Financing Health Services For Migrant Farmworkers And Their Families

THE PRESIDENT'S Committee on Migratory Labor, composed of the heads of five member agencies—the Departments of Agriculture, Health, Education, and Welfare, Interior, Labor, and the Housing and Home Finance Agency—has prepared a working paper on Financing Migrant Health Services.

The paper is basically a resource document and covers various methods currently in use or proposed to finance health services for foreign and offshore workers, and for domestic farmworkers in the continental United States. Health services as defined by the committee range from preventive services (including sanitation) through short-term and long-term medical care.

The committee found that the current programs and proposals for financing migrant health services run the gamut of those found in existence for the general population. Responsibility for planning, providing, and financing these services has been taken in the community by various groups such as individual employers and employer associations, private medical personnel and medical organizations, public health agencies, civic and church groups, private and public welfare agencies, private insurance carriers, and migrant labor crewleaders and the migrants themselves.

The committee considered existing voluntary health insurance programs, provision for medical care and indemnity under workmen's compensation laws, medical and related care under public programs such as general assistance (with special consideration to residence requirements), and a variety of grower- and community-sponsored programs and proposals.

The committee also compiled a number of recommendations made by recent conferences on agricultural migrants and by national voluntary organizations as a guide to interested private and governmental agencies in their consideration of methods of financing the health care of agricultural migrants. The inclusion of specific programs or proposals does not imply endorsement, nor the omission of others, unacceptability.

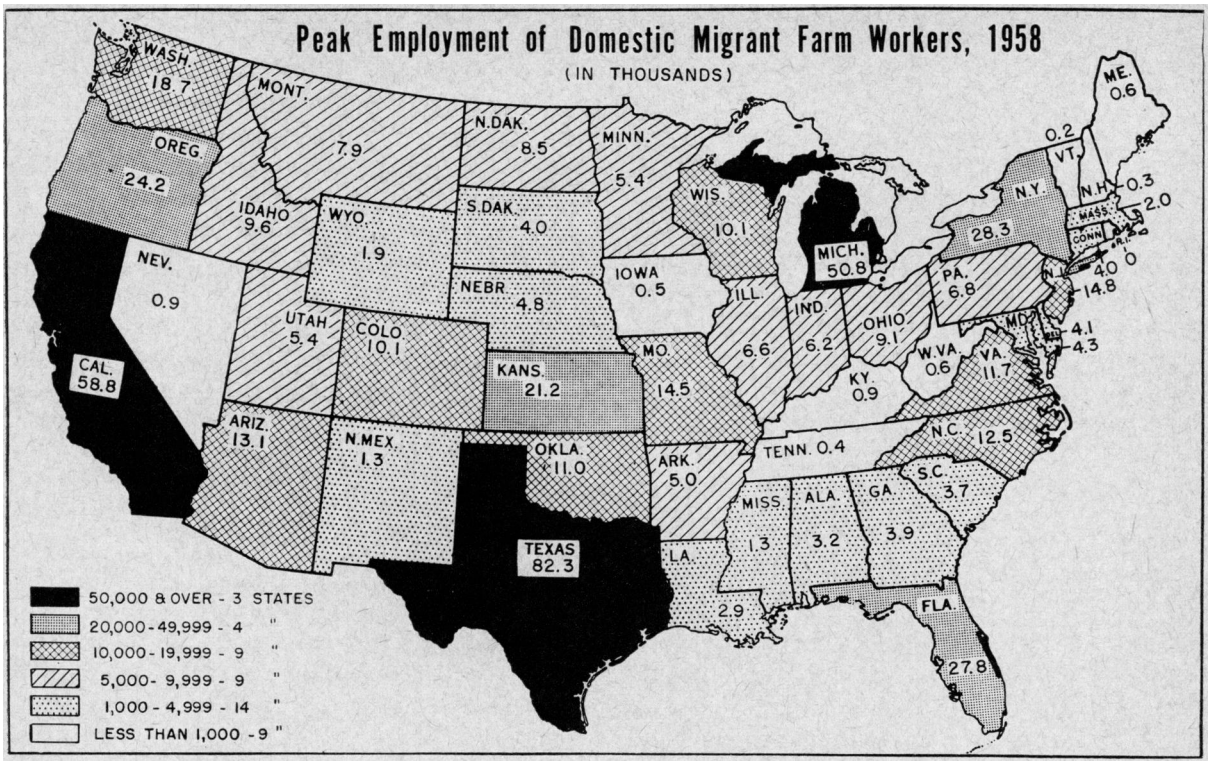
Of particular interest is the summary of health insurance coverage in existence for Mexican nationals, British West Indians, and Puerto Rican contract workers, by type of carrier, coverage, premiums, and benefits. The health insurance arrangements are made under the auspices of governmental agencies, but are provided by private insurance companies. They cover the foreign and offshore worker from the time he enters the United States to work (and in some instances even before arrival) to the time he leaves. Domestic migrant agricultural workers as a labor force group are not so covered, except in scattered and minor instances.

The digest of farmworker coverage under workmen's compensation laws, by States, is also an important and useful source table. There are no States in which the law—compulsory or elective—applies to migrant farm labor as such. If migratory farmworkers are covered, it is by virtue of the fact that agricultural workers per se are covered. Under some State laws, even if workers are covered as a class, they may not be covered as individuals because of numerical exemptions per employer.

An analysis of medical and related care under public programs highlighted the residence requirement for eligibility under most State and local general assistance laws and regulations. Residence requirements varied from 6 months to 5 years out of the last 9 years, with 1 year the average. Since so many migrant workers are "stateless," and hence ineligible for voting and other rights and responsibilities of citizenship, they are not the beneficiaries of reciprocal arrangements among States whereby residents of one State may be cared for while temporarily residing in another.

Some States which are hosts to a large number of migratory farmworkers have made efforts to provide some modicum of medical and hospital care, for example, New York, Florida, Pennsylvania, and Maryland.

Under the State programs, conducted with Federal aid, involving crippled children and vocational rehabilitation for adults, there is no reference to requirement for residence in the



Federal act. States are encouraged to be liberal by the Federal agencies involved.

Certain types of illnesses which are of public concern, for example, tuberculosis and venereal diseases, are also treated with greater liberality by some States, regardless of the residence of the patient. Migrant labor is considered a high-risk group with respect to incidence of communicable disease. Maternity, chronic diseases in young children, and accidents also bring some relaxing in State residence requirements.

Local communities in some areas have attempted to meet immediate problems of health services for migrants by setting up clinics, as in Fresno, Calif. Church groups have sometimes identified health needs in migrant camps and acted as referral agencies. Junior leagues have set up sick baby clinics and provided free medical and nursing aid. Local public health departments have added extra nurses to their staff during the peak of the crop season. They have set and maintained levels of sanitation and environmental health in migrant labor camps.

The major part of funds to finance health services for migrant agricultural workers has come from private sources, and much has come involuntarily. Hospital and medical bills are simply left unpaid at the end of the crop season. These are eventually charged to charity care, unless the "home" county or the individual growers or the growers' associations or processing companies can be persuaded to meet part or all of the bill.

With few exceptions, there is little evidence that efforts to provide migrants with health services even temporarily consider at the same time possible ways to reduce needs, and thereby costs, through improvement of housing and sanitation, accident prevention, and other measures. Although many adaptations have been made to try to fit programs to migrants, at the present time none that the committee identified provides for more than the temporary period of a migrant's residence and employment in a single location except programs for offshore and foreign workers and isolated programs for domestic workers under somewhat similar working conditions. Moreover, the extent and kind of services afforded mi-

grants, and the circumstances under which they are offered and financed, differ widely from one locality to another. A typical domestic farm migrant is unlikely to find the same conditions prevailing in any two places where he lives and works during the year, especially if his work itinerary covers two or more States.

Migrants share with other low-income farm people problems in financing health care through insurance or other means; they share with most other farmworkers lack of workmen's compensation coverage; and they share with other mobile groups problems of obtaining care in areas where residence restrictions are applied as a condition for eligibility. Proposals directed toward these broader groups hold promise for the migrant population.

Among the continuing needs in order to facilitate the provision and financing of health services to domestic migrants are (*a*) the stabilization of their employment situation; (*b*) the incorporation to the fullest extent possible in the domestic worker program of the standards now found in the foreign and offshore program; (*c*) the availability of some common denominator of health service and educational and informational effort from one community to another.

A Charge on Our National Conscience

It is intolerable and indecent for a society to produce by overworking and underpaying human beings. Even if the product may cost more, we, in this country, usually accept the difference in cost because it is the man that counts—not the thing.

It is my conviction that the migrant farmworker will never take his place as a fully useful citizen, and never be able to successfully resist exploitation, until, first, Federal legislation guarantees him a decent minimum wage upon which he can build a decent and independent life; second, unless he has fairly continuous employment; third, until he receives the equal protection of all Federal and State laws, such as enforced housing codes, enforced safety codes, accessible health services, and protection of his person in the form of compensation for injury and unemployment.

Progress in the health of migrants depends upon the removal or adaptation of residence requirements in the States.

The Federal Government can act in certain directions—research and inform—but it cannot teach or develop and enforce housing codes or State highway safety codes or care for the medical needs of all our citizens. The States must do that, and the communities within the States . . . only they can take the big step, removing the residence requirements that keep the school doors locked against migrant children.

The migrant and his family are lonely wanderers on the face of our land. They are living testimonials to the neglect that is possible in a wealthy and aggressive economy that prides itself on the protection of the individual. They have no lobby—no power at the polls. Their lot often seems hopeless. But if we really want to help, we can—continuously, undramatically in action, not mere words. We must, for the migrant is a charge upon the conscience of us all.—HONORABLE JAMES P. MITCHELL, *Secretary of Labor. (Excerpts from statement at hearings of the National Advisory Committee on Farm Labor, February 5–6, 1959.)*