. In each new location housing must be available. Local health workers must be ready to provide services if the health of both migrant and resident population is to be protected. Other community services must be stretched to accommodate the strangers.

The number of migrants of greatest importance in planning health services is not the national total, but the number in a particular locality at a particular time. All but two States have at least a few migrants for at least a short time. In many States, however, the area requiring farm workers from outside is exceedingly restricted. Of the total of 3,068 counties in the Nation, about 800 are estimated to have as many as 100 or more domestic migrant workers and family dependents at the peak of the season. Only about 75 counties have more than 3,000. Twenty-two of these counties, however, have more than 10,000 migrants at

A health center operated by a voluntary group in a labor camp.

the peak. The peak period may last for only a few weeks or for several months.

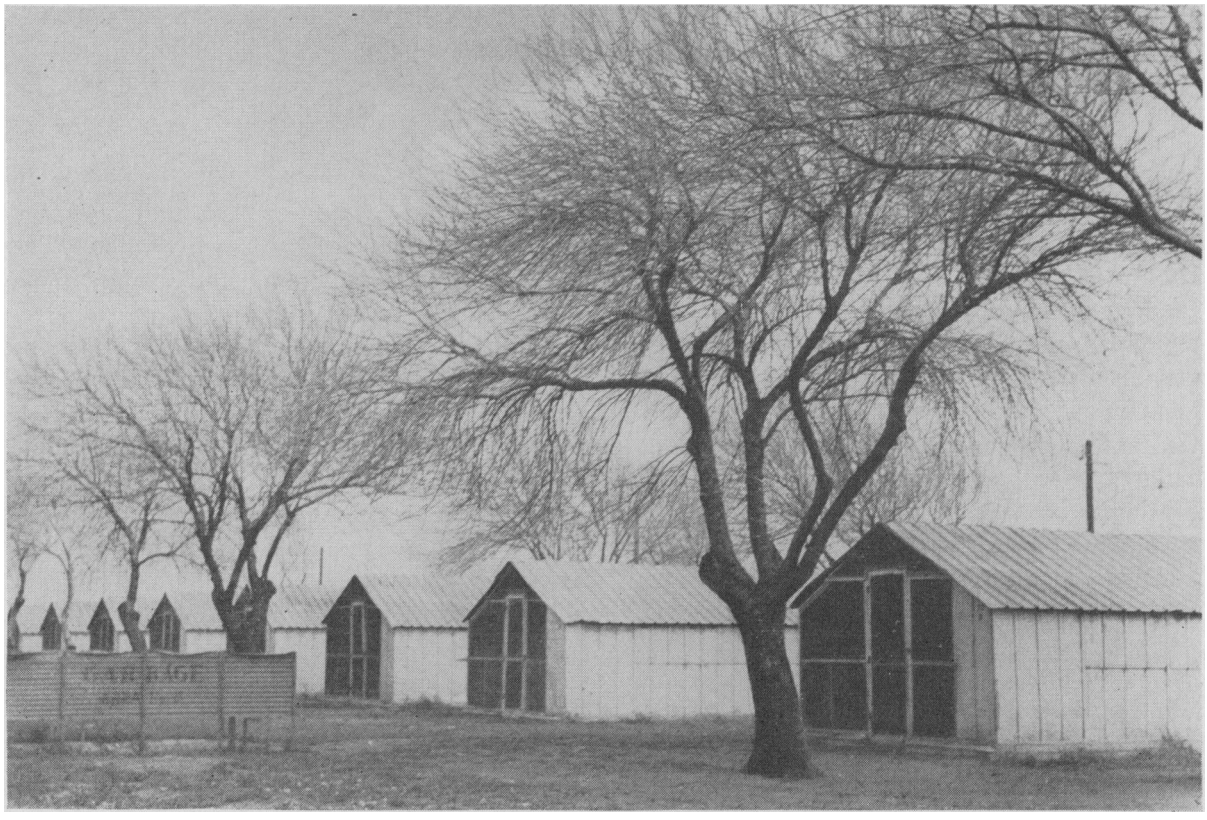
The impact of migrants on a county varies according to the size of the resident population and the availability of health resources. A county with 100,000 people may be fairly well equipped to care for the health needs of its permanent residents. Stretching these services to meet the needs of a few thousand temporary residents may require special planning but may not interrupt the usual routine very drastically. If, on the other hand, 10,000 or more migrants flock into an area whose resident population is no more than a few thousand, the health problems confronting local physicians and public health workers may be doubled overnight. Migrant work areas are predominantly rural, and many have a shortage of local health resources even for permanent residents.

Federal vs. Local Responsibility

The interstate aspects of the problem become clear from a look at the main routes migrants travel. On the east coast, about 50,000 migrants start in the south in the spring and move back in the fall. From south Texas, at least 100,000 fan out to other parts of Texas and to the North Central, Mountain, and Pacific Coast States. Another 80,000 or 90,000 move within California and to adjacent States.

Because of this interstate movement, some people have looked at migrant health as an interstate problem, one that might properly come under the jurisdiction of the Federal Government. On this basis, the Federal Government undertook the organization and financing of the agricultural workers' health associations during World War II. Local physicians and public health agencies worked through these associations with the Federal Government in providing services in major work areas along each of the main migrant routes. The major part of the financing came from the Federal Government. Federal funds were discontinued after 1947.

Today, pressures continue to be brought upon the Federal Government for financing



Well-maintained family units in a large labor camp.

migrant health care on the basis that the migrants are nonresidents and, therefore, not the responsibility of the State or local area where they work and live temporarily. On the other hand, some people are beginning to look upon migrants as part of the permanent population of an area even though they live there for only part of the year.

Local Efforts to Assume Responsibility

The view that migrant farm workers and their families are a permanent and essential part of the local economy is leading some localities to try to provide for them accordingly. Generally, these localities find that providing better housing, encouraging migrant children to go to school, and arranging for health services pay off in terms of greater assurance of dependable workers when they are needed and reduce chances of disease arising and spreading among both migrants and local residents.

Partnership between local medical societies and public health workers has been arranged in Fort Lupton, Colo., Fresno County, Calif., and a few other areas. Local physicians and public health nurses have teamed up in staffing clinics held during workers' off-hours. These clinics provide services to prevent and control the spread of communicable disease. They also provide medical care for people who need it. They have been set up in places and at times convenient for the workers, many of whom do not have their own transportation and cannot well afford to lose time from work to bring their children in for immunization or to get treatment for sickness or injury.

Arrangements such as these are born of a need mutually recognized by local physicians, local public health workers, and other local residents. These workers, assisted by volunteers, have community support behind them. But even under the best circumstances many problems arise. With the best of planning, a newly opened clinic may attract only a handful of patients at first. Some of the first patients may be more curious than in need of care. Considerable patience is required. Public health

nurses may need to visit migrant families and encourage them to come to the clinic before there is any great demand for service. Once understanding and acceptance of the service have developed, however, the demand may well test the endurance of the staff.

One Clinic's Operation

A look might be taken into a clinic that has operated for about 5 years in a large labor camp in a building provided by the employer. On a typical day the clinic starts in the early evening. There are only a few patients at first, but more and more come until the small building is jammed. Some people have had to arrange with others for transportation. Many bring small children. There are 60 patients, but at least twice as many people are waiting.

A volunteer from a local women's organization takes down essential information at the reception desk. In a small room at one side, a public health nurse advises mothers on the care of their small children. In another room a physician from the local medical society, assisted by two public health nurses, is examining and treating a steady flow of patients. The local welfare agency pays each of the six physicians who serve on a rotating basis a set fee for each clinic session he conducts.

The cases seen include a child with a lacerated foot, a suspected case of tuberculosis referred to the county hospital for X-ray, a case of venereal disease, a sprained arm, several pregnant women, and two members of a family referred to the clinic because another family member has recently been hospitalized for typhoid fever.

A class in home nursing is conducted by a Red Cross volunteer in a small back room. Here, and in the waiting room, people seem to welcome the chance for sociability.

By agreement among the local medical society and other local agencies, the small fee that is supposed to be charged each patient is often waived. This is especially true when opportunity for work has been scarce in recent months and the families living in migrant camps have little or no money. Under such circumstances, local people believe that asking even a small fee will discourage people from coming for needed care and defeat the purpose of the clinic.

Variation in Local Projects

The situation varies widely from place to place. Local needs differ and local resources for meeting these needs likewise differ. The migrant population group itself varies from one place to another, and these variations require different approaches if needs are to be served. Differences in language present an obvious problem when the Spanish-speaking migrant comes to a local physician or to a public health clinic in northern Michigan or Wisconsin. Differences in health beliefs and practices may be equally baffling to the physician or nurse who is trying to explain to a migrant mother how to care for her children.

Often there will be a need for supplementing local health resources when the migrant influx is at a peak. Some communities have found inactive local nurses who are willing to help in a migrant project. Physicians from nearby towns have participated in clinics set up in or near migrant camps. The Home Missions Division of the National Council of Churches, the Catholic Charities, women's organizations, and other groups have provided volunteer assistance in clinics, transportation and interpretation to migrants, and interpretation to communities at large of what a clinic was trying to do. Also they have financed services for individuals, and provided direct financial support for clinic operation. Employers and their associations may furnish a building for a clinic, assist in financing, or lend support in other ways. Farmers' wives and their organizations are still another source of interest, support, and active participation on a voluntary basis.

Role of Federal Agencies

Although local projects necessarily vary according to the local situation, they are likely to have certain needs in common. For example, a need that is repeatedly voiced by local physicians and public health workers is for some method of assuring continuity in the services provided as people move from place to place. Questions of how to finance health services

through voluntary health insurance and other means also frequently arise.

Other problems that confront most communities when they become interested in trying to meet migrants' health problems include adapting health services to population groups that differ markedly from the resident population in personal characteristics and in living and working conditions; developing community understanding of migrant problems; and encouraging community support in meeting them.

The major role of the Public Health Service is one of consultation and technical assistance to State and local groups in meeting these problems. Both the Public Health Service and the Children's Bureau have assisted in planning experiments with health records to be carried by migrant families. Although we do not feel that the experiments thus far have provided definitive answers to the problem of providing continuity of health services as migrants move, we have learned much that can be applied in a future study of this problem.

Another role, chiefly informational, has been passing on to new areas the ideas and plans that other communities have found successful. The Public Health Service has served from time to time as a catalyst to bring together individuals and groups concerned with specific health problems associated with the migration of agricultural workers and their families.

The philosophy in terms of the long-run interests of both the domestic migrant and the community, including the Nation as a community, is that migrants need to be viewed as an integral part of the general population. They form an essential part of our human resources. Their problems arise to a considerable extent from a mobility that is required by our agricultural economy in its present stage of development.

Special services may be required at times to meet emergency conditions. Generally, however, it seems desirable to meet the needs of migrants through the framework of existing community services for other citizens, with such modifications as may be necessary to meet the migrant's peculiar working and living conditions.

"The Rest of Us"

Certainly the whole Nation profits by migrant labor. Much of the food that reaches our family tables is harvested and processed by migrant workers. The communities where migrants work and live temporarily profit most of all. Sometimes local people say, "We have no responsibility for migrants. They don't pay taxes." Some of these same people might find it difficult to pay their own taxes if migrants failed to appear at the critical times in crop production and harvesting.

All of us have a responsibility for understanding the important contribution the agricultural migrant makes to our economy. We have a further responsibility for helping him and members of his family share in community services on a continuing basis, including health services. The Public Health Service is sincerely interested in helping to identify the health problems both of the person who is on the move and of the communities to which he returns for a short time each year and to plan for meeting these problems.

REFERENCE

(*1*) Leone, L. P., and Johnston, H. L.: Agricultural migrants and public health. Pub. Health Rep. 69: 1–8 (p. 5), January 1954.