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HISTORY OF MIGRANT HEALTH

With monotonous regularity for more than 50 years, commissions, committees and study groups have reported on the problems of migratory farmworkers including their illness and disability and their lack of access to community health services. In part their poor health is attributed to their poor environment and in part to their poverty, lack of education, cultural differences in perceptions of health and health care, and lack of access to health care.

As early as 1909, President Theodore Roosevelt's Country Life Commission recommended improvements in farm labor camps. In 1915, President Wilson's Commission on Industrial Relations declared that the conditions under which migratory workers lives are such as "to inevitably weaken their character and physique, and to make them carriers of disease..."

As Dust Bowl refugees swelled the ranks of the farm migrants in the 1930's the National Catholic Rural Life Conference bemoaned the fact that "Many of these farm laborers live in wretched hovels rather

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than homes; they work long hours, receive little pay, and eke out their existence under conditions of abject poverty. Because of their squalid living quarters as well as insufficient and unbalanced diets, they are an easy prey to all sorts of illnesses ..."

In 1940 the Public Health Service compared disabling illness rates for interstate transients and for residents of similar socio-economic status during a three-month period. For each of the disease groups observed, except degenerative diseases, the rate for family interstate transients was higher than for poor residents. For digestive diseases and for accidents the rate for transients was two and one-half times that for residents.

The high rate of digestive disorders was considered by the Public Health Service to be "significant" and related to "the conditions under which many ... migratory agricultural workers live ..." The report also noted that "over half (57.8 percent) of the disabling illness of family transients received no medical attention at all, while among residents the proportion was only one-third. ..."

A brief partial respite in the gloomy past of migrants' health conditions came during World War II. Health services for poor rural residents were generated by the Farm Security Administration during the depression of the 1930's. The Farm Security Administration early learned that a program established for county residents failed to reach equally or more needy transients who were in a county for only a brief period to meet peak farm labor demands. In the early 1940's, the war-time farm labor shortage provided the stimulus that was needed to establish a health program for migrants adapted to their special situation.

The program was implemented through nonprofit Agricultural Workers Health Associations. The first Association started operating on an experimental basis in 1938 in the Southwest. During 1938 it handled approximately 15,000 patients through 18 offices in California and Arizona at a cost of $400,000 or an average cost of $26.67 per patient per year.

By the mid-war years, six Agricultural Workers Health Associations were operating under contract with the War Food Administration in the U. S. Department of Agriculture. They were organized to include States

along each major route of migration. They served primarily residents of government-financed farm labor camps and reached a peak of 102,000 persons (including both domestic and foreign workers) in any one year. The monthly cost per person averaged about $2 for the entire period of the wartime operation. Medical, dental, hospital and nursing services were provided with heavy emphasis on nursing services.

With the liquidation of all "emergency" programs immediately after the end of the war, the Agricultural Workers Health Associations were discontinued. The medical officers and other professional health workers who had been assigned to the War Food Administration by the Public Health Service to administer the program returned to the Public Health Service or left the Government altogether.

In 1947, an interagency committee involved all major Federal agencies whose programs had a bearing on migratory labor. This committee reported on migrants' health and other problems and made extensive health recommendations. These recommendations were circulated to all State Health Departments as well as to many other public and voluntary agencies. They had little effect.

Then followed more than a dozen years of studies, conferences, reports and recommendations but little action. Most of the activity in the late 1940's and the 1950's was limited in scope of service, in geographic coverage, or in both. In New York, for example, a special staff of nurses assisted by county public health nurses conducted clinics, and provided health examinations, immunizations, and health education. They also took special measures for the control of syphilis. Local areas in a number of States conducted limited tuberculosis and venereal disease screening programs in migrant labor camps. Often the cases identified by screening programs had already disappeared by the time the findings became available.

The fact that many babies in the families of seasonal farmworkers were dying in California's wealthy San Joaquin Valley attracted nationwide publicity in the early 1950's and stirred the State first to make a study and then to take some limited action. The study recommended "greater decentralization of health facilities, utilization of growers' camps, and establishment of local clinics in outlying communities...; because the status of nutrition has a direct effect upon health, attempts should be

made locally to provide at least one nutritionist for each county health department. ...; a planned and organized system of medical care on a state-wide basis...particularly in view of the fact that many (workers) ... are not county residents."

The most positive outcome in terms of improved conditions was the establishment of the West Side Clinics in Fresno County in 1951 with grant assistance from the Rosenberg Foundation. In some respects, the new services in Fresno County resembled those of the Agricultural Workers Health Associations. In one important respect they differed--that was in the tremendous involvement of the community, from migrants, themselves, to influential growers. When the Foundation grant expired, the West Side clinics seemed likely to be closed. Deep community involvement was then the fact that overcame the hostility of the local medical society toward these nontraditional ways of serving people and won support from the county board of supervisors for continuation of funds.

Successful as the West Side demonstration was, it served for many years only as a nice example of what might be possible under very special

circumstances. It was not copied even in adjoining areas of Fresno County--not to speak of other counties in California. People from all over the Nation and the world came to observe the work of the nurses in the camps and the services of the crowded night clinics. Still little happened elsewhere.

On the other side of the continent a similar project developed in Palm Beach County, Florida, at about the same time as the one in Fresno County. Here, too, the demonstration continued year after year without being copied even in adjoining counties. Through vast reaches of agricultural areas between California and Florida, there was one Children's Bureau--financed demonstration in Colorado, and a few local service projects sponsored by Catholic or Protestant church groups. There was little communication among these project sponsors, or between them and professional organizations in other areas to which "their" migrants went at other times of the year.

For the migrant, community neglect compounded his self-neglect. And self-neglect was to a considerable extent induced by his feeling of rejection by communities. The only interest most communities had in the migrants was to have them present when they were needed, and to have them leave as soon as possible when the need was over.

In all the years between the 1940's and the 1960's, the way was open for States and local communities to accept migrants and to plan to extend local health services to them for the duration of their stay. No restrictions were placed on Federal funds allocated to States for health purposes that would necessarily limit their use only to persons who were considered to "belong." In fact Federal representatives frequently used their persuasive powers to encourage the use of funds for care of migrants. But the State and local doors to migrants remained generally closed.

Medicaid and "Partnership for Health", both programs in which the States set the priority, up to the present time show little disposition suddenly to lift the migrant from the bottom of their priority list where he has been for so long. Those with the most experience who have worked the longest toward extending health care to migrants again and again affirm the continued need for the special attention to migrants' needs which is provided through the Migrant Health Act.

Now, as in 1962 when the Migrant Health Act was first passed, there is a need--not for special studies or demonstrations--but for service to migrant

people, geared to their special situation and need, with the possibility of continuity of care as they move from place to place increasing as each locality takes responsibility for extending its health services to them for the duration of their stay. Preventive services--immunizations, health education, nutrition counseling, topical application of fluoride, child-spacing services, and others--need to be an integral part of the "one-door" provision of health care at times, at places, and under circumstances that make it possible for workers and family members to use care conveniently and with self-respect. To supplement the outlying clinics, arrangements continue to be needed for special tests and treatment, and for health services when no clinic is operating.

Nor can the health and safety of migrants' living and working environment be neglected. Along with camp certification and legal enforcement of regulations, education of the grower continues to be needed as to his responsibility, and education of the migrant and his family as to theirs. The working environment, too, increasingly needs to be a concern as new health safety and hazards develop and old ones continue.

Many more aides recruited from among migrants and ex-migrants need to be trained and given opportunities for working up the health career ladder, first serving as liaison health aides to help meet a variety of needs in the clinics and the homes of migrant families.

At the other end of the professional worker scale, continued effort needs to be made to involve medical, dental, nursing, social work and other students and faculty members as well as volunteers from church-related institutions, youth groups, civic organizations and a variety of other sources. Each migrant health project should continue and grow as a channel through which the efforts of groups like these can be productive, and through which the benefits of programs for crippled children, mentally retarded, vocationally handicapped, Medicaid, Partnership for Health, and others can reach the migrant population.

The advice of migrant people should continually be sought to help orient project staff members and other project participants to the needs and desires of migrants as people. And the use of migrant health projects as a beach-head for broader developments to serve other needy rural people should be encouraged, with full use of all available resources.