# Residence Rules and Migratory Workers

by Margaret Greenfield

Migratory farm labor has less available medical care as well as higher levels of infectious and parasitic diseases, circulatory diseases, and accidents than any group in our population. Despite the slowly growing extension of clinic services through federal and state subsidized pilot projects, great gaps continue to exist in medical care, chiefly because so many lack legal residence.

Migratory workers as a group can be automatically classified as medically indigent. State law requires that counties provide aid to the medically indigent who are lawful residents. The State law also requires that a county hospital must admit any expectant mother who is unable to pay for her care and must admit any person in need of immediate hospitalization on account of accident or sudden sickness or injury.

Legal residence is defined as three years in the State and one year in the county where application is made. If an applicant for assistance or medical care has no county residence, then the county where he last resided continuously for one year immediately preceding his application is responsible for his support. If the applicant has no such year's residence within the three years preceding his application, that county wherein he was present for the longest time during the period, is responsible.

Under the law it is the duty of every county to pay for any treatment of its own indigent residents that is furnished by any other county, unless a reciprocal agreement relating to medical care exists between them.

Although reciprocal agreements are increasing, intercounty billing still takes an inordinate amount of time on the part of social service departments, collection departments, and the State Department of Social Welfare, which has the responsibility of deciding such disputes between counties.

County residence requirements do not apply to a large segment of the medically indigent--recipients of the categorical aids, including the needy aged, blind, disabled, and families with dependent children, since the county that gives the aid is also responsible for hospitalization. With the exception of AFDC families, however, it is unlikely that such recipients would be working on the crops.

## County Policy

Residence requirements are a definite hindrance in giving hospital care to migratory farm workers except in a medical emergency. Of the 35 counties that are heavy employers of such labor, only 15 will give service to someone who has State but not county residence, and only 9 of these will serve an individual who has neither state nor county residence. For the most part, service is given only during the period of investigation and authorization to return to legal residence, or when the applicant has expressed an intent to reside in the county.

Fresno, San Joaquin, Santa Clara, and Stanislaus counties, each employs more than 10,000 agricultural migrants at the peak of a normal crop season. Except in an emergency, the Fresno county hospital will accept no out-of-state resident, and will take someone from another California county only when he has declared an intent to reside in Fresno County.

San Joaquin county hospital accepts only nonresidents who plan to establish residence in the county. Neither of the other two counties will serve a nonresident.

Of the nine counties that employ between 3,000 and 10,000 domestic migrants, no service is given nonresidents in Contra Costa, Kern, Kings, Sonoma, and Tulare counties. Imperial, San Benito, and Sutter counties do not care for out-of-state residents and serve residents of other counties only when they cannot, for one reason or another, be returned to their legal residence. Of this group of counties, only Merced appears to have a socially sophisticated admissions policy, for the county hospital extends service when the medical director advises that such care is necessary in order to prevent future illness or disability, or to prevent the patient from being unable to care for himself or his dependents, or otherwise to prevent such a person from becoming a public charge, and if return to legal residence is considered impractical by the director of public welfare.

From 500 to 3,000 domestic migrants are employed at the height of the crop season in 22 counties. In 13 of these no hospital service is given nonresidents.[1] Of the other 9 counties, Alameda, Glenn, Monterey, and San Bernardino furnish service in urgent cases during investigation and establishment of legal residence, and all except Alameda continue care if the patient cannot be returned to a legal residence. Alameda takes care only of tuberculosis and obstetrical cases when the patient refuses to return to a legal residence. In this group, Butte, Colusa, Mendocino, and Solano counties have somewhat more liberal policies, the decision on whether or

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[1] El Dorado, Lake, Madera, Modoc, Napa, Placer, Riverside, Sacramento, San Mateo, Santa Barbara, Santa Cruz, Tehama, and Yuba.

not to accept nonresidents being determined on an individual case basis, although in these counties, also, an individual who seems likely to remain in the community would have more chance of obtaining care than someone who was clearly migrant. The other county in this group is Los Angeles, which does not give hospital service to residents of other states but will serve residents of other counties if they are residing or visiting in the community, and not in a condition to be returned to their legal residence.

In seven other counties where between 100 and 500 domestic migrants are employed at the season's peak, three--Marin, Shasta, and Yolo--do not pay for hospitalization of any nonresident, and two--Orange and Ventura--will not help migrants from other states. Orange serves State but non-county residents only when they are physically unable to return to their legal residence, and Ventura extends service to this group only under special circumstances. Siskiyou County serves a non-State, noncounty resident only if return to his legal residence is not authorized or he is too ill to travel. San Luis Obispo gives medical care only to persons who have moved to the county and have not had time to complete the residential requirement.

In discussing the residential requirement as a factor of eligibility for county hospital care, it is important to remember that county hospitals must admit emergency cases and that interpretation of "emergency" depends very much on the admitting physician, and sometimes his interpretation is a broad one. On the whole, however, the residence requirement is used to keep people out of the county hospital and to cut down on costs.

## The Farm Labor Market

Before we go on to possibilities of coping with this problem, let us examine the total situation a little more fully. California agriculture has always been dependent upon great numbers of itinerant workers to harvest its crops. More than 200 different farm products are grown for the commercial markets, and the harvest peaks are so distributed that the demand for seasonal workers in particular crops stretches over the whole year. The areas of labor demand are widely distributed from the Imperial Valley on the Mexican border to Tehama County at the northern end of the Central Valley, a distance of 800 miles. From the earliest periods in the State's history, there has been a large pool of labor, not directly associated with individual farms, which is a necessary supplement to local labor forces during periods of high labor requirement.

Giant corporation farms are the chief employers. More than three-fourths of the farm land in California is in enterprises of a thousand acres or more. In Kern County, for example, one farm enterprise comprises 2,800 square miles, an area twice the size of the State of Rhode Island. The ratio of hired farm workers to family labor in California is twice that of the nation as a whole. In 1962, family labor constituted 29 percent of the average agricultural work force, year-round workers 29 percent, seasonal domestic workers 32 percent, and foreign nationals 10 percent. At the peak of the season, 44 out of every 100 seasonal workers were local residents; 32 were foreign nationals, chiefly Mexican; 16 were migratory workers from other California counties; and 8 were from other states. The fact that two out of three of the migratory workers are now California

residents is an important factor in considering the problem of medical care. It must be remembered, however, that although the proportion of interstate migrants is small, at the peak of the season they may number as many as 25,000 laborers plus their families.

Today we are discussing here only the problem of medical services without going into the reasons why public medical care is necessary--a labor market that does not provide its workers with income high enough to maintain even a minimum standard of living. And let us not forget that for more than 60 years the problems of migratory farm labor have occupied public attention. Committees and commissions, official and private, federal, state, interstate, and local, have investigated the situation and made recommendations to improve it, but living conditions--housing, health, sanitation--although improved over the grapes-of-wrath days, remain far below the standards for workers in other industries. These workers, moreover, have little social insurance coverage.

## Social and Other Insurance

Since 1956 agricultural labor has been covered by the federal old age, survivors and disability insurance law if the individual's cash pay by a single employer amounts to $150 during a calendar year or if he works for one employer 20 days or more during the year. There is no unemployment insurance coverage.

California agricultural workers are covered by workmen's compensation for which the employer pays, and since October 1961, by nonoccupational disability insurance, for which the worker pays 1 percent of his wages up to $3,600. Disability benefits have been available since May 1962. Benefits, as for other workers, range from $25 to $70 a week, according to base-period wages, up to 26 weeks a year, plus $12 a day for hospitalization up

to 20 days. Whether a migratory farm laborer would be eligible for disability insurance benefits would depend on whether he had received wages of at least $300 during the base period. The employer is liable for making the insurance deduction from the worker's pay. As of September 1963, claims attributable to agricultural wages were much lower than anticipated, partly because of limited knowledge about the program.

There have been many recommendations to cover all farm workers with some form of health insurance. The California Farm Bureau Federation has for some time offered a group hospital-surgical insurance plan to its member employers for permanent employees and their families, and at present has some 700 families enrolled. The Federation, along with the California Medical Association and California Physicians' Service, for the past two years has been exploring the feasibility of a health insurance program, on a pilot-project basis, to cover outpatient services for seasonal farm employees and their families. Preliminary plans call for financing by payroll contributions to be made by both growers and workers.

Such a plan seems highly infeasible chiefly because the income level of the migrant group is too low to pay any reasonable premium even when shared by the employer. Furthermore, since no hospital benefit is contemplated at present, residence requirements would still exclude the migrant family from county care. Moreover, since such insurance would cover only working months, the laborer and his family would be without medical services the rest of the year. This is a praiseworthy project, however, especially as it reveals recognition by the growers that they have some responsibility for their workers. Today virtually all of basic industry and a good many commercial corporations are paying in full for the health insurance of their workers. It is time that agriculture caught up with the modern world.

In the late 1930's domestic migratory workers in California were covered by the Agricultural Workers Health and Medical Association formed by the Farm Security Administration, with the cooperation of the California Medical Association, the State Department of Health, and the State Relief Administration. A migrant worker made application for medical treatment at the Association's district office or camp treatment center. He then selected his physician from a list of participating physicians or was treated by the local part-time physician in charge of the treatment center. The Association was billed for the medical or hospital services rendered. Workers were obligated to repay the cost of service if requested, but their economic status usually precluded any expectation of repayment. This program continued with federal financing throughout the war and was discontinued shortly after hostilities ceased.

Mexican nationals are the only transients now covered by health insurance. This is by international agreement, and the premiums are paid by the workers. Some of the larger farm labor camps maintain medical clinics in cooperation with the insurance companies with whom policies are covered. As of June 1959, the program provided medical, surgical, and hospital benefits at a $4 per-month premium. The program also paid $15 per week cash benefits up to a maximum of $1,000 for partial disability; $10 per week up to a maximum of 26 weeks for temporary total disability, and an accidental death benefit of $2,000.

## What Next?

The question still confronting us is what to do about domestic migratory workers and their families. As I pointed out earlier, two-thirds of these have California residence if not county residence. Theoretically, if they fall ill and meet other eligibility requirements, the county in which they have longest residence is responsible for their care. Unfortunately this does not always work out because counties of which they are not legal residents hesitate to give care when they are uncertain which county is legally responsible and not sure that their bills will be honored by the responsible county. It seems to me that the only practical way to handle this situation is for the State government to take responsibility for medically indigent persons whose county residence is not established. Several other states handle the problem in this way.[1] In New York, for example, the needy migrant who has no settlement in the state and has not lived there for one year becomes a state charge with full state reimbursement for costs of care and assistance provided by the local agency. According to recent studies in New York City and selected up-state districts, all nonresidents including agricultural migrants, made up less than two percent of the caseload and of the total relief expenditures during the year. Hospitalization was a major cause of dependency among all nonresidents.

California county hospitals, of course, are at this time receiving substantial state and federal contributions in the medical-aid-to-the-aged program. During fiscal year 1962-63, for example, county hospitals

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[1] Florida, New York, North Dakota, Pennsylvania.

throughout the state received more than $41 million[1] for care of aged persons, the overwhelming majority of whom would have been their sole responsibility before January 1962. Additional State payments include sums for outpatient care in the county hospital clinics of persons eligible for services under the State public assistance medical care program.

Since California needs a great many out-of-state workers to harvest its crops and the entire state economy benefits by their work, it might well be argued that the State as a whole--meaning State government--has a moral responsibility for medical care to these migrants also. State government, however, is usually loathe to start new welfare programs without aid of the federal government. The federal government is already making considerable contributions to state welfare programs, so there is good precedent for a federal subsidy for care of out-of-state migrant workers. Indeed, many study commissions have favored the idea of federal aid for migrants since the federal government has jurisdiction over interstate commerce. A federal contribution to the cost of general assistance--the only program in which neither state nor federal government now participates--would be a better way of accomplishing this end, particularly if it were offered on the basis of abolishing residence requirements, as in the Medical Aid to the Aged program. A social security act which would include nationwide health insurance would also accomplish the purpose--but we don't dare discuss that.

So far we have been talking about governmental action. But there is another point of view, and that is that the taxpayers should not be expected to subsidize the growers' employees. Since seasonal labor is needed in

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[1] Almost 30 percent of county hospitals' total expenditures.

agriculture and since agriculture nowadays is big business for the most part, it should assume responsibility for its workers. There are localities in the country where this is done. Direct medical services are sometimes made available to migrants by employers in some areas. In other places, companies assume responsibility for aid in financing rather than providing direct services. In one state a small levy is assessed on all members of a particular farmers' association per ton of product delivered. This sum is used to meet unpaid hospital and medical bills left at the end of the crop season. The size of the levy per ton is determined at the end of each season by the amount of unpaid bills and the total tonnage harvested by each member. At the time bills are incurred, the worker is expected to pay to the extent of his ability. If an amount is still outstanding, the employer must pay 10 percent or the first $10, whichever is the greater. The remaining amount is met by the growers' association.

These are examples of what the agricultural industry could do--aside from some rational reorganization of the farm labor market, which might be too difficult. I have suggested what the state and federal governments could do. Perhaps the speaker from the county supervisors association will tell us what county government and the local community can contribute toward solving this problem.

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