Migrant Farmworkers in Wisconsin

Migrant farmworkers all over the country face the same problems—too little money, poor health, and too little schooling. These are the problems of migrants who rely on farmwork for their livelihood, not the part-timers who work on farms during vacation from high school or between semesters at college. This article documents the situation for Wisconsin's migrants, most of whom travel over 4,000 miles each year in search of work.

After two decades of steady decline, migrant farmworkers now constitute only about 5 percent (115,000) of U.S. hired farmworkers. A survey of migrants in Wisconsin shows them to have lower incomes, less schooling, and poorer health than other farmworkers and the general population, so they still need the attention of public policy. To that end, the Wisconsin survey helps to portray who they are, where they come from, and under what conditions they live and work.

Wisconsin's migrant farmworkers are representative of those in the Midwestern migration stream. About 90 percent originate in the Rio Grande Valley on the Texas-Mexico border, are primarily Hispanic, and travel long distances to pick and can fruits and vegetables.

Migrant workers employed in Wisconsin agriculture peaked at 15,000 in the mid-1950's and now number about 3,000 traveling with about 1,500 dependents. About one-fourth of them travel alone across the country, leaving their families at home; about one-eighth travel with a friend or relative; the rest travel in family groups—working couples accompanied by their children or other relatives (fig. 1).

Wages for Most Supplemented by Transfer Payments

The migrants we surveyed earned about 72 percent of their total yearly family income from migrant farmwork. Their farm income in 1977 was just below $1,200 per capita, with almost 90 percent of the workers and their families having per capita incomes below $2,000. This compares with the 1976 annual per capita income of $6,300 for Wisconsin residents and $6,400 for the Nation as a whole.

About 35 percent of the families had income from wages only; 29 percent had a combination of wages plus nonwelfare Federal transfer payments (unemployment compensation, workers' compensation, social security, veterans' benefits, or disability payments); 23 percent had income from a combination of wages, transfer payments, and loans; and the remainder had income from various other combinations, including public welfare assistance. Wages were the only source of income for 42 percent of the fieldworkers and 29 percent of the cannery workers; 37 percent of the cannery workers received wages plus Federal transfer payments compared with only 18 percent of the fieldworkers. Workers in large canneries are often covered by social security or unemployment compensation; some even receive health insurance benefits. This is less likely to be the case for migrants working in fields.

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One of the lucky ones. Most children of migrant farmworkers do not get regular medical attention.
Approximately 65 percent of the workers or their families received public assistance (fig. 2). Fifty-six percent of the migrant families received food stamps, chiefly while they were in Wisconsin, and 28 percent received unemployment compensation, mainly while in Texas. Sixty-six percent of eligible migrant families participated in the Women, Infants, and Children nutrition program (WIC), offered only to families with pregnant or lactating women, or children under age 5. That compares with estimates that about 45 percent of the eligible Wisconsin population participates in the WIC program.

Thus migrants' income comes from wages, Federal transfer payments, State public assistance, in-kind programs, and other sources. Not only do the source and amount of income vary each month, but the payments must follow the migrants as they move from State to State.

**Little Medical Care Despite Poor Health**

In health surveys by the National Center for Health Statistics and others, respondents are often asked to evaluate their health status by answering the question, "In general, would you say that your health is excellent, good, fair, or poor?" Thirty-six percent of the migrant workers perceived their health to be "fair" or "poor" (fig. 3), compared with only 13 percent of the total U.S. population. Migrants who considered their health to be fair or poor tended to be older, female, have less education, and speak only Spanish.

The medical conditions that most frequently bothered the migrants were headaches, eye trouble, backaches, tooth and gum trouble, nervousness, irritability, insomnia, and low spirits. As in most health surveys, women reported more symptoms than men. However, for both men and women, migrants visited physicians and medical facilities consistently less than others did. For example, 57 percent of the migrants had visited a physician in the year before the interview, well below the national figure of 76 percent reported by persons with family incomes below $5,000.

Especially lacking are visits for preventive care. About 30 percent of the migrant workers said they had never received a general physical exam when there were no signs of illness, 25 percent had never been to a dentist, and 35 percent had never had their vision checked. Once again, these proportions are much higher than those of the U.S. population. The same applies to the time since their last visit for those who had received a general physical, dental, or eye examination. The clear pattern is that migrant workers receive less preventive medical care than other groups in the United States. This includes dental care, vision care, general physical exams, and also, for women, pelvic exams, Pap tests, and early prenatal care.

What are the barriers to receiving this care? Basically, they have to do with matters of distance, clinic hours, language, and money. Migrants report
a lack of nearby medical facilities, problems in arranging transportation, and services not open nights or weekends. In addition, there are virtually no Spanish-speaking health professionals in the rural areas where they work.

A network of migrant health clinics is run by the Office of Migrant Health of the U.S. Department of Health and Human Services. These clinics, however, are few and far between. Wisconsin, for example, has only one migrant clinic in the entire State.

Migrants most likely to use medical services tend to be older, female, and bilingual. Because they are so poor, migrants often cannot afford medical treatment. A few families (about 15 percent in Wisconsin) were eligible for Medicaid. Of those who received medical care in the year before the survey, about 40 percent used the services of the migrant health clinic. Another 20 percent had some type of private health insurance plan. About 18 percent paid their bills out of pocket, and the remainder (about 18 percent) paid their bills through a combination of methods.

Children’s Schooling, Health Care Similar to Parents

Most children of migrant workers travel with their parents. After the age of 12, they are legally permitted to work in Wisconsin with parental consent. During the summer months children under 12 are likely to be in migrant education classes (funded by the Wisconsin Department of Public Instruction and administered by the Texas Migrant Council).

In 1983, approximately 2,500 migrant children attended schools in Wisconsin that received migrant education funds. To qualify for this program, the children and their parents had to have moved from one school district to another for the purpose of seeking agricultural work within the past 6 years. About 34 percent of these children were born in Texas, 21 percent in Mexico, and the rest in other States. About 40 percent of the children had moved to Wisconsin within the past year; the remainder had lived in Wisconsin for 2-6 years.

Who Are Migrant Farmworkers?

Only 5 percent of the Nation’s hired farmworkers migrate over a county or State line, stay overnight, and are actually “migrant” workers. In addition, about half of these migrant workers are students or housewives; farming is not their main occupational pursuit and they work only a few days or weeks to earn extra income.

This article addresses the remaining migrant workers—those whose livelihood depends on following the cultivating and harvesting seasons across the country. These workers are the ones who travel thousands of miles in search of migrant work and spend over 100 days per year in farmwork. Farmwork is their main source of income rather than a source of supplemental wages.

Data presented in this article are from a 10-percent random sample survey of Wisconsin migrant farmworkers conducted in 1978, supplemented by additional information obtained from employers in 1981.

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How Reliable Are the Estimates?

Some estimates of numbers of farmworkers may be called into question. Federal statistics rely on a Current Population Survey (CPS) administered to a sample of U.S. households in December to measure the number of migrant workers. December, of course, is the least likely month to find migrants performing agricultural work in the United States. However, in the CPS survey, respondents are asked if they had done any farmwork in the previous calendar year.

According to Whitener (Monthly Labor Review, June 1984), the number of persons identified as farmworkers in the CPS appears generally to agree with those who report farmwork as their occupation in the U.S. decennial census. However, persons without permanent residence are one of the most undercounted groups in national censuses and surveys, and the special subgroup of migrant farmworkers falls into this category.

To illustrate the difficulty of counting migrants, here are a few of the problems and questions raised in the Wisconsin survey. Since migrants moved from location to location, not only from State to State, but often within States, when does one count them? When they enter the State? When they leave the State? When they reside at their main employment location? Who gets counted as a migrant worker? Does one count only workers who are on payrolls? Only heads of households who utilize and are paid for the labor of their families and children? Should one count the children and relatives separately? Is there a possibility of double-counting the same worker at two different locations? Do children work in some locations but not in others? What about undocumented workers? Will they be on payrolls? Will they answer survey questions about farmwork? What about itinerant laborers who drift from site to site, never staying more than a week or two in one location?

Even with the tidy definition distributed by the Department of Agriculture, i.e., persons who cross a county line and stay overnight when earning a wage or salary in farmwork, we may have difficulty counting all those who fit the definition.

![Figure 4](image-url)
Children of migrant workers received little preventive health care. For example, pediatricians recommend yearly checkups for young children. But only half of the migrant children under 12 got them, and only a third of the migrant children age 12-15 (fig. 4). A similar situation exists for dental care. About one out of three children under 16 had seen a dentist in the past year, and again the older children went less than the younger children.

Immunizations, however, appear to be up to date in this population. About 90 percent of children age 3-16 were immunized for diphtheria, pertussis, tetanus, polio, measles, and rubella. Most immunizations are received in school health programs directed toward migrant children. Our research indicated that older children were more likely to be immunized than younger children, mainly because of exposure to immunization programs in schools.

Conclusions

Although the number of migrant agricultural workers has steadily declined over the past 20 years, due to the development of mechanized harvesters and use of herbicides and pesticides that have replaced hand cultivating and weeding, they are still needed for some farm operations. These workers tend to be older, rely on migrant work as their primary occupation, have minimal formal schooling, and live in poverty. Their health status tends to be poorer than most Americans. Barriers of money, work schedules, language, and distance discourage their seeking medical care. Especially lacking in this population is preventive care—for both adults and children. National policy must continue to address the needs of this impoverished work force.

For Additional Reading...


In-Kind Benefits Help Reduce Poverty

When determining the number of poor, government statisticians look only at cash income, not at other benefits received as goods and services, such as food stamps, public housing, and medical care. What if they did? Would they find that poverty has been eliminated and is no longer a problem? Recent evidence suggests some people would continue to need assistance and poverty would still be a problem.

In-kind benefits for the poor increased dramatically between the mid-1960’s and early 1980’s (fig. 1). The official measurement of poverty considers only money income and not “in-kind” benefits (such as food stamps, public housing, or medicaid), which are received as goods and services rather than as money. If in-kind benefits were valued and included as income, the poor population would be greatly reduced. Even so, the percentage of poor would still be higher in nonmetro areas than in metro areas and some groups, including blacks and people in female-headed families, would continue to have high poverty rates.

In assigning a value to in-kind benefits for this article, I used the market value method. The market value is equal to the purchase price of the good or service (see box on "Valuation Techniques and Data"). For example, the market value of food stamps is the dollar value of the food coupons. I selected the market value method because it values in-kind benefits higher than other methods and reduces poverty the most. All other poverty estimates fall between the official and market value counts.

In-kind transfer payments valued by the market value method in this article are listed in table 1. (See box on “Selected In-Kind Programs” for a brief description of each). People receive poverty-oriented transfers only if their income and assets fall below program guidelines. For example, a family of four was eligible for food stamps in December 1983 if its gross monthly income was less than $1,073 and its assets, such as cars, savings, and stocks had a value of no more than $1,500. General transfers have no income or asset tests for eligibility requirements. For example, medicare helps pay the medical expenses of the elderly, whether they are poor, middle-class, or wealthy.

Table 1 lists only programs considered in the Census Bureau’s data. Because of a lack of data, it excludes other in-kind benefits, such as group health insurance paid by employers. Both poverty-oriented and general transfers were used in the analysis because the poor can receive benefits from both types of programs. A program can help alleviate poverty even if it is directed toward the general population rather than just the poor.

Even when a value is assigned to in-kind benefits, nonmetro areas continue to have a higher poverty rate than metro areas (fig. 2). Adding in-kind benefits reduced the 1983 poverty rate by a third: from 15.2 to 10.2 percent for the United States, from 13.8 to 9.1 percent for metro areas, and from 18.3 to 12.8 percent for nonmetro areas.

Table 1—In-kind benefits

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