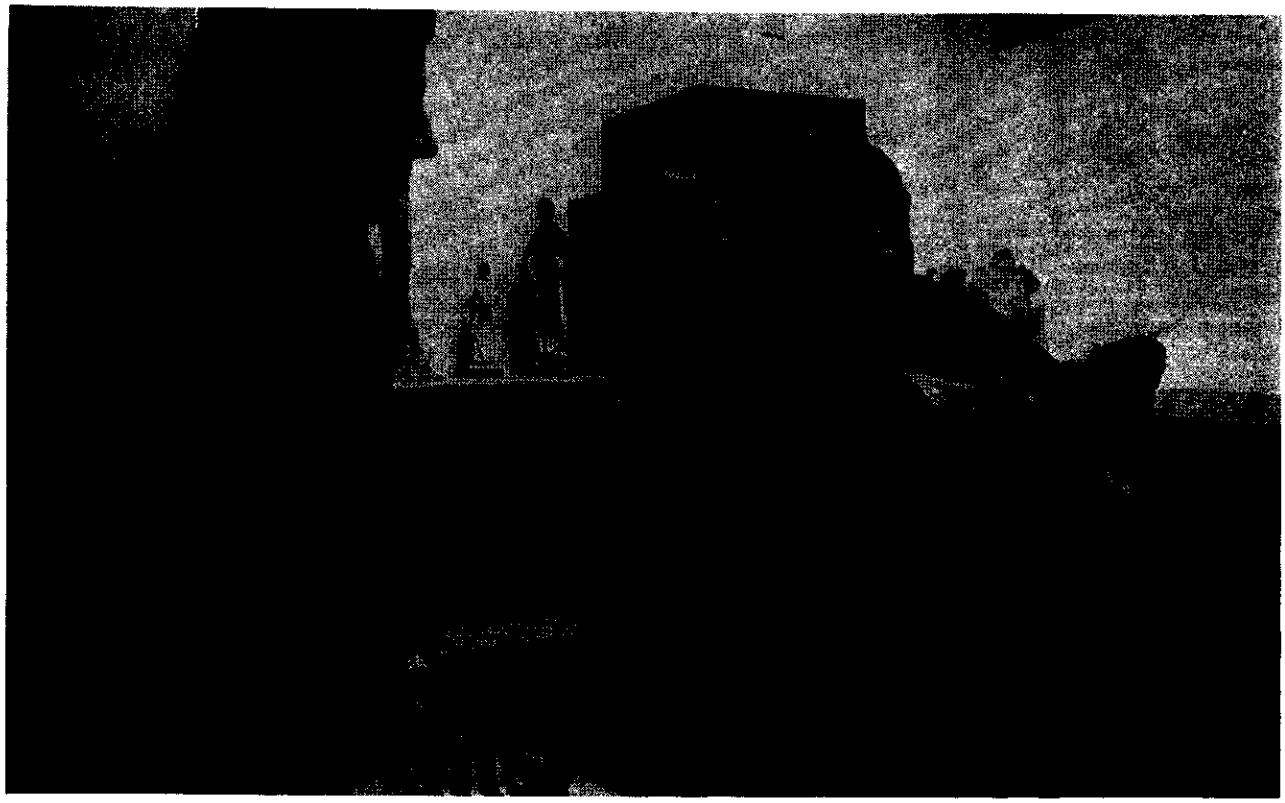

Author Marion Moses and Cesar Chavez, director, United Farm Workers Union AFL-CIO, discuss the union's health and welfare program.

"Viva la Causa!"

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A nurse who worked with the migrant farm workers found that their cause had to be hers; it was as important for her to work as a boycotter during the grape strike as it was to remain in the strikers' clinic she'd helped set up. Only after they had established their rights and organization could the farm workers turn to setting up permanent clinics and a health care plan which would provide the kind of care they wanted. This is the story of that five-year effort told by a nurse who was part of it.

MARION MOSES

We as health practitioners have much to learn from the poor. Perhaps we can begin by trying to understand the despair and distrust of those who have had only crumbs from the tables of the medically affluent for too many years. The poor are teaching us that the struggle for health care is inseparable from the struggle for human dignity.

No group has demonstrated this more clearly than the migrant farm workers who, though exploited and oppressed, have developed, through their own organization, a health care system that is economically and professionally sound. They did it without pilot projects, demonstration grants, or federal money. They did it with the help of professionals but without the control of professionals.

I first became interested in the problems of farm workers in the spring of 1964 while I was a student on the Berkeley campus of the University of California. My introduction came from a student sitting at a card table surrounded by pictures showing conditions of poverty among migrant workers in California. During the next few months, I worked with the Citizens for Farm Labor and met many of the labor officials, ministers, lobbyists, and others who were trying to bring the plight of migrant workers to the consciousness and the consciences of the American public.

We reactivated an organization called the Student Committee on Agricultural Labor (SCAL) and gradually began to build a base on the Berkeley campus, for activities relating to farm workers. It was during this time that I first heard of Cesar Chavez and Delano and other valley towns that I later came to know well. It was at this time also that I first learned of efforts to organize farm workers who were excluded from the labor legislation which protected the rights of other working men and women.

The struggle in which later I was to become involved began in Sep-

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During the grape strike in California, the author volunteered to help provide health care for strikers and their families. She went for a month and remained for five years.

tember 1965 in Delano, a small town situated in the southern part of one of the world's richest agricultural areas, California's San Joaquin Valley. Filipino members of the Agricultural Workers Organizing Committee, AFL-CIO, walked out of the grape vineyards demanding a 10-cent-an-hour increase in wages from $1.10 to $1.20 and the right to have a union. They were joined by the National Farm Workers Association led by Cesar Chavez and the grape strike was on. After five years of strike and boycott, the United Farm Workers, AFL-CIO (the two groups merged in 1966), signed contracts with over 90 percent of the area grape growers. The union now has many other contracts in California, Arizona, and Florida.

From the earliest days of the strike, union members and leadership were concerned about health care. Local doctors refused to care for the strikers, and volunteer doctors and nurses from San Francisco and Los Angeles gave weekend help to Peggy McGivern, a registered nurse who was a full-time volunteer with the union.

At the time, I was working at the Kaiser Research Institute in San Francisco and was a part-time volunteer with the local Bay Area support committee. I made my first visit to Delano, a five-hour drive from San Francisco, in January 1966. I walked in the door of the strike headquarters around 8 o'clock in the morning and someone asked, "Can you type?" and handed me 25 letters to union leaders throughout the country asking for support.

The next three nights I slept on the floor of a farmworker's home. Mornings I was out on the picket line at 5:30 A.M. and I ate in the strike kitchen at an abandoned camp about 2 miles from strike headquarters, appropriately called "The Camp." The Camp was an active place. It was there that food and clothing donated by supporters was stored and dispensed and picketers got gas for their cars. There would be a clinic there, too, one day but at that time a "clinic" was set up on Sundays in the kitchen of "The Pink House," a house in Delano used by the organizers.

As the strike continued and more health professionals got involved, donated equipment and drugs began to come in. The clinic was moved to a room in "The Gray House" another house in Delano which was used by the boycott staff. This proved quite satisfactory until the union was informed that zoning laws were being violated.

After unsuccessful attempts to rent clinic space in town, a trailer was rented and moved out to The Camp. The next year a house trailer, donated by a young man going into the priesthood, was renovated for clinic use and moved to "The Forty Acres," land the union had acquired outside of Delano.

This trailer clinic was the mainstay of the union's health program until a permanent building was opened in October 1971. Initially the clinic was used only by strikers who were treated free but, as word got around, more and more union members began using it. So, we had a small paying clientele as well. The clinic was never free to members except in the earliest days before it was really organized.

I had quit my job in San Francisco in May 1966 but continued to work per diem while I went through the agonies of deciding whether or not to work as a full-time volunteer in Delano. I had participated in the 300-mile march of farm workers from Delano to Sacramento the previous month, and this direct experience with the dignity and commitment to non-violence of workers seeking redress for years of neglect and exploitation made me increasingly dissatisfied with my desk and paper job. I knew the town was remote and the valley was hot and dusty and dull. I knew there would be no salary, just room and board and $5 a week. I worried about where I would live, what I would eat, what I would do for money. I worried about inconsequential things that never concern me now.

In July I went to Delano and told the union that I would stay a month. I stayed five years. And when I left, it was to go to school with a promise to return in five years as a doctor. Before I left, one of the farm workers wanted to know how long before I would come back to be their doctor. When I said five years he replied, *"Ah, cinco anos en la escuela de la huelga y cinco anos en la escuela de medicina."* (Five years in the strike school and five years in medical school.)

"VIVA LA CAUSA!"

Among volunteers who helped the author staff the clinic for farm workers, housed at first in a trailer, were Carmen Vidal (left) who served as a nurses' aide and Margie Ginsburg, R.N. (center).

During the first few months I worked in the strike clinic in Delano I learned what degrading and humiliating treatment the poor receive in county institutions. I spent hours and hours with them in welfare offices, county hospital emergency rooms, and outpatient departments. When I was still naive enough to believe that if a hospital administrator knew of a hardship he would do something about it, I went to one telling him that there were no chairs for the women to sit on in OB-clinic. His answer was that no one had to wait long enough to need a chair!

I remember accompanying one woman, who had just had a miscarriage and was bleeding heavily, to an emergency room only to have the staff insist that she clear "financial" first. I knew this took almost half an hour and insisted that she be seen immediately; she had been bleeding heavily for the 35 minutes it had taken us to get to the hospital. I was told the sooner they got the information the sooner she would be seen. Further insistence brought a policeman who threatened to arrest me. When I agreed to go as soon as a doctor was found for the woman, a doctor was found.

I was again almost arrested at this hospital for insisting that a woman with severe chest pain and a known history of cardiac disease be seen immediately and not be left waiting outside on a hard bench. When the policeman came to "take me in," the woman's son reminded him that we were from the union and had very good lawyers. Again I missed a chance to go to jail.

One of the more insidious difficulties at one hospital was a complete disregard of the rights of relatives and patients to information. During one hour a day, a doctor was available by phone and if he was not reached during this time (as was usually the case) one had no choice but to wait until the next day at the same time and try again. Even for a nurse it was almost impossible to get even the most elementary information about follow-up care, medications, treatment, and so forth.

Day after day people came to the clinic with problems and we did our best to help even though often the real problems were not medical at all. We relied completely on volunteer doctors and I looked forward to their weekend visits not only to work out problems that had come up during the week but because usually I would get my one good meal of the week if the doctor took us out to eat as most of them did. The clinic was small, drugs and equipment were in short supply, and the medical problems of the patients staggering. It was difficult to keep doctors coming under such trying circumstances. But enough came and one in particular, Dr. Jerome Lackner, an internist from San Jose, supplied the continuity of encouragement, support, and medical expertise which kept the program going until the day when a clinic that could provide comprehensive, 24-hour, ambulatory care became a reality.

I visited the many camps in the Delano area and got to know the Filipinos and their special problems. I made hundreds of home visits to families in Delano with their many children and their warmhearted openness to "*la enfermera.*" I learned respect for the herbs they used and the common sense of many of their home remedies. I learned to compromise so that the penicillin was taken with the herbal drink. Who was to say which one really cured the sick baby?

My role as a nurse became quite "extended" the summer of 1967 when I was asked to leave Delano to boycott California grapes. The clinic, though crucial, was peripheral to our main concern: the powerlessness of the farm workers. I was being told that the best way to give medical care to farm workers was to stop giving direct care myself, to suspend loyalties and trust built up after long hours, and go to a city 3,000 miles away to boycott grapes. I resisted. I made excuses. I rationalized that the people needed me. I was the only provider of health care for a small but important part of our membership—the strikers and their families. I can still hear Cesar saying with gentle exasperation, "Marion, what good will it do to have a clinic if we don't have a union?" I went on the boycott.

I was sent to Toronto, Canada with $100, a one-way plane ticket, and instructions to "stop the grapes." I was frightened and unsure of myself in the beginning but gained confidence after a year of boycotting in which I worked not only in Toronto, but in Montreal, Philadelphia, and Brooklyn. I spent some time in New York City fund raising and organized a benefit at Carnegie Hall for the clinic.

I returned to California in January 1969 and two months later was appointed administrator of the clinic by the union board. My job was to develop, plan, organize, and

Today the farm workers' union is setting up new clinics. In Delano a building has replaced the original trailer and one containing an x-ray lab donated by the Southern Region, International Ladies Garment Workers Union.

recruit workers for a permanent clinic building that the union would build on the Forty Acres. I also was to work closely with another volunteer whose job was to develop the health and welfare plan.

I was trying to decide what to do first when my mind was made up for me by a farm worker and her baby. I had gone out to the now quiet and deserted trailer clinic, and was sorting through some old correspondence when a woman came in with a sick baby. I could hardly tell her that the clinic wasn't open and that if she left me alone and waited for two years there would be a splendid new building there with three doctors and four nurses. I took care of the baby.

Two days later she returned with a friend who also had a sick baby. My hopes of having time to plan and recruit without the tremendous burdens of direct care disappeared. Before long I was making house calls again and keeping regular clinic hours every day. Again I asked doctors to volunteer on weekends and we operated this way until a few months before the permanent clinic was opened in October 1971. Another registered nurse came later that year so I was able to spend time on other aspects of the health program.

The keystone of the union's health program is its Health and Welfare Plan. The contracts between the union and the growers provide that 10 cents an hour be paid into a central fund. This is jointly trusteed by the union and the growers and used only for medical benefits for the workers. Union negotiators fought very hard for this clause and our initial experience with it was a bitter one. For over two years after the agreements were signed the grower trustees stalled and maneuvered so that the union was unable to get a health plan operational. Without control of the plan's administration, benefits, location, and methods of implementation the union knew it had nothing but a patronizing handout from the growers that could be manipulated or withheld at whim. The growers refused to accept the idea that this was workers' money and workers should decide how it was to be spent.

Finally, all the union members in California working under these contracts threatened a walkout if this clause was not enforced as agreed upon two years earlier and the union won control of the plan which by this time was already formulated.

The union leadership had made two basic decisions: the plan would be self-insured, and benefits and implementation of the plan would be worked out and approved by the workers themselves.

Working on the health plan was one of the most demanding and enjoyable tasks in which I was involved. We began by visiting every ranch in California where we had a contract (mostly wine growers at this time) as well as ranches where the membership was strong and contracts were anticipated. Meetings to which most of the local members and their families came were very long but the people were enthusiastic and responsive.

We asked questions, we listened, we learned. What do you want your union health plan to include? They wanted everything—dental care, medicines, ambulance, hospitalization, maternity, glasses, surgery—everything! We learned about local problems and resources. We found out how many primary care physicians were in the area, how they treated farm workers, and what they charged. We learned which doctors refused to see farm workers or refused to see anyone until they had paid.

We collected and organized this information along with data on numbers of workers, age distribution, and family size. We did a more extensive survey in the Delano area and then met with union health plan consultants in San Francisco. Costs were difficult to estimate because we were talking about a group of people who had never had any health insurance. We knew farm workers were a high risk group because of poverty and medical neglect, but how risky?

The consultants conservatively estimated that the plan the workers wanted would cost about 68 cents an hour. We had 10 cents. Back we went to the workers.

This time we made up cards of different colors to represent different benefits and attributed values to them (dental—5 cents, ambulance—1 cent, maternity—3 cents, and so on). We asked the workers to select any cards they wanted for any group of benefits as long as the total did not add up to more than 10 cents. After several hundred workers had done this, we put together the most frequent combinations and we had our health plan.

Almost without exception the workers had given highest priority to health, not sickness, benefits. They wanted to be able to see a doctor, to pay for medicines, get prenatal care, and have blood tests and x-rays. They very much wanted hospitalization but it required too much of their meager 10 cents.

"VIVA LA CAUSA!"

They chose to try to avoid the hospital by being able to seek care at the first sign of something wrong.

The most important characteristic of the health and welfare plan is the fact that the workers enforce and police it themselves. They approve all claims and investigate them if necessary. This is done by committees elected at each ranch. All claims must be signed by the ranch committee and providers must send in proof of treatment before a claim is paid by the central office. Thus, committee members not only learn how to process claims but, more importantly, are able to educate members on their rights and responsibilities. They make sure that workers understand that it is a self-insured plan, and false claims or abuse of the plan only hurts them. More than 200 ranch committees in California, Arizona, and Florida have handled the claims more efficiently than harried central office clerks could ever do.

The benefits of the plan include doctor visits, prescription medicines, x-ray and laboratory, maternity, a small hospital and surgery benefit, and a death benefit. Since inception of the plan, it has been possible to lower the number of hours for eligibility and increase the benefits. From August 1969 to September 1972 the plan paid out over $2 million in benefits. The workers named their health plan "The Robert F. Kennedy Farm Workers Medical Plan" in tribute to a man greatly loved and still deeply mourned.

The story of the RFK Plan does not end here. The workers realized that being able to pay for care was no assurance of its quality. They suspected that the doctors, druggists, hospitals, and others who had shunned them when they were poor and needy would welcome their insurance money. They expected to be exploited as they had been before.

At first, many providers scoffed at the workers and said the insurance was worthless. The benefits were small and many doctors and hospitals wanted a larger percentage of the bill paid before they would treat the workers. But as the benefits got larger, providers began to tailor care to the benefits with predictable results. Workers who had never gotten a blood test in the years they were seeing a physician would often get four or five in one week. Chiropractors began taking more extensive x-rays and so on.

The workers had to deal with the central question of any health plan: How do you control costs and quality of care when the providers of that care are not a part of your system? The answer, of course, is that you can't. It was decided that, although it meant a great investment in time, energy, and resources, only by having its own clinics could the union begin to deal with health care issues in all their broad implications including worker education and preventive medicine.

The current thrust of the union's health program is to try to fill the increasing demands for clinics in areas where the membership is large enough and strong enough to support them. Experiences with the clinics already operating under the RFK Plan have been so satisfying that any worker who comes in contact with them begins to work in his own area to organize one.

The RFK plan functions very differently where there are union clinics. A prepaid arrangement has been worked out but all workers in the plan in a given area covered by the clinic must first agree that the clinic will be the sole recipient of health plan benefits. If they do, the plan pays a certain amount per worker per month to the clinic. In return the workers get unlimited plan benefits provided by the clinic. In addition, the worker pays a small usage fee whenever he receives service. Benefits to providers not part of the clinic system are on a limited fee-for-service basis.

Gloria Soto was one of many patients who came to the clinic for help.

The plan has two clinics at present: one in Calexico and one in Delano. Both give complete ambulatory care on a 24-hour basis and emergency care. The doctors are on staff at local hospitals where they admit patients and also deliver babies.

Calexico is a town of 12,000 in the Imperial Valley just across the border from Mexicali, which has a population of 500,000. Many of the residents of Mexicali are poor farm workers from the interior of Mexico who hope to get work in the United States. If they succeed (most do not), they are issued Green Cards which classify them as resident aliens and allow them to cross the border and work legally in the states.

The Green Carders, as they are called, are the major users of the Calexico clinic. They are lettuce workers who migrate up to Salinas for the summer harvest and work their way back down to the Imperial Valley for the winter lettuce. Their families usually live in Mexicali. Originally, a clinic was set up in Mexicali. Carol Traynor, the nurse who now works in Calexico, worked for a time in Mexicali and has told me almost unbelievable stories of the problems she met there. After the clinic was moved to Calexico, it took a long time to get it going because of problems with getting people across the border for medical care.

Community health aides are trained by the medical staff to take initial medical histories. Home visits are made in Mexicali and follow up is intense. The Calexico clinic has

only one language, Spanish; the one in Delano has four, English, Spanish, Tagalog, and Arabic.

Delano is a town of 14,000 surrounded by several smaller towns. It has a fairly stable year-round work force and the area's major crop is table grapes. The clinic there has been in operation much longer and statistics are available.

There were 10,000 M.D. visits in the first six months of operation. The most frequent cause for the visits was hypertension and a large percentage of the patients are being treated for tuberculosis. Diabetes also is a frequent problem. Margaret Murphy, the registered nurse who administers the clinic, is especially proud of the high number of people without specific complaints who came in for physical check-ups, the low number of emergency visits, and the high percentage of kept appointments.

The clinic uses community aides and provides home visits as well as extensive tuberculosis screening in the surrounding labor camps. Both clinics stress prenatal and well baby care and hold parents' classes. There is one nurse practitioner in the system at the present time, Nancy Quigley. She covers the Delano clinic on the doctors' two days off and, during the other five days, runs the health program for the 200 people who live and work at the union's national headquarters 70 miles away.

The farm workers have come a long way since 1965 when the grape strike began. The United Farm Workers Union is now involved in a nationwide boycott of lettuce and farm workers throughout the United States are organizing in their own states and seeking union help.

There are approximately 3.1 million farm workers in the U.S. of whom about 2 million are migrants.

Agriculture is the only industry in the U.S. that is still a major employer of child labor. A study by the American Friends Service Committee showed that 25 percent of the agricultural work force in 1970 were children under 16(1). Poverty is widespread and more than half live in families whose incomes fall below $3,000 per year(2). The Bureau of the Census reported that median family income of household heads who were farm laborers was $2,600 in 1965. By comparison all heads of families in the U.S. had a median income of $6,900. The Bureau also reported that 59 percent of all substandard housing was in the rural areas(3).

The high correlation between low income and infant mortality is well known. The infant mortality rate of 44.9 per 1,000 births among the poor in rural areas is more than double that of middle income infants in urban areas where the figure is 21 (the national average is 25). One third of all maternal deaths are of mothers in rural areas with a rate of 40.9 per 100,000 live births. The national average is 33.3 with a drop to 25 in urban areas of the country(4).

These problems of the poor are common to rural and urban alike. But farm workers are subjected to a more insidious hazard—occupational disease due to pesticides and other agricultural chemicals. Agriculture has the highest occupational disease rate in the state of California, one of the few states that collects such statistics(5). But this is being changed by the workers themselves who are becoming more knowledgeable and are demanding more safety equipment and protection.

The first ban on DDT in California was in a farm worker contract three years before the statewide ban

The author made hundreds of home visits to farm workers in the Delano area and got to know them and their special problems.

in California went into effect. The biocidal chlorinated hydrocarbons Aldrin, Endrin, and Dieldrin were banned in farm worker contracts four years before the Environmental Protection Agency restricted the use of these poisons. The signing of the table grape contracts was delayed by at least a year because the workers refused to compromise the issue of worker and consumer health and safety in regard to pesticide use.

Outside of the union's efforts there has been little effort to educate farm workers about the dangers of pesticides and how to protect themselves against them. This is one of the most difficult clauses of the contract to enforce. In a routine inspection of several ranches I found some that were not complying with the simple clause that soap and water must be supplied on all spray rigs so that workers can wash their hands immediately after and before eating. It took weeks of pressure, constant checking, and worker demand to assure that all spray rigs had soap and water for washing as well as a separate container for drinking water.

Other health and safety factors cides but are nonetheless important. It is sobering and disturbing that farm workers have had to negotiate in their contracts for toilets in the fields and for cool, potable drinking may be less hazardous than pesticosts and high salaries of outsiders water. And, having serviced contracts, I know how difficult it is to enforce these regulations.

I believe the success of the farm workers' approach to a health care plan is based on three things. First, they insisted on having their own program and refused to seek or accept federal funds. The support of the workers came first, then the program, and then concerns about money. Poverty areas in the United States are strewn with the bones of health programs that died when the money ran out and the community could not support the administrative brought in to "help."

Second, and more important, the workers realized that an ounce of prevention is worth a pound of cure. I use this cliché because it is one that is universally accepted as true and almost universally ignored in health planning. I remember a meeting we had with Blue Cross in Los Angeles at which the union was advised not to self-insure and to put all their money into hospitalization insurance. The workers reasoned that Blue Cross was offering them not health insurance but sickness insurance; it paid you to be sick and did nothing to keep you well. Putting their meager earnings into the giant Blue Cross system meant tailoring their needs to the demands of Blue Cross and not using their resources to solve the basic health problems of the people.

The third and most important aspect of the workers' success was that they began to improve their health care by attempting to change the social and economic conditions that led to and created the problems in the first place. In this process they are dealing with the health care crisis in its true dimensions.

It is in this area that I think 99 percent of the problems of health practitioners working with the medically indigent surface, where their differing aims and backgrounds come into sharp focus. It is here that the professional, no matter how liberal or well-intentioned comes to a crucial hurdle. The people want social change, the professional wants medical care as well. How relevant his or her method of achieving this goal is to the problem at hand, is the dilemma.

In many ways the professional is a victim of what he learned in school—which has a lot to do with sickness and almost nothing to do with health. A failure to achieve a common purpose results in conflicts over the means and the problem becomes even more complicated. The result is control of the situation by whichever faction gets the upper hand. Unfortunately, in the area of health care the professionals generally get it by virtue of deep-seated traditions and biases about the way problems are solved. Often the problem never even has a chance to develop because health planners leave the people out of the decision-making process altogether. This may be done blatantly or subtly by means of a community board which everyone pretends to believe has power.

The idea that nonprofessionals might make decisions is anathema because "they don't have the facts or the expertise." This is in many cases true, and no one has worked harder than the medical profession to see that they don't get them. For health planning to have any meaning we must get away from the high priest mentality which sees the patient as a supplicant. There are so many professionals defending their right to exist as power brokers that the unwary fall victim to the myth of the expert and lose control over their own programs.

The farm workers avoided this trap with a sure skill, and every professional privileged to work with them has an opportunity to try to learn this and begin to deal with his or her own professionalism.

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