Resource ID# 4942

Migrant and Rural Health in the United States

DRAFT: HLJohnston
March 3, 1972

STATES

The faces of the rural poor are more often white than either brown, red or black. The faces of the migrant segment are typically brown or black.

I am neither brown nor black. I am also not poor. For others to speak on the behalf of minority groups who suffer from poverty has recently gone out of style.

So what are my credentials to appear here today?

Mainly my credentials are based on my unique experience as a worker in the Federal government. For nearly 30 years I have had an opportunity to visit out-of-the-way rural communities in nearly all States--some communities too small even to appear as dots on the map. I have had an opportunity to visit with migrants living in their own homes in isolated rural ghettoes and in migrant labor camps far removed from major highways, well hidden from public notice. I have had an opportunity to talk with the physicians, nurses, and other health professionals who serve migrants and other low-income rural people.

Prepared by Helen L. Johnston for Committee on Health Care of the Poor, McAllen, Texas, February 25-26, 1972.

I have seen one nationwide program to deliver health services to such people wither and die because it was considered only one of the emergency programs of World War II. I have seen the discouragement when the program was terminated and the effort to stimulate the continuance of at least some of the needed health services. I have helped to develop and administer a program to serve migrants initiated under a 1962 law.

I have personally been engaged with others in the Public Health Service and recently in the Health Services and Mental Health Administration to get recognition of the health problems of people living in rural areas, and of the special problems of migratory farm workers and their families. We see the problem of migrants as the "tip of the iceberg." Less visible, but critical, is the underlying problem of the lack of health manpower and other essential resources to serve the needs of the permanent residents of rural communities. This problem afflicts most rural communities,

whether poor or affluent. It is likely to be most acute in grossly deprived communities.

The underlying rural health problem was recognized by an Interbureau Committee's report on migratory labor to the Surgeon General of the Public Health Service in 1952. But when legislation finally came 10 years later to help relieve the problem, it was geared solely to migrants. In 1970 this legislation was amended to broaden the target population to include other seasonal farm workers and families who live and work with migrants.

The appropriation for the migrant health program has never matched its legislative potential. In the first year the appropriation was $750,000. It has increased to nearly 30 times that much in the current fiscal year. Still the total is a pittance--less than $20 per person in the target population compared with the 1970 national average per capita expenditures for health purposes of more than $300.

Population

The first question people usually ask was also your first question--how many people are involved? One of my surprises as I became involved in working on migrant health problems was the difficulty of getting population estimates. Each agency had its own definition of migrant, and its own estimates, based on its own need for operating data. Some agencies were concerned with counting farm placements or farm workers from outside the local area. With the turnover in farm labor, the number of farm placements might be two to ten times the number of persons involved. The number of farm workers, even if the account was accurate, did not take into account nonworking family dependents who might be travelling with workers. For purposes of planning and arranging health services for migrants for the duration of their stay, whether at home base or up North, it was necessary to have estimates of the number of persons to expect, with as accurate a picture as possible of their sex, age, and other characteristics.

After mining the resources of the Census Bureau, the Department of Agriculture, the Department of Labor and other public and private agencies dealing with migrants, we concluded that trying to count current migrants was like trying to count moving needles in a haystack with a base as large as the 48 contiguous States. This situation remains little changed.

A person's past experience is no guide to his future. The person who moved last year may not move next year and vice versa. Even at the local community level it is generally difficult to get more than rather gross estimates of the number who move in or out during a crop season. A census taken at one point in time gives only part of the picture, since most areas show considerable turnover during a season. Knowing the average number of persons likely to be present at any one time is important for planning and providing health services; it is also important to know how many different persons will be in the area when it comes to certain types of services such as immunizations for children.

National population estimates in 1970 took into account data from local migrant health projects, the Department of Labor and the Department of Agriculture. The 1970 estimates suggest that there are between one-half and three-quarters million persons--men, women, and children--travelling from place to place to earn a major part of their annual income from work in agriculture. The people travel so far from home that they cannot return each night. Instead they must set up temporary living quarters at one or more places away from their homes, usually in a migrant labor camp.

The population of seasonal farm workers and families who live and work during certain seasons side by side with migrants exceeds the population of migrants. The total including migrants and other seasonal farmworkers and families, can probably be rather conservatively estimated at about 1.6 million.

Technology

The impact of technology on agriculture has been dramatic in the last half century. The Nation's farm labor force has declined steadily

with the decline in hired farm workers and in family farm operators proceeding at about the same pace until the mid-1950's. Then the decline in family farm operators became faster than that of hired farm workers.

Migrant "drop-outs" from Texas started forming Spanish-speaking neighborhoods in the slums of Detroit, Michigan, Racine, Wisconsin, and other northern cities at least 30 years ago when the sugarbeet harvester started replacing migrants in the northern beetfields. An army of crouching pickers moving slowly across the cottonfields of west Texas was being gradually replaced about the same time by cotton harvesting machines. Thus the area around Lubbock, Texas, with its former influx of 10,000 or more migrants, became a migrant supply, rather than a migrant demand, area.

Pea harvesters, bean harvesters, sweetcorn harvesters, tomato harvesters and cherry tree shakers are among the other machines that have replaced

thousands of workers for thousands of man-hours. Such inventions will continue to displace workers although some need for migrants seems likely to continue for a number of years.

Technology destroys jobs. It does not eliminate the people available for work. Many people may continue to move hither and yon with less and less work opportunity offered to them anywhere.

The space-age engineers recently thrust upon the labor market because their sources of work opportunity suddenly dried up have many things going for them. They are highly educated. They have sophistication in tapping resources to help them. The national investment in preparing them for their specialized type of work is large, and their future utilization is not likely to be left to chance.

The seasonal farmworker is different. Whether or not migratory, he is likely to belong to a black, brown, red or white minority--lacking in skills, undereducated, bewildered by the machines that have replaced

him, and poorly prepared to cope with the uncertainties of his future. He has only his hands, a strong back, and a willingness to work--often for long hours under adverse conditions--at wages so low few others would be willing to accept them. Spanish is the first language for about three-fourth of the migrant population, originating chiefly in Texas, the Southwest and Puerto Rico. Thus, even mastery of the English language may be so minimal as to disqualify a worker for the sporadic training courses in new job skills that might otherwise be available to him.

Increasingly in our highly industrialized world, seasonal farm workers and others like them find no place to go. Nor do they have unemployment compensation to tide them over temporary periods of unemployment.

For those who stay in one place long enough to qualify, welfare assistance may be available. In many places those who continue to move sporadically from place to place find themselves disqualified for welfare because of their lack of "intent" to continue to reside in the local community. The

questions they are asked when they apply for welfare are such as to disclose their intent to move on at some time in the future. If they happen to be accepted by a welfare worker in one location as eligible, this is no assurance of similar acceptance elsewhere since the eligibility screening requirements vary from one State to another.

The "Streams"

The term usually used for the place of origin of migrant farm workers and their families is "home-base." Some home-base areas are also agricultural work areas. They may offer more consistent employment to migrants than they find anywhere else during the year. Other home-base areas are places to which the people return when they can find no work available elsewhere but neither does the home-base offer work opportunity.

Three major farm labor-supply areas form home-bases for migrants. The largest is South Texas which furnishes farm labor for States as distant as Florida, New York, the upper Great Lakes States, the Southwest and the Pacific

Northwest. Altogether, agricultural areas of about 30 or more States depend on farm labor from Texas at the peak of their crop season. As the people move northward, they become more and more strange, and less likely to find others like themselves who speak Spanish.

Another major supply area is in the Southwest and a third is in the East including Florida, other southeastern States, and Puerto Rico. Florida is the most important of the Eastern homebase areas.

Southeast Missouri--the so-called "bootheel"--is another locality that supplies hundreds of migrant farmworkers, chiefly to the midwest. Still other small home-base areas are developing in the north in places such as Toppenish and other rural areas of Washington, and the Benton Harbor area of Michigan. Usually migrants from these northern communities move lesser distances. They may move only within the State where they originate.

The term "stream" is used to describe the general routes followed by large numbers of workers from their home-base areas in the south to their

seasonal work areas in the North. The East Coast stream rises chiefly in Florida and Puerto Rico. It flows as far north as New York and the New England States. The West Coast stream rises in Texas and the Southwest. It flows northward to the Pacific Northwest. The Mid-States stream rises chiefly in Texas and disperses in all directions. The major movement is to States around the Great Lakes and in the mid-west. Traditionally the move north starts in the early spring and the return move ends in the late fall.

As work opportunities lessen in many places, the so-called streams are becoming more and more commingled. Lack of work in south Texas during the winter for example, has led to migration from south Texas to south Florida. From there the people are likely to go north, perhaps as far as New York, before returning to Texas. After several years of migration along the East Coast, some seldom return to their former home-base.

Not only have movement patterns changed. The composition of the stream population has also changed. About 50 years ago, many recent immigrants

from Europe were part of the farm labor force on the East Coast. World War II opened up opportunities for these people in defense industry. They moved to cities. Their children attended city schools on a regular basis. This segment of the seasonal farm work force has now disappeared almost completely.

A dozen years ago, the East Coast stream population was nearly all black except for Puerto Ricans who came directly from Puerto Rico to work in the Middle Atlantic and New England States. A few Indians and French Canadians also joined the farm labor force in the upper New England area. Now perhaps one-fourth of the East Coast population is Spanish-speaking, originating in Texas or Puerto Rico. Immokalee and other Florida communities have become the "homes" of many former Texans.

Population shifts elsewhere have also changed the character of the migrant population. In the 1950's and early 1960's, such States as Texas, California and Michigan depended heavily on "braceros," single male workers legally imported from Mexico who came to United States farms under a program

supervised by the Department of Labor. This program was terminated in the mid-1960's. "Wetbacks," illegal entrants from Mexico, have also formed an important segment of the farm labor force of a number of States in the past.

Border crossers, legal and illegal, continue to exert a constant pressure all along the U.S.-Mexican border. For every migrant who finds a permanent job somewhere and leaves the migrant stream, there are new recruits from a seemingly inexhaustible supply of poor people on both sides of the border.

As the streams of people flow generally northward, the problems of impoverished rural people from ~~other~~ southwestern States, Florida, Southeast Missouri, and Puerto Rico become the problems of local farming areas of New York, Michigan, Wisconsin, Washington, Oregon and about 40 other States. Nationally, the total population of migratory farm workers and family members exceeds that of Fort Worth, Jersey City, or Syracuse. Taken together with seasonal workers and families like themselves who do not migrate they exceed the population of Kansas City, Buffalo, Miami or Milwaukee.

The migrant problem cannot be accurately measured in total population numbers alone, however, Rather the number of persons involved needs to be multiplied by the number of times the people move. At each of their temporary locations they need housing. They also need access to such as services/education and day care for their children, and health care for their families. While some move only to one location and back again, others move to a half-dozen places during a single season.

Health Problems

Generally the health needs of migrants and other seasonal farm workers and their families are like those of other people. These needs, however, are severely aggravated by many factors:

Poor housing is typical both at home-base and in their northern work areas. Frequently they are exposed to cold without adequate bedding or clothing. They lack adequate facilities for cooking and food storage, adequate water for general family use, and adequate waste disposal. A whole family may eat, sleep and carry on all the activities of daily family living within a space smaller than the average family's living room.

Poor nutrition results from almost complete lack of food in extreme cases when work is not available, and lack of access to places where the food dollar will buy the most.

Poor education, especially among adults, results from dropping out of school at fourth or fifth grade to help the family earn a living.

Poverty reflects both low wages and underemployment. The average annual earnings in 1970 from both farm and nonfarm work was $1,640 per farm worker.

Geographic isolation is among the factors wh ich restrict their access to community services.

Social isolation, resulting in part from language differences and minority group status, is another barrier to their use of community services.

The health problems of migrants also have a community aspect. Typically their home-base areas are deficient in physicians, dentists, nurses, social workers and other health manpower even to serve residents. They lack the capacity and they often lack the willingness to gear their health services to migrants. A similar situation prevails in most northern work areas.

As the migrant with needs for health services proceeds from community to community he finds that the rules for gaining access to services vary from

one place to another. He may go to a hospital and be told that he should first go to a doctor. Or he may go to a doctor's office and be told that he should first go to welfare. Whatever he learns in one place is likely to be inapplicable in another, and the blame for doing the wrong thing is likely to be placed on him. The "run-around" may be the one consistent feature of the health care delivery system that he finds wherever he goes.

The local health worker who encounters a migrant has the problem of not knowing about previous care the migrant has received. Extensive experimentation with personal health records to be carried by migrants has led to minimal success. The record served a useful purpose only when both the migrant and the professional health worker involved understood the purpose and the use of the record. So far no way has been found to get information about the record to all health professionals who might at some time have contact with migrants.

On the East Coast an inter-area referral system based in Florida has had limited success. About half of the patients referred get some follow-up

services as the result of the referral. In some cases the health worker receiving a referral seeks out the migrant and in others the migrant seeks the source of health care. The uncertainty of a migrant's destination, coupled with the other uncertainties of his life, make it somewhat surprising that some, in fact, do present success stories for either the use of a personal health record or the use of an inter-area referral system.

Resources Available to Help

A. Special migrant programs

The Migrant Health Program, operating since 1962, authorizes grants by the Department of Health, Education, and Welfare to public or nonprofit private agencies to help support the provision of health care to migrants. At best the program is a stop-gap designed for people who belong to no community, but underfunded to begin to meet the problem. As implemented at the local level, it frequently amounts to an attempt to build a superstructure to serve migrants where the basic structure to serve rural residents is extremely shaky.

The Economic Opportunity Act of 1964 recognized the special needs of migrants and the related needs of other low-income seasonal farm worker families. The Program has provided assistance to relieve immediate problems of temporary housing and day care. It has also provided education and skill training, in-stream assistance including food, and resettlement assistance. In addition, a number of VISTA volunteers have served migrants in various ways.

Special provisions of the Farmers Home Administration Act enable the Department of Agriculture to make long-term, low-interest loans for the construction or rehabilitation of farm labor housing.

Title I of the Elementary and Secondary Education Act has special provisions for the education of migrant children. Grants are made by the Office of Education to State Departments of Education for this purpose. At the discretion of the State or local district, health services can be provided which are essential to a migrant child's being able to learn.

The former Farm Placement Service of the U.S. Department of Labor was recently reorganized as the Rural Manpower Service. The change represents a significant shift in the program's major emphasis. Special services geared to migrants include arrangements for training in new skills and relocation assistance. They also include advocacy when health services are required.

B. Programs for general population

Many health programs for the general population can be adapted so that migrants are served. The Crippled Children's Program has accepted eligible migrant children. Vocational Rehabilitation has served eligible migrant adults. In Michigan, the State welfare agency pays hospital bills incurred by migrants. Medicare benefits are available to qualified migrants. National Health Service Corps recruits can be assigned to communities where needs arise in part from a periodic influx of migrants. The Family Health Center Program, just now getting started, has potential for the development of services for migrants. Rural satellites of Health

Maintenance Organizations have similar potential. The Regional Medical Program can help to support adaptations in service to meet the special needs of migrants. It is already helping to improve the basic health service delivery structure in many rural areas.

Both special migrant programs and programs for the general population, however, present a fragmented, fractured picture. With rare exceptions, the services offered lack continuity in either time or space. They may be better than the services of a dozen years ago. They still leave much to be desired.

As Comprehensive Health Planning agencies get started at the State or areawide level, groups such as migrants and other low-income seasonal farmworkers present a special challenge. The question is, how are migrants represented? Do they have a voice? Does anyone think, or speak, for them? Can CHP agencies in different areas and States relate their planning in such a way as to diminish the present variability in health services and the way they are offered to migrants?

Suggested Ways to Assist Migrants

The best way to assist migrants and other low-income rural people is to work with them on their terms toward their goals and objectives. The new farmworkers' family health center at Toppenish, Washington, is an example of what can be done when farmworkers and professionals get together. The farmworkers' organization is now operating its own health center set up with the information, advice and direct assistance of the University of Washington, the Regional Medical Program, the Regional Office of the Department of Health, Education and Welfare, church organizations, and many other groups.

The leadership of Cesar Chavez in farm labor organization may not win him popularity contests in many rural areas. Yet through their own farm labor organization, migrants and other seasonal farm workers eventually can establish their own health programs with contributions from employers negotiated as part of the fringe benefits under their work contracts. Assisting the union in its health program development, as assistance is requested, is another way of

working with migrants and other low-income rural people on their terms toward their goals and objectives.

Providing a setting in which people can cope with problems is another way to assist. This means using whatever resources are available, and organizing them in an appropriate way, so that health manpower in the requisite number, working out of facilities with the requisite space and equipment, will be consistently present to serve people in an understandable, acceptable way when and where the people need service.

The place to begin is not with the superstructure, as we have in the past migrant health program, but rather with the basic health care delivery structure in rural areas. We have been trying to build an attic before we built the house. If we get the house built first, adding an attic will be much easier.

In building the basic structure, we need to look at programs for the general population to get the barriers removed that now restrict migrants'

access to health care. Such a barrier is the eligibility determination process for Medicaid as it now exists in most States. If, for example, documentation of past earnings is required, few migrants can qualify. Moreover, eligibility requirements vary from State to State and the migrant who wanted to qualify for Medicaid on a continuing basis would have to go through the screening process repeatedly. Few approaches to obtaining care would be likely to turn migrants off more quickly.

We also need to look at developing programs such as the Family Health Insurance Plan to assure ourselves that barriers of this nature which will keep migrants outside the program are not built in. The enrollment feature of Health Maintenance Organizations is another potential barrier to serving migrants. If an HMO is established to serve an enrolled population, what will happen if migrants come to the HMO area temporarily? Especially if an HMO satellite center is the major source of care in an outlying community, how will the needs of people such as migrants be met?

A third measure to help people cope is to provide health education for problem-solving as they define their own problems in the setting where they live. This means much, much more than using health education films, pamphlets or radio programs with individuals or groups of migrants. It means personal contact with the people to listen and understand what they say. It further means working with them in their setting so that the solutions developed with their participation match the problems and the situation.

Obviously, a professional health educator or other health professional cannot sit on the doorstep of every migrant family to carry out health education. But health education leadership can be provided that will help migrants, themselves, to become effective health educators. This process may need to begin with some sitting on doorsteps especially if the professional health educator has never previously been exposed to the migrant situation.

Finally, massive rehabilitation effort is needed in some of the major supply areas from which migrants are drawn. The purpose would be to

eliminate the lack of education, lack of skills, lack of good health and often lack of hope that breed poverty and desperation great enough to make people move down a hopeless road to agricultural jobs that continue to disappear as the years pass. We have learned from vocational rehabilitation that a fairly massive expenditure for full-scale rehabilitation often turns a severely handicapped person into a productive worker. We have applied the principles of rehabilitation to land in massive soil conservation effort that has turned barren areas back into production. We are only beginning to try this approach with communities of people. In Casa Grande, Arizona, the Arizona Job College has a program for basic education, skill training, day care, health services, and other supportive services for former farm workers and other people stranded there without employment and with no place to go. The objective is to work with the people until they get productive employment and can go their own way. The program has operated for too short a time to prove itself, but it looks promising. In New Mexico, a somewhat similar program is called "H.E.L.P."--Home, Education, Livelihood Program.

We have had many piecemeal, short-term approaches to the problems of deprived people living in communities that have been identified for generations as pockets of acute rural proverty. We have also seen a great deal of total neglect, except perhaps as journalists visit occasionally and write dramatic reports that are forgotten almost as soon as they are published.

The problems are not new. The need for a massive rehabilitation effort has been recognized for a long time. Thus a writer in the Department of Agriculture's Yearbook for 1940 concluded--more than 30 years ago:

> "There are certain needs--food, housing, clothing, sanitation, and medical facilities--that have their basis in man as a biological being. These needs...should be established as primary minimums of an agricultural program."
>
> ...
>
> "When a set of conditions making for rural poverty is of long standing, influences a large segment of the rural population, and

comes to be recognized as socially unhealthy...it becomes desirable, even imperative, that measures for improvement be applied in the interest of general rural welfare. That such conditions do exist in America...cannot be gainsaid."