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A STUDY OF MEDICAL PROBLEMS ASSOCIATED WITH TRANSIENTS

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A STUDY OF MEDICAL PROBLEMS ASSOCIATED WITH TRANSIENTS

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in cooperation with
The Division of Public Health Methods, National Institute of Health

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All original data collected during this study were secured in and by the cooperation of agencies, both public and private, that give assistance to transients. In the Transient Case Study alone, approximately 200 such agencies in 20 towns and cities gave office space and many types of help so that transients might be interviewed at the time of application for assistance. This cooperation often entailed considerable rearranging of worker time, office space, and method of handling beneficiaries.

The United States Public Health Service hereby expresses its appreciation to all individuals and agencies that cooperated in making the study. The list of persons and agencies is too long for enumeration, but it may be said that almost without exception it includes all such agencies in the study cities. The administrators of several national organizations, both official and private, made available the resources of their respective field offices. Among these organizations are the Farm Security Administration, the American Red Cross, the Salvation Army, and the Volunteers of America.

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CONTENTS

Transients building a home in California.

A STUDY OF MEDICAL PROBLEMS ASSOCIATED WITH TRANSIENTS

Introduction

This study, initiated with the specific objective of investigating the public health problems that exist in or are caused by migration and transiency, consists of an analysis of available published material and a field study of case data collected in 20 cities in 15 States. The public health aspects of transiency have been recognized in general for a great many years. Previous studies were concerned very largely with specific problems as, for example, those carried out by the United States Public Health Service as early as 1913.[1]

The present study is intended to cover the major phases of the transient health problem, but for purposes of orientation, reference is made to the predisposing or exciting causes of migration or transiency, the problems occurring as a result of migration, and those arising from unusual or variable demands on medical facilities. Among the specific questions which the study will attempt to answer are the following:

1. What factors are associated in the causation of transiency, and how important is the desire for health as one of them?
2. What statutory provisions serve to discriminate against transients?
3. What are the administrative practices of agencies giving public assistance to transients?
4. What are the definite medical needs of transients, and how completely are those needs met?
5. What influence do transients have on community health?
6. How can the medical problems associated with transients and transiency best be solved?

It is a matter of common knowledge that throughout the United States nonresidents or transients are treated differently from residents in many of their contacts either with private social agencies or with governmental bureaus, departments, and local authorities. Recognizing the complexity of the requirements for eligibility for public assistance, as well as of the laws, regulations, and administrative policies by which such requirements are put into operation, certain highlights of these social practices have been analyzed in the study, a discussion of which will be found in Parts I and II.

[1] See references (*19*), (*75*), and (*110*).

Even a cursory examination of the transient problem leads one to the conclusion that transiency is "the pathology of migration." Hence, an understanding of the complex of migration is a prerequisite to any practical solution of the problems associated with transiency.

The term "transient," as used in this study, may prove confusing unless it is understood at the outset that the word, although in common usage, has various connotations not only in the different geographical areas of the country but also in legal and administrative contexts. The term "transient," as it is interpreted in this discussion, designates any needy person in any community who is discriminated against in that community's program of material aid or medical care by the adoption of residence and technically related requirements. Putting it into the simplest possible terms, the group of persons referred to here as "transients" is made up of those persons "on the road" who are unable to maintain themselves insofar as the necessities of life are concerned. Among the necessities which these individuals find themselves unable to secure through their own resources is medical assistance of all kinds. It was therefore with specific reference to the availability of medical assistance and the transients' need for it that this study was initiated.

Sources of data.—In the bibliography attached there will be found a list of available documentary or previously published material consulted in the course of the preparation of this bulletin. Citations and reference sources are noted throughout the text.

TRANSIENT CASE STUDY

In the spring of 1938, a total of 1,893 transient families and 9,040 unattached transients were interviewed by trained case workers in 20 cities distributed over 15 States of the United States. The data on each case had to be secured in one interview, inasmuch as there was no certainty that the same individual or case could be reached again. Persons interviewed were those applying to social or medical agencies for assistance of some kind. In each instance the interview was conducted after it had been determined that the applicant was a "transient" or nonresident. The interview was conducted before any decision on the application had been made.

Inasmuch as the transients interviewed for this study constituted a mechanically controlled random sample of all transient applicants in the city at that time, and since each individual interviewed was automatically a transient because he had been so classified by an official of some public assistance agency, the sample is believed to be representative and of sufficient size to merit detailed analysis. In

this connection it might be noted that in some States the act of classification by an official of some agency as a nonresident is virtually the only one necessary to determine transiency.

In the selection of towns and cities to be studied,[2] care was taken to include representative parts of the country, towns and cities showing the greatest concentration of transients, and various types of transients. The last-named consideration is thought quite important in a survey of the entire transient problem. Within the selected towns and cities, every organization rendering any type of assistance to transients was included in a preliminary survey. Based on estimates of the number of transients seen by the several agencies, a selection of agencies to be studied was made so that approximately 90 percent of the current flow was represented. Furthermore, the selection gave equal consideration to those of all types, social and medical, case-work and mass-care, handling either families or unattached cases. In all, about 200 agencies were selected for study.

Sampling within the agency was controlled so that the same proportion of all applicants was interviewed in each of the types of agencies. Interviewing was conducted over a period of 6 weeks and simultaneously a count was taken of all applicants to the selected agencies so that the flow was measured and the sampling periodically adjusted. Ninety-five trained case workers under both local and regional supervision completed the interviews. The case data thus collected are based on depositions made by individual transients. While it is not possible to verify these data, they are believed to be as reliable as any information secured by the interview technique.

STUDY OF AGENCY PRACTICE

In order to determine the manner in which public assistance of the several types is given to transients, the restrictions placed upon aid to this group of persons, and the administrative practices of agencies giving aid to transients, as compared with their statutory provisions, schedule data were collected by interviewing the responsible heads of the several medical and social agencies in the 20 cities included in the Transient Case Study.

Data were compiled on the 432 agencies that had given some type of assistance to one or more transients during the month preceding the interview. Agencies refusing free care to transients were not included in the analysis.

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[2] Phoenix and Tucson, Ariz.; Hot Springs, Ark.; El Centro, Los Angeles, and Stockton, Calif.; Denver, Colo.; Jacksonville, Fla.; Atlanta, Ga.; Boise, Idaho; New Orleans, La.; Minneapolis, Minn.; Albuquerque and Roswell, N. Mex.; Cincinnati, Ohio; Philadelphia, Pa.; El Paso and San Antonio, Tex.; Ogden, Utah; and Seattle, Wash.

TUBERCULOSIS STUDY

An additional body of data on the incidence of pulmonary tuberculosis among transients was secured through collecting chest roentgenograms of migratory agricultural workers in 19 cotton camps in Maricopa County, Ariz. For this purpose a mobile X-ray unit was used. All cotton camp tenants over 14 years of age and within a reasonable radius of the unit were invited to come in for examination. A total of 583 persons responded and were given the X-ray examination. The films thus collected were interpreted independently by two roentgenologists, one from the staff of a local tuberculosis diagnostic clinic and the other from the United States Public Health Service.

When interpretation of the films was made, one or both of the roentgenologists occasionally classed the film as "suspicious" insofar as the presence or absence of "active pulmonary tuberculosis" was concerned. When the interpretations of the two roentgenologists were different, the case was tabulated as "negative" in preference to "suspicious" or "active." Similarly a case was called "suspicious" in preference to "active" if both interpretations appeared on a single film. In this way the cases tabulated as "active" represent only those on which there was complete agreement.

TRANSIENT SYPHILIS STUDY

In order to investigate the incidence of syphilis among transients, beneficiaries of the Shelter Care Division Hospital of the Cincinnati Department of Safety were chosen as the population to be studied. The institution handles a relatively large number of transients and requires that each beneficiary have a physical examination by the medical staff soon after admission and once a week thereafter. In every case, on admission the applicant is classified by a trained social-service worker as "local homeless," "State transient," or "nonresident." This classification made possible a comparative study of the several groups. Blood specimens from 1,170 beneficiaries of the hospital were examined by the Kahn and Kolmer techniques in the United States Public Health Service Venereal Disease Research Laboratory at Stapleton, New York.

LOUISVILLE CITY HOSPITAL STUDY

As a measure of illness experience and of the frequency with which transients are accepted or rejected at large city hospitals, a study was made of the records of 1,488 applications to the Department of Admissions at Louisville (Ky.) City Hospital. This group of applicants

is essentially similar to those considered as "transients" throughout this study. It is recognized that a few of the applicants may not have been needy and in that sense not transients, but it is not believed that the number is large enough to prejudice the validity of the group as a transient group.

CALIFORNIA GENERAL HOSPITAL STUDY

In March 1939, a questionnaire was sent to each of the 66 general hospital in California, under county or nonprofit association control, listed in the 1939 Hospital Number of the Journal of the American Medical Association. The responsible authority of each hospital was asked to supply data on the number of transients admitted to in-patient service during 1938, on either a free or part-pay status. Replies were received from 42 hospitals. The resulting data on the number of transients hospitalized during the year are believed to constitute a satisfactory sample on which to base some conclusions as to the cost of hospitalization of transients in an area where the problem is particularly acute.

Summary and Conclusions

There is in the United States a large but fluctuating number of needy individuals, variously estimated at 200,000 to 1,000,000, who are discriminated against in programs of material aid and public medical care by the application of residence and technically related requirements. Such persons are called "transients" in this study.

The study is limited to the continental United States and is concerned with the health of transients as it is affected by their mode of life and social opportunities. It attempts to determine: (1) The origin of transiency from migration and the importance of lack of health as a cause; (2) the statutory limitations on public assistance to transients; (3) the administrative practices of agencies giving assistance to transients; (4) the medical needs of transients; (5) the influence of transients on community health; and (6) the most equitable and practical solution of the medical problems of transients and transiency.

Original and documentary data related to this subject are presented. Sources of published material used are given in the references. Original data collected and used include: (*a*) About 11,000 schedules recorded by trained workers in 20 cities of 15 States, containing the migration history, personal characteristics, and disabling illness and medical care history during a 3-month survey period of some 16,000 transients who were applying for public assistance; (*b*) 432 schedules on the admission policies of public assistance agencies in the same cities; (*c*) records of application of 1,488 transients for in-patient

care at a large charity hospital; (*d*) serological reactions of 1,170 inmates of a large municipal shelter for homeless men; (*e*) results of chest X-ray examinations of transients in 19 cotton camps in a southwestern State; and (*f*) replies from 42 local governmental and nonprofit association general hospitals in California to a questionnaire concerning the number of transients hospitalized during 1938.

MIGRATION AND TRANSIENCY

Migration has been an outstanding characteristic of the people of the United States. Students of migration in this country are convinced that, since the forces causing it are still operative, it will continue and may increase in the future. It produces not only demographic effects, in that the age, sex, and race compositions of populations are materially influenced, but also a number of effects on social organization in general and community, family, and individual adjustment in particular. It is in the failure of individuals to orient themselves properly to new environments, especially in their failure to maintain or secure economic self-sufficiency, that transiency arises.

It seems indisputable that, if migration is to continue, and some proportion of the migrants may be expected to fail in their attempts at rehabilitation, social planning should be directed toward guiding the streams of migration and relieving the destitution of the unsuccessful. These functions can be carried out successfully only by cooperative Federal and State action.

Interstate migration is motivated largely by economic need, and only a small part of the whole is caused by ill health. Practically all the pathological conditions for which transients move across State lines are pulmonary, usually tuberculosis, and most migration of this type is directed toward the Southwest. It is estimated that there are now in the southwestern States at least 10,000 tuberculous transients who are unable to pay for needed sanatorium care. The highest proportion of individuals who became migrants because of health was found among transients interviewed in Hot Springs, Ark., followed in order of importance by Tucson, Ariz.; El Paso and San Antonio, Tex.; Denver, Colo.; and Los Angeles, Calif. By place of origin the highest proportion of health migrants was found among transients from the eastern States. One part of migration, usually not recognized, is that which was started because of economic conditions but turned toward the Southwest because of ill health.

Another large part of the transient problem that has been ignored in most studies and writings is intrastate migration. It is principally rural-urban and a considerable proportion of the individuals move in search of medical care—a factor found to be almost negligible in interstate migration.

No exact census of transients in the United States has ever been possible because of the very nature of migration and transiency. An estimate, based on data collected during the first quarter of 1938, indicates that some 400,000 transients applied for public assistance in 1 year throughout the country.

Data on transient cases in 1934 and 1938 indicate that families make up about one-fifth of the total cases, although the percentage probably is much higher in some cities. The transient family seems definitely to be increasing in size, particularly among transients from the States furnishing the greatest part of the transient population. There is also some evidence that the largest families are the least mobile.

In general, transients are younger than residents on the relief rolls. As between interstate and intrastate transient family heads, the interstate group contains the smaller proportion of persons 55 years of age and over and of youths under 25 years of age, while among the unattached the interstate group shows the smaller proportion of aged but a greater proportion of youths.

If classified according to the last State in which they had lived for as long as 1 year, practically half of the family transients interviewed came from 4 States, Oklahoma, Arkansas, Missouri, and Texas, and half the unattached interstate transients came from 11 States.

About 70 percent of the families and 77 percent of the unattached had been migrants for less than 1 year, while among those who had been migrants for as long as 2 years practically all of the family cases and more than nine-tenths of the unattached had lived in the State of interview 1 year or more.

These data indicate that the transient population is not, as is often stated, made up largely of a group of individuals who have chosen a life of migration. While some few do follow a pattern of seasonal movement or just wander from place to place as opportunity for economic improvement presents itself, it is believed that approximately three-fourths of the interstate transient group is made up of families and individuals who are in the process of relocation.

STATUTORY LIMITATIONS ON PUBLIC ASSISTANCE TO TRANSIENTS

The majority of States have among their statutes so-called "poor laws," "pauper laws," "public assistance laws," or "public welfare laws." In these laws the State imposes upon itself or its political subdivisions the obligation to relieve the destitute. Provision for public medical care usually is embodied in these laws—hence relief for the sick-poor is set within the framework for relieving destitution.

In 39 States the "poor laws" include other sections called "settlement laws" in which, with few exceptions, it is provided that the benefits of relief to the destitute are to apply only to persons defined by law as residents of the State or certain of its political subdivisions or both. There may or may not be further provision for the medical relief of nonresidents.

The history of settlement law may be traced to the feudal era in England. The English influence in this country is partly due to the legal concepts inherited and brought from England by the first colonists who, if not always racially identical, were culturally similar to the English. Settlement laws of the original colonies have served as models for subsequent State settlement laws. Another reason for the adoption in the United States of settlement laws closely resembling those of England during the seventeenth century is found in the similarity of social and economic conditions existing in the original colonies and England at that time. In both countries the chief occupations were agricultural and, with a relatively limited labor supply, the laboring classes were surrounded by a series of restrictions designed to attach them, as far as possible, to the locale where they happened to be settled. However, the most important reason for the existence of settlement laws, and the most important consideration in discrimination against the transient today, is the attempt of the individual communities to protect themselves from persons likely to become dependent.

"Commorancy" or residence, as such, in a given locality and over a stipulated period of time is a common prerequisite to settlement in the laws of all States, and the list of conditions under which residence must be accomplished in the various States is a long one. On the subject of where a person must have lived to acquire residence, the 39 States having settlement laws have 13 different provisions. This confusion alone has contributed a great deal to the difficulties involved in dealing with transients.

Provisions in regard to the length of residence required for settlement are more complex. Time required varies not only between States, from 6 months to 5 years, but often between political subdivisions within States, according to the person's financial status, his property ownership, or his state of health or that of members of his family.

Analysis of the provisions of the settlement laws over a period of 25 years shows that during that time one-third of the States have increased the period of residence required for settlement. Settlement laws in all but seven of the States having such laws make restrictive provisions that bear on either the continuity of residence or its chronological precedence to application for public assistance.

Sixteen States void the entire period of residence if it is interrupted by a period during which the person is not self-supporting and, in others, provisions change the period required if the individual receives specific kinds of support.

Citizenship is a prerequisite to settlement in one State and in one county of another State. In three States persons may be prevented from acquiring settlement in a town or county by a formal warning from the authorities to depart. Several States provide that employees and patients of State institutions either may not gain settlement or may do so only after a relatively prolonged period.

Statutory enactments on loss of settlement may be as effective in barring transients from public assistance as those relating to acquiring settlement. The situation regarding loss of settlement is less complex only because fewer States have statutes on the subject. Three States provide for loss of settlement solely on acquisition of any new settlement, six on acquisition of a new settlement in another State, and nine on acquisition of a new settlement within the same State. Eighteen States provide for loss of settlement by absence for a specified period which varies from 1 month to 5 years. In six States, the stipulated period for loss of settlement is less than is that for acquisition, and one State voids settlement after assistance as a pauper for 5 years.

Thirty-nine States make provision in their poor-laws for the relief of nonresidents. In 32 States it is mandatory, in 2 it is mandatory for certain cases only, and in the other 5 the statutes are only permissive. In 24 States responsibility for the relief rests on local political units, in 3 States the State alone is responsible, while in 10 States there is joint responsibility.

Relief to nonresidents in some States is available only to those who are sick; in other States it depends on funds being available. Several States limit such relief to those "who have been committed to jail," "have been injured on the State highways," or "who are indigent by reason of physical or mental infirmity." Others specify "State paupers" (undefined) or "those who are not residents of any individual township." Probably the most important restriction on assistance to nonresidents is the stipulation, made by 19 States, that such aid be temporary or emergency only.

The settlement laws are the embodiment of a discrimination which most States and communities exercise against persons who have become or who are likely to become dependent on the community for assistance. Formulated originally both to protect the poor-funds of the community and to restrict the movement of needed workers, they have been handed down to a society in which the free movement

of labor is essential and economic distress in local governments is almost universal. The result of such a combination is easily predicted.

Many migrants have lost all rights to assistance in any State. Others are entitled to receive only "emergency" assistance, and the majority have no governmental organization to which they can turn for aid. It should be emphasized, however, that the settlement law *per se* is not the cause but only the statutory method through which transients are made the object of discrimination. Discrimination is equally definite where no such statute exists.

ADMINISTRATIVE PRACTICES OF AGENCIES GIVING PUBLIC ASSISTANCE TO TRANSIENTS

Three-fourths of the 432 agencies that assist transients in the 20 study cities are social, i. e., their primary function is to dispense general relief; and one-fourth are primarily medical. Medical agencies, however, handle only 13.1 percent of all applications from transient families and 7 percent of those from unattached transients. A count of transient applications in 1938 indicated that, in addition to the applications for aid at medical agencies, 2.7 percent of those at social agencies were also for medical care. In the 20 cities there are the same number of hospitals that give assistance to transients as there are clinics (or out-patient departments). General hospitals represent almost 63 percent of such hospitals, and maternity hospitals about 20 percent.

Of the 324 social agencies, 57 percent are mass-care agencies and they handle two-thirds of all applicants to social agencies. The remaining 43 percent are case-work agencies and handle one-third of the cases.

Thirty-two percent of agencies providing medical care to transients are under governmental control, while among those not giving medical attention to transients the percentage is only 13.3. However, the governmental-agency applications included three-fourths of all persons who applied to medical agencies and one-third of all who applied to social agencies. Of all agencies giving medical care to transients, more than one-third restricted the care to emergency service only; another third gave ordinary care to selected cases only; and less than a third had no restrictions upon the type of medical attention furnished. Of the 146 general hospitals in the 20 cities, only 30 gave any medical care to transients and only 7 gave it without restrictions.

Data on residence requirements of out-patient departments in general hospitals of the United States were available in studies from

the National Health Inventory. These show that while only slightly more than half of all out-patient departments, both free and other, make residence requirements for eligibility for care, 91 percent of local governmental and 73 percent of State out-patient departments do so.

Regardless of location with reference to settlement law and of the organization in control, discrimination against the transient in public assistance agencies is the rule, and public assistance agencies that treat transients on the same basis as residents are the exception.

The findings (1) that governmental agencies handle the greater part of applications to medical agencies, (2) that a higher proportion of governmental than of nongovernmental general hospitals give free care to transients, and (3) that a greater proportion of them adhere to the settlement restrictions, were to be expected. That almost half of all governmental as well as nongovernmental agencies in States with settlement laws have stricter settlement requirements than the law provides is not so well known. This seems to indicate that it is not entirely the settlement law that deprives the transient of relief.

The analysis of agencies in the 20 cities by restrictions upon type of care given is probably a representative picture of the provision of medical care to transients. When it is seen that almost two-thirds of the agencies giving medical care to transients restrict the care to either emergency or selected cases, the difficulties facing the transient who requires medical care are at once apparent.

ILLNESS EXPERIENCE AND MEDICAL CARE OF TRANSIENTS COMPARED WITH THOSE OF RESIDENTS

It was found that 13.6 percent of the 9,040 unattached transients who were interviewed and 21.7 percent of the 7,105 transients in interviewed family cases had had disabling illness during the 3-month survey period. Interstate family transients had a 74 percent higher disabling illness rate than did residents, and the rate for interstate unattached transients was 45 percent higher than that for residents of comparable age and sex. Transients not only had a higher disabling illness rate than all residents considered in the Health and Depression Study, but higher even than the "poor" residents.

On the basis of mobility, transients who have been migrants less than 2 years have less disabling illness than those who have been migrants a longer period of time, and as the period of stay in the State of interview increases, the disabling illness rate becomes higher. In any comparison of disabling illness rates between interstate and intrastate transients, if only the individual making the application for

public assistance is considered, the intrastate group exhibits a higher rate of disabling illness, and makes a considerably higher proportion of applications for assistance to medical agencies.

Analysis of disabling illness by diagnosis groups shows that interstate transients have, like residents, the highest disabling illness rate from the respiratory diseases. In the unattached, this diagnosis group is followed, in order of importance as a cause of disability, by accidents, puerperal conditions, communicable diseases, and digestive diseases. Degenerative and nervous conditions and rheumatism fall at the end of the six most important groups. Among family interstate transients, communicable diseases, puerperal conditions, digestive diseases, degenerative diseases, and accidents follow respiratory conditions in order of importance.

The disabling illness rates of all interstate transients exceed those of residents for all conditions except degenerative, nervous, and rheumatic diseases. The greatest excess of disabling illness among interstate transients, as compared with residents, appears in the unattached who seem to have more than seven times as much disability from communicable diseases and almost five times as much from accidents, as do residents of comparable age.

From these data it is seen that transients, either interstate or intrastate, have considerably more disabling illness than persons who have resided in communities long enough and under such conditions as to have the status of residents.

Intrastate transients have even higher disabling illness rates than do the interstate. It is believed that this difference is due to the greater proportionate migration of intrastate transients to cities in search of public medical care which they do not believe is available to them at home in smaller communities. That a larger proportion of intrastate than of interstate transients' applications were to medical agencies is a corollary of their search for medical care.

Data on disabling illness rates by degrees of mobility definitely suggest a health selection in migration. The pattern appears to be as follows: Among all interstate transients the most recent migrants have the least number of disabling illnesses, and as migration continues the incidence of disabling illness increases. However, as illness strikes more frequently, the result seems to be that migration is delayed and often the migrant settles down in some community and eventually becomes a resident. This tendency may be responsible for the high rate of illness and disease found in cities among the local homeless, many of whom may well be former interstate transients disabled for migration by chronic or recurring diseases.

There are several reasons why transients exhibit a very high rate of disabling illness. First, they are more likely than residents to suffer

accidents while traveling from place to place. They are exposed to the risk of communicable disease to a much greater extent than are residents, who do not often live in the insanitary conditions found in camps, shelters, and other forms of temporary habitation. A second and more important reason for a high disabling illness rate among transients is that they are "marginal" individuals. A majority of them start migration because they are unable to support themselves at home, and it has been shown repeatedly that the poorest fraction of the population has the highest illness rates. Third, some of those found as transients have migrated because they are ill, and finally the very fact that they receive less medical care than needy resident groups may well tend to increase their illness rates. One-ninth of all disabling illness experienced by members of transient families (but excluding families headed by persons eligible for Federal hospitalization) was hospitalized, less than a third received only the attention of a physician, and almost three-fifths did not come to medical attention. For similar illnesses residents received 3.2 percent more hospitalization, 21.4 percent more attention by physicians, and some type of care in 24.5 percent more of the illnesses reported.

A considerable proportion of the unattached interstate transients interviewed are eligible for Federal hospitalization. One-ninth of all unattached transients were beneficiaries of this service as United States veterans, and 3.4 percent were eligible for medical care as merchant seamen. These two groups received some kind of medical attention for 83 percent and 96.4 percent of their disabilities, respectively, while only 66.2 percent of those experienced by other unattached transients were given medical attention. Veterans were hospitalized for 50.2 percent of their reported disabilities, seamen for 40.3 percent, and other unattached transients for only 28.3 percent.

Data on 1,444 nonresident applications for in-patient care at Louisville City Hospital show that those by Kentuckians constitute more than half of the total. About three-fourths were made by white persons and slightly more than half by females, the excess of females over males occurring principally in the age group 15–24. The greatest number of intrastate applicants (Kentuckians) in relation to the population of the place of residence came from counties touching Jefferson, the county in which Louisville lies.

Disposition of the transient applicants at this hospital was as follows: (*a*) 43.7 percent were admitted; (*b*) 11.6 percent were referred to other hospitals; (*c*) 3.6 percent were referred to practicing physicians; and (*d*) for 41.1 percent no provision for medical care was made. The proportion by place of residence of applicants accepted for bed care at Louisville City Hospital was between 40 and 50 percent for all nonresidents except those from Jefferson County, only 8.6 percent of whom were admitted.

Discrimination against transients was discussed from the viewpoints of cause, history, trends, and *modus operandi*. Data on medical care received by transients show the results of this discrimination. No class or type of transient, except special beneficiaries of the Federal health services, receives as much medical care as even the poor in resident groups. Although most students of the subject agree that care received by many residents is not adequate for the maintenance of health, transients receive even less care than do residents.

THE INFLUENCE OF TRANSIENTS ON COMMUNITY HEALTH

Transients may be found living under all kinds of sanitary conditions. While some transients resemble, in their hygienic surroundings, residents of the same economic status, a greater proportion are forced to exist under almost every imaginable variety of insanitary condition. Wretched housing among transients is found in every State, but more frequently in the Southwest since transients are found there in the greatest numbers. The majority of transients live in temporary shelters that range downward in degrees of sanitation from the Farm Security Administration camps and the better grower camps, through the worst of grower camps and the poorer tourist camps to the most insanitary of all, the squatter camps or jungles. In the latter are often found all conceivable violations of hygienic standards in excreta disposal. The water supply even for drinking purposes is often the nearest stream, pool, or irrigation ditch. Serious overcrowding in the shelters is almost universal even in the grower camps.

As a result of these conditions a high incidence of typhoid fever and, particularly, of dysentery, occurs among transients, especially among the migratory agricultural workers. On the basis of disabling illnesses reported by transients in interviewed cases, the incidence of typhoid fever was approximately 34 times as high as among all residents of the United States in 1938.

Various organizations have been vitally concerned with this aspect of transient life, and there is some evidence that housing conditions in general are improving. Both the Farm Security Administration camps and those grower camps built and maintained under the jurisdiction of competent health authorities have done a great deal to improve the living conditions of transients. It remains to be seen whether good camps can be provided in sufficient number to raise the standard of sanitation for any significant number of transients.

No thorough studies of the diets of transients have been made, but a partial one showed that on the basis of milk consumption the diets of transient children are very inadequate. Since the majority of migratory agricultural transients in the Southwest come from the

West South Central States, their diet is very likely to be that of the poorer residents of those States, made even more inadequate by the financial distress into which the transients have fallen. It is believed by all competent observers that their diets fall far short of minimum requirements in total calories, vitamin and mineral content, and digestibility.

As evidence of the results of inadequate diets among these transients it was found in one study of the children of migratory agricultural workers that 27.9 percent of them had nutritional and dietary defects, not including dental caries and decalcification. During the Transient Case Study 6 transients were interviewed who had been disabled by pellagra, a deficiency disease, during the 3-month survey period. The cumulative effect on future health in the western States of allowing children to subsist on very inadequate diets is one that should be given serious consideration by health authorities.

The incidence of active pulmonary tuberculosis among all transients who apply for public assistance is probably around 2 percent for the country as a whole and somewhat higher in the Southwest. In some cities to which there is considerable migration because of pulmonary conditions and in which migratory labor is not in very great demand, the incidence of active pulmonary tuberculosis among transients may be as high as 9 percent.

Almost without exception the nonresident or transient tuberculous person is excluded from the sanatorium or must spend a long time in residence before hospitalization. This can mean only that he is forced to continue spreading the infection to nontuberculous individuals.

According to a survey of unattached homeless men in one city, the incidence of serologically detectable syphilis appears to be about 8 percent for white interstate unattached transients and about 29 percent for colored. This is approximately 2 percent less than the rates determined for the corresponding local homeless groups in the same city. As in tuberculosis, the transient with syphilis is usually "ineligible" for public treatment, despite the fact that one of the most important public health considerations in the treatment of syphilis is the protection of the rest of the population by making each case noninfectious.

Smallpox is not only occurring at a high rate among transients but is being spread by them from one community to another and from State to State; meningococcus meningitis epidemics also seem to be encouraged by the housing of transients in congregate shelters.

A very great danger to the health of communities exists in the possibility of the introduction by transients of relatively unknown diseases. For example, all the known requirements for the introduction of malaria into a number of States exist in the transient

situation today. This disease and trachoma are probably now being carried to California and other parts of the West by transients from the South Central States.

A very important effect of interstate transients on communities is the cost of public medical care given to them. For hospitalization alone it has been estimated that transients cost Los Angeles County (Calif.) $170,000 annually. From the records of admissions of interstate transients to 16 county hospitals in California, an annual cost per county of $26,000 was estimated. The Louisville (Ky.) City Hospital Department of Admissions estimates that the hospitalization of nonresidents in this institution cost Louisville taxpayers about $14,000 in 1937 and around $9,000 in 1938. It is of interest to note that more than half the applicants and transients admitted to this institution were intrastate transients.

The effect of transients on community health is to increase the hazard of ill health to residents and to raise the incidence of most of the communicable diseases. The incidence of tuberculosis, syphilis, gonorrhea, and malaria almost certainly is increased in a community by adding transients to the resident population. This is partly due to the higher rate of these conditions among transients; but it results chiefly from the fact that transients are not given equal consideration in community programs of sanitation, preventive medicine, and isolation of infectious cases of communicable disease.

The discrimination noted against diseased transients in hospitals, sanatoria, and clinics undoubtedly has an economic basis. The cost of hospitalization for the average long period of institutionalization in pulmonary tuberculosis is so high that no community feels willing to provide facilities or pay for hospitalizing nonresidents with this condition. Hence there result the settlement laws with their special restrictions against persons with pulmonary tuberculosis. The States have felt that if nonresidents were admitted to State tuberculosis sanatoria it would serve only to attract more indigent tuberculous persons from areas where free hospitalization for this disease is not available to all persons suffering from it.

The data presented on the cost of public hospitalization now being supplied to transients in general hospitals seem to show that an enormous load from this cause is being carried by some communities, in spite of the fact that transients generally receive considerably less medical care and hospitalization than do residents.

Recommendations

The conclusions expressed in this report have resulted from the analysis of original data collected during the course of the study, from the various studies, books, and articles published on transiency and related subjects, and from the advice and counsel of various authorities.

Specific recommendations as to the most equitable and practical solution of the medical problems associated with transients are: (1) In any plans formulated, the basic consideration that migration and transiency are permanent characteristics of American society and economy must be given a prominent place. (2) There should be a national policy on migration, and an organization to direct and influence migration should be created on the Federal level. (3) There should be instituted a program of hospital and sanatorium construction and maintenance and of public medical care for the medically needy, through the combined efforts of the Federal Government and the States, that would make available in every State adequate medical care and a public institution bed for each needy individual who required it. These services should be similarly available to all needy persons regardless of residence status. In the case of transients with pulmonary tuberculosis and other chronic debilitating conditions, provision should be made for returning these cases to the last State in which they had legal settlement if it is certain that proper medical care, including hospitalization, is immediately available there and if it is not more important socially that they be hospitalized as transients. (4) The presence of a considerable number of interstate transients in any State should be recognized as a special health problem in the allotment of Federal funds to States for the maintenance and improvement of local public health facilities. (5) The Federal Government should neither formulate nor contribute funds to a health program organized exclusively for transients. Determination of the transient's settlement status, the investigation of his financial need, and his certification for any needed medical care should be handled by such public social organizations and personnel in each community as carry out similar functions for residents. Determination of medical need and administration of all public medical care given to the transient should be allocated to that public medical agency in each community charged with similar responsibilities for needy residents.

PART I

MIGRATION AND TRANSIENCY

MOBILITY OF THE UNITED STATES POPULATION

The extraordinary geographic mobility of the American people has been a subject for comment by a host of both native and foreign observers. The whole development of the civilization of this continent is, directly or indirectly, associated with migration. Immigration settled these shores; internal migration peopled the continent. The westward trek of the nineteenth century is still in our memories. In fact, there is even now a significant east-to-west trend in migration. Since the end of the nineteenth century, however, there has been a simultaneous and parallel migration from west to east, as well as a significant, if less well defined, movement between the north and the south. These are the currents that would appear heaviest if a flow map were drawn to scale showing the numbers of migrants concerned.

Three other migrational tendencies, however, have contributed and are at present more than ever contributing to the phenomenon of our tremendous mobility. One is the classic rural-urban pulsation, which, in contrast to the other movements mentioned, is not peculiarly American but is characteristic of all countries or regions that are in the process of industrialization.[1] This has, in general, taken the form of migration from the farms and rural communities to the city. Recently, however, as a result of the depression, there has been a city-to-farm movement as well.[2] Still another migration pattern is that incidental to the seasonality of certain trades and industries, preeminently in agriculture. Finally, there is the migration caused by trades in which, seasonally or otherwise, the labor demand has varied so much from week to week, or from day to day, that it has brought about a certain shifting labor supply known as casual labor.

Migration is a phenomenon of both the past and the present and may be expected to continue. That it will be a problem in the future is suggested by three considerations: (1) The factors conducive to migration are still operative; (2) in the opinion of a number of

[1] There is attached a composite reference list covering what are believed to be the significant publications bearing on the subjects discussed. If specific citation is made, publications are referred to by number, e. g. (*44*).

[2] See especially (*51*) and (*113*).

authorities, sound economic policy will, in the future, demand additional migration particularly from certain problem areas that are harboring a larger population than they can support;[3] and (3) there is evidence that the mobility of Americans is increasing. The National Resources Committee has pointed out that the proportion of the native population living outside the State of birth has increased steadily since 1890.[4]

Migration must, therefore, be accepted as a social phenomenon that will continue. Its effects must be reckoned with in all social planning. Since it is obviously impossible to ignore migration and futile for social agencies and the law to discourage it, an examination of some of its social costs becomes pertinent so that transiency, one of the problems, may be considered in proper perspective.

SOCIAL COSTS OF MIGRATION

Although it has been contended that the social interrelations affected by migration are fewer in modern society than in a more primitive one, the effects of present-day migration are, nevertheless, evident and, in view of the greater population involved, more intense. First are the demographic effects, many of which are so well recognized that they are considered part of social law.[5] Migration may well have direct relationship, for example, to the differences in birth rates between city and rural communities. The trend of migration from rural communities with high birth rates to cities with low birth rates undoubtedly exerts a negative influence on population growth, especially since the effect of the newcomer's need for economic adjustment in the city is further accentuated if he belongs to one of the racial minority groups. Migration may also influence birth and death rates by changing the age and sex composition of whole communities, if not by more subtle changes in social attitudes and characteristics.

Migration may have an even more direct demographic influence either in the area from which it originates or that to which it is directed. Certain regions attract the aged and are correspondingly affected by the change in the age composition of their populations.[6] Cities ordinarily attract the able-bodied at their most productive age, but farm-to-city migration, just as migration in general, is said to be sex-selective and to contribute further to the disproportion of women over men usually present in cities.[7] There is some indication that women are more migratory than men and predominate

[3] See (*51*), (*113*), and (*7*).
[4] See (*86*).
[5] See (*96*) and (*133*).
[6] See (*56*).
[7] See (*86*) and (*133*).

among the short-distance migrants, while men predominate among long-distance migrants.

It cannot be denied that the chief reasons prompting migration are economic, nor that the economic factor makes the transient particularly vulnerable since he belongs to the lower income groups.[8] Economic adjustment in a new environment is difficult for any migrant, especially if the new environment is more complex than the old. The likelihood of dependency, even if only temporary, is great, and it becomes greater as the occupational and economic adjustments and the migration extend over longer periods of time.

The dependent migrant, whether he needs material relief or free health and medical service, will be penalized, if his migration occurred recently enough, by statutes, court decisions, or administrative rulings. Furthermore, if the number becomes large enough, local and State authorities have been known to take drastic measures specifically directed against migrants as a class. Thus California, Florida, Colorado, and Arizona recently have used such means as the "border blockade" and the "hobo express" or have threatened to call out State militias in order to keep out those who were thought likely to become dependent.[9] Hostility toward newcomers may be the cause of even more violent action, such as race riots, if minority groups are involved. This has been exemplified in the case of Negroes when they moved northward during and immediately after the World War, and Filipinos when they appeared in the agricultural labor market in California.[10]

The adjustment problems of the migrant are not only economic but cultural as well, particularly when, as today, the migrating populations frequently come from culturally distinct zones. Social difference of itself leads to a form of stratification and a resultant ostracism that tends to complicate the adjustment. These difficulties are further intensified if the migrant comes from an educationally backward group or one with a lower standard of living than that of the community to which he moves. When this is true, there arises the problem of participation in the community activity that social workers have repeatedly stressed, that is, the migrant's lack of participation in such life or his positive exclusion from it. Thus mobility is unfavorable to community organization and indeed has a disintegrative influence upon it.

The disorganizing influences of migration extend even more strongly into the family. That migration may act as a discouragement against marriage has been pointed out, as has the predominance of unattached men and women, particularly among migrants in the

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[8] See (*74*).
[9] See (*51*) and (*7*).
[10] See (*70*) and (*106*).

cities. The interrelations between divorce and mobility,[11] and desertion and mobility have also been commented on.[12]

Disorganization of the individual migrant personality must also be counted among the costs of migration. It may be that the migrant from the country to the city encounters such a new and unfamiliar universe of experience that the change causes a distinct shock, or his personality may more directly be adversely affected by the social and economic pressure under which he finds himself. In any case, certain symptoms of personality disorganization seem to accompany mobility. Mobility, in general, and country-city migration, in particular, have been thought to have direct relationships to the incidence of crime.[13] Similarly, internal migration as well as that from foreign countries is believed to have a direct effect on the incidence of insanity [14] and even suicide.[15] This is quite apart from so-called psychopathological migration.[16]

With this discussion of some of the social costs of migration, it becomes evident that transiency can be understood only if it is seen in relation to these other problems. Transiency, the pathology of migration, includes all those conditions that accompany migration and that raise social problems.

VOLUME OF TRANSIENCY

For the purposes of this study, and in an attempt to fix unequivocally the term "transient" for administrative or legislative purposes, the definition in the Introduction has been cast in terms of rather specific social disabilities that are imposed upon migrants in distress and in need of assistance. Such migrants, at that point, become transients. For reasons obvious from the very nature of migration and transiency, it is almost impossible to estimate the number of persons who are, at a given moment, either migrant or transient. In spite of the difficulty of making a census of this sort, estimates have been attempted of which the best available ones indicate that approximately 500,000 persons cross State lines annually with intent of changing residence.[17] There is some indication that the actual number must be larger, if one considers the number of transients—migrants in distress and seeking relief—to be found in the country.

A census of transients in seven cities [18] taken in March and April 1938 in the Transient Case Study, as compared with the number of

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[11] See (*84*).
[12] See (*77*).
[13] See (*77*), (*18*), (*104*), and (*99*).
[14] See (*81*), (*94*), and (*98*).
[15] See (*20*).
[16] See (*72*) and (*73*).
[17] See (*74*).
[18] The seven cities are Atlanta, Denver, Jacksonville, Los Angeles, New Orleans, Phoenix, and Seattle.

transient case registrations in the same seven cities under the Federal Transient Bureau program in 1934, leads to the conclusion that the number of transients in 1938 is not far below the estimate of migrants mentioned above. This is based on an assumption, believed to be sound, that the transient case load of the seven cities represented the same proportion of the total for the country in each year. Since the number of registrations for the country in 1934 is known, an estimate made on this basis is warranted. Four hundred thousand transient persons is believed to be a fair estimate of those actually applying for assistance annually in the United States. Inasmuch as the transient category, as defined here, is in no sense inclusive of all migrants, the number of migrants must be even larger than formerly estimated.

FAMILY ATTACHMENT

A good deal has been said about the transient's lack of family attachment. So far as this has been true—and no doubt it was true during past decades—it was a condition of life imposed upon him by the exigencies of migration. Recently, however, the condition seems not so prevalent in spite of these exigencies. Evidence of this appeared in analyses of the case load of the Federal Transient Bureau in 1935 and has since been confirmed in other studies. Among cases registered by the Federal Transient Bureau for June 1935 [19] fully 22 percent were families; the Transient Case Study census for the period March to May 1938 indicates about the same proportion, i. e., 20 percent of families. It may very well be, however, that there has actually been an increase in the number and proportion of families on the road since 1935. A comparison of transient family applicants for April 1935 with those for April 1938 in the seven index cities previously referred to shows a threefold increase in the number of families.

The implications of the growing importance of the family in transiency can be properly measured only if one considers all the factors that make the family so much more vulnerable in a social sense and its failures so much more serious than is the case with the unattached individual. Merely that a family case concerns an average of four individuals while an unattached case concerns only one makes the family a far more serious problem; this quite apart from such nonquantitative considerations as have already been noted in the discussion of the social costs of migration.

SIZE OF THE TRANSIENT FAMILY

The size of the transient family, as revealed by the Transient Case Study, has further significance. It would seem that concomitantly

[19] See (*125*).

with the growth in importance of the family in the transient situation the size of the transient family has increased. The analysis of the Transient Bureau case load in June 1935 indicated that the average size (3.1 persons) of families registered with the Transient Bureau was substantially lower than that of families among the resident relief population (4.4 persons). That this differential seems to be disappearing is indicated by the Transient Case Study which found the average size of families to be 3.8 persons.[20]

Transient families tend to differ somewhat in size according to the place of origin. Transients from the South Central States (particularly Oklahoma, Arkansas, and Missouri)—whence in recent years there has been the greatest migration to the West—show larger families on the average than do those from elsewhere. Families from the South Central region averaged 4.1 persons, from the Southwest, 3.8 (the national average); but among transients originating outside these two areas, the average family was only 3.3 persons.

Race may also have some influence on the size of the family, although the sample on which this judgment is based is rather small. The average size of the 115 Negro transient families found in the sample of the Transient Case Study was only 3.2 persons.

From available data it appears that family size bears some relationship to degree of mobility.[21] Families showing the least mobility, commonly the victims of unusually stringent settlement laws in the States where they were found making application for public assistance, were also the largest. These families which, for lack of a better term, are here called "technical nonresidents" had an average of 4.0 members each. On the other hand, those that showed the highest degree of mobility and are here called "itinerants" were substantially smaller, with an average of 3.4 members. Families representing an intermediate degree of mobility, the "recent migrants," averaged 3.7 members.

AGE

It has been pointed out before that the migrant and transient groups on the average tend to be younger than the needy resident group of the population.[22] Both unattached transients and the heads of transient families, taken as groups, were found by Webb [23] to be younger than the group of residents on relief. The Transient Case Study

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[20] It should be noted that the definition of a family group, as used by the Federal Transient Bureau, was far broader than that used by the Transient Case Study. The former used the economic household as the family unit; the latter considered only the biologically related family.

[21] See table 8 and accompanying text for a definition of the criteria used in measuring mobility.

[22] See especially (*112*) and (*125*).

[23] See (*125*).

found additional interesting differentials. Interstate transients (persons lacking residence for legal settlement purposes in the State in which found) in both unattached and family cases include a smaller proportion of aged persons, 55 years of age or over, than do intrastate transients (persons having State residence but lacking it in the community in which found). At the other extreme of age, under 25 years, intrastate family heads show a greater percentage of youths and the intrastate unattached a smaller percentage than do the corresponding interstate groups. Table 1 shows the age distribution of the two groups.

TABLE 1.—*Distribution of heads of families and of unattached persons in a selected sample*[1] *of interstate and intrastate transients, according to age*

Age group	Interstate transients		Intrastate transients	
	Family heads	Unattached	Family heads	Unattached
	Number			
Total	[2] 1,702	[3] 8,286	190	752
Youth (less than 25 years)	218	2,500	32	158
Prime (25–54 years)	1,337	5,292	137	490
Aged (55 years and over)	147	494	21	104
	Percent			
Total	100.0	100.0	100.0	100.0
Youth (less than 25 years)	12.8	30.1	16.8	21.0
Prime (25–54 years)	78.6	63.9	72.1	65.2
Aged (55 years and over)	8.6	6.0	11.1	13.8

[1] Selected from transients applying for public assistance in 20 cities covered by the Transient Case Study. The Study extended over a 6-week period between March 8, 1938, and May 7, 1938.
[2] Excluding 1 of unknown age.
[3] Excluding 2 of unknown age.

A greater proportion of the aged among interstate transient family heads (8.6 percent) than among interstate unattached transients (6.0 percent) augurs an increasing age among transients, as the number of transient families increases. This preponderance of the aged is particularly marked (10.7 to 12.0 percent) among the heads of the group of families from the South Central States (Oklahoma, Missouri, and Arkansas) that constitute the most baffling and perhaps most important problem among all migrants at the moment.

PLACE OF ORIGIN

In order to arrive at a workable determination of "place of origin" among transients, it is necessary to describe the expression in terms of a standard or point of reference that is unambiguous but not too complicated to apply to a given case. Thus "place of origin" cannot well be defined in terms of present legal settlement since many transients do not have settlement anywhere. Similarly, in many other

cases it would be quite impractical to attempt to determine for a given individual the State or community in which he had last had settlement, largely because of the variety of conditions attached to acquisition and loss of settlement in the several States. Hence, the only feasible scheme appears to be to accept an arbitrary approximation of settlement and consider "place of origin" of a transient as "the State in which he last stayed continuously for at least 1 year before entering this State this time." The State thus ascertained as "place of origin" of a transient may be the State he is in now if his last entrance into the present State did not occur long enough ago to gain legal settlement for him, and if, at some time before this last entrance, he had lived in this State for 1 year. Making length of stay in a given State the deciding factor provided a criterion of mobility by fixing a simple chronological point of reference for subsequent migration and made it possible to measure the time spent in migrations.

It was found that half (49.4 percent) of the interstate family transients interviewed in 20 cities originated in 4 States, Oklahoma, Arkansas, Missouri, and Texas. While this admittedly reflects to some extent the greater attention given to the Southwest, toward which transients from these States have recently been migrating, it may also be said that the Study's emphasis on the Southwest was not out of proportion to the size of the transient problem in that section as compared with the rest of the United States.

Further credibility is given to the foregoing figure by the different places of origin found for unattached interstate transients, 49.8 percent of whom came from 11 States, approximately the same States as those previously mentioned by Webb[24] as the most important places of origin of transients. Accordingly, the concentration in place of origin of family transients would seem not to be a reflection of the character of the Transient Case Study sample but rather of the transient situation itself. The 11 States, in order of importance as sources of origin of unattached interstate transients, are: California, New York, Texas, Illinois, Michigan, Pennsylvania, Missouri, Ohio, Oklahoma, Tennessee, and Colorado.

MOTIVES FOR MIGRATION

Motives for migration, in the case of families, differed somewhat according to the regions from which the families came. Among the unattached, on the other hand, no significant differential in motive could be discovered on which origin might have a bearing. The economic factor predominated in every instance, as has already been pointed out for migrants generally. For the unattached, in all but

[24] See (*125*).

12 percent of the total cases, economic factors had at least some influence. In 76.2 percent of the unattached cases the economic motive appeared either alone or in combination with factors other than health.

The percentage of health migrants was very small among the unattached interstate transients, as shown in table 2. It should be noted, however, that in the case of unattached Negroes and unattached females health migration was relatively more frequent. Table 3 shows by place of interview the motive for migration of unattached transients.

The motivation of family migration was slightly different from that of the unattached. While the economic motive predominated to practically the same degree as it did with the unattached, the health motive entered much more frequently. In contrast to motivation of the unattached, region of origin did seem to exercise some influence on migration motive in family transients, as shown in table 4. The region of greatest net exodus, i. e., the South Central States,[25] showed the lowest percentage of health migrants and the highest percentage of economic migration. In contrast the Southern, the Atlantic, and the New England States showed a much higher percentage of health migrants among family cases.

TABLE 2.—*Distribution of a selected sample*[1] *of unattached interstate transients of different sex and race, according to motive for migration*

Motive for migration	All unattached interstate transients	Sex		Race		
		Male	Female	White	Negro	Other
	Number					
Total	8,288	8,047	241	7,404	623	261
Health	408	353	55	360	44	4
Health alone	259	220	39	220	36	3
Health and other	149	133	16	140	8	1
Nonhealth	7,880	7,694	186	7,044	579	257
	Percent					
Total	100.0	100.0	100.0	100.0	100.0	100.0
Health	4.9	4.4	22.8	4.9	7.1	1.5
Health alone	3.1	2.7	16.2	3.0	5.8	1.1
Health and other	1.8	1.7	6.6	1.9	1.3	.4
Nonhealth	95.1	95.6	77.2	95.1	92.9	98.5

[1] Selected from transients applying for public assistance in 20 cities covered by the Transient Case Study. The Study extended over a 6-week period between March 8, 1938, and May 7, 1938.

[25] The States included in each of the regions are as follows: Southwest: Arizona, California, Colorado, Nevada, New Mexico, Texas; Northwest: Idaho, Montana, Oregon, Utah, Washington, Wyoming; South Central: Arkansas, Kansas, Kentucky, Missouri, Oklahoma; South: Alabama, Florida, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia; North Central: Illinois, Indiana, Iowa, Michigan, Minnesota, Nebraska, North Dakota, Ohio, South Dakota, Wisconsin; Atlantic: Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, West Virginia.

TABLE 3.—*Distribution of a selected sample*[1] *of unattached interstate transients interviewed in different cities, according to motive for migration*

City of interview	All unattached interstate transients	Motive for migration		
		Health alone	Health and other	Nonhealth
	Number			
Total	8,288	259	149	7,880
Southwest	3,169	96	88	2,985
Tucson, Ariz.	72	6	7	59
El Paso, Tex.	207	17	5	185
San Antonio, Tex.	281	13	14	254
Los Angeles, Calif.	760	25	21	714
6 other cities	1,849	35	41	1,773
Hot Springs, Ark.	160	97	5	58
9 other cities	4,959	66	56	4,837
	Percent			
Total	100.0	3.1	1.8	95.1
Southwest	100.0	3.0	2.8	94.2
Tucson, Ariz.	100.0	8.3	9.7	82.0
El Paso, Tex.	100.0	8.2	2.4	89.4
San Antonio, Tex.	100.0	4.6	5.0	90.4
Los Angeles, Calif.	100.0	3.3	2.7	94.0
6 other cities	100.0	1.9	2.2	95.9
Hot Springs, Ark.	100.0	60.6	3.2	36.2
9 other cities	100.0	1.3	1.2	97.5

[1] Selected from transients applying for public assistance in 20 cities covered by the Transient Case Study. The Study extended over a 6-week period between March 8, 1938, and May 7, 1938.

The factors of race and sex seem to have influenced family migration differently from the way in which they affected the migration of the unattached. Negro families showed a substantially lower percentage of migration because of health than did whites—9.6 percent for the former as contrasted with 24.7 percent for the latter. More migration because of health occurred in households headed by women than in those headed by men; the differential, however, was not so great as between unattached women and men. In 35.3 percent of the migrations of women-led households, health was a factor, but in families with male heads the percentage was 22.2. The corresponding percentages for unattached women and men, it will be recalled, were 22.8 percent and 4.4 percent, respectively. Table 5 shows the cities that bear the principal burden of family health migrants.

TABLE 4.—*Percentage distribution of a selected sample[1] of interstate transient families with different regions[2] of origin, according to motive for migration*

Region of origin	All interstate transient families		Percentage distribution of families according to motive for migration				
	Number	Percent	Health alone	Health and other	Economic alone	Economic and other	Other
Total	[3] 1,693	100.0	6.0	11.5	67.9	8.3	5.8
Southwest	419	100.0	5.3	9.5	70.9	7.9	5.5
Northwest	98	100.0	6.1	12.2	63.3	13.3	5.1
South Central	694	100.0	3.0	10.7	76.9	6.2	2.6
South	91	100.0	13.2	14.3	58.2	6.6	7.7
North Central	296	100.0	8.8	14.2	54.7	11.5	10.8
Atlantic	95	100.0	16.8	13.7	45.3	12.6	11.6

[1] Selected from transients applying for public assistance in 20 cities covered by the Transient Case Study. The Study extended over a 6-week period between March 8, 1938, and May 7, 1938.

[2] The States included in each of the regions are as follows: Southwest: Arizona, California, Colorado, Nevada, New Mexico, Texas; Northwest: Idaho, Montana, Oregon, Utah, Washington, Wyoming; South Central: Arkansas, Kansas, Kentucky, Missouri, Oklahoma; South: Alabama, Florida, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia; North Central: Illinois, Indiana, Iowa, Michigan, Minnesota, Nebraska, North Dakota, Ohio, South Dakota, Wisconsin; Atlantic: Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, West Virginia.

[3] Excluding 9 families whose region of origin was outside the United States and 1 family for whom the region of origin was unknown.

TABLE 5.—*Distribution of a selected sample[1] of interstate transient families interviewed in different cities, according to motive for migration*

City of interview	All interstate transient families	Motive for migration		
		Health alone	Health and other	Nonhealth
	Number			
Total	1,703	103	195	1,405
Southwest	1,430	79	176	1,175
Tucson, Ariz	40	5	13	22
Denver, Colo	51	4	7	40
Los Angeles, Calif	568	37	86	445
7 other cities	771	33	70	668
Hot Springs, Ark	26	17	0	9
9 other cities	247	7	19	221
	Percent			
Total	100.0	6.0	11.5	82.5
Southwest	100.0	5.5	12.3	82.2
Tucson, Ariz	100.0	12.5	32.5	55.0
Denver, Colo	100.0	7.8	13.8	78.4
Los Angeles, Calif	100.0	6.5	15.1	78.4
7 other cities	100.0	4.3	9.1	86.6
Hot Springs, Ark	100.0	65.4	0	34.4
9 other cities	100.0	2.8	7.7	89.5

[1] Selected from transients applying for public assistance in 20 cities covered by the Transient Case Study. The Study extended over a 6-week period between March 8, 1938, and May 7, 1938.

In order that definite knowledge of migration by transients might be secured, they were asked a number of questions concerning the destination sought at the outset of migration, the reasons for choosing the original goal and the specific factors sought there, whether this goal was reached, the reason for coming to the present locality, and the length of time spent since coming.

Between choice of destination and factors sought, on the one hand, and the original reason for leaving the State of origin, on the other, there was apparently a very decided coincidence. In approximately 75 percent of all cases the economic motive figured, either alone or in combination with factors other than health, as the reason for leaving the State of origin. The choice of destination was similarly determined. Among the unattached, economic factors or related factors such as the presence of friends and relatives at the chosen destination influenced the choice in 80.9 percent of the cases; among families these considerations influenced 73 percent of the choices.

A similar coincidence can be noted between the choice of destination because of health factors and departure from the point of origin for health reasons. It will be recalled that health reasons for leaving the point of origin were given in 4.9 percent of unattached cases and 17.5 percent of family cases. Health considerations, such as climate, the availability of watering facilities (as at Hot Springs), or the hope for medical care, determined the choice of destination in 7.5 percent of all unattached cases and 21.2 percent of family cases. In each case the excess of destinations chosen for health reasons over the number of migrations because of health is natural and logical since once the transient had chosen to leave his home State, even if for economic reasons, climate and similar considerations would carry some weight in his choice of the most desirable goal. What seems very much more significant, however, is the small proportion of cases in whose choice of destination the hope of medical care exercised the decisive influence. Table 6 shows that the hope of medical care was a factor in the choice of destination for only 1.2 percent of family cases and 2.0 percent of unattached cases. It seems obvious that the transient knows that by leaving his home State he cannot hope to secure more medical services than are available to him at home, however poor and inadequate those at home may be. His gamble in migration for health reasons is staked almost entirely on the imponderables of a salubrious climate.

TABLE 6.—*Distribution of a selected sample*[1] *of interstate transient families and of unattached interstate transients, according to original purpose of migration*

Original purpose	Family attachment			
	Family		Unattached	
	Number	Percent	Number	Percent
Total	[2] 1,659	100.0	[3] 7,656	100.0
Economic improvement	968	58.4	5,345	69.8
Union with friends, relatives, etc	276	16.7	1,363	17.8
Climate and related benefits	340	20.5	463	6.0
Medical care	21	1.2	154	2.0
Other	54	3.2	331	4.3

[1] Selected from transients applying for public assistance in 20 cities covered by the Transient Case Study. The Study extended over a 6-week period between March 8, 1938, and May 7, 1938.
[2] Excluding 44 interstate transient families for whom the original purpose of migration was unknown.
[3] Excluding 632 unattached interstate transients for whom the original purpose of migration was unknown.

A final test which it is here proposed to apply to the rationality of transients' wanderings is the test of duration of migration. From table 7 it will be seen that 70.6 percent of the family cases and 77.2 percent of the unattached have been migrants for less than 1 year and that only 8.9 percent of the family cases and 13.2 percent of the unattached have been migrants as long as 2 years. Four unattached persons and one family head stated that they had never lived continuously in any State as long as 1 year.

TABLE 7.—*Distribution of a selected sample*[1] *of interstate transient families and of unattached interstate transients, according to period of time since migration began*

Time since migration began	Family attachment			
	Family		Unattached	
	Number	Percent	Number	Percent
Total	[2] 1,699	100.0	[3] 8,255	100.0
Less than 3 months	321	18.9	4,089	49.5
3–5 months	368	21.7	1,058	12.8
6–11 months	509	30.0	1,232	14.9
12–23 months	350	20.6	774	9.4
24–35 months	85	5.0	390	4.7
3–4 years	27	1.6	264	3.2
5–9 years	20	1.2	284	3.4
10 years and over	[4] 19	1.1	[5] 164	1.9

[1] Selected from transients applying for public assistance in 20 cities covered by the Transient Case Study. The Study extended over a 6-week period between March 8, 1938, and May 7, 1938.
[2] Excluding 4 interstate transient families for whom period of time since migration began was unknown.
[3] Excluding 33 unattached interstate transients for whom period of time since migration began was unknown.
[4] Includes 1 family the head of which had been a migrant since birth.
[5] Includes 4 transients who had been migrants since birth.

The relationship between the transient's absence from his original point of departure and the length of his last continuous physical stay in the State in which he was found may also be used to test the

rationality of his migration. The following definitions are used in order to provide a simple statistical measure of the duration of migration:

1. A *recent migrant* is any transient who left his State of origin[26] less than 2 years prior to the date of interview, but has not lived continuously in the State where he is now found for as long as 1 year immediately preceding that date. Recent migrants fall into two distinct classes, further defined below:

1a. A *recent short-duration migrant* is any *recent migrant* who (*a*) has been away from his State of origin less than 6 months, (*b*) has been in the present State at least 3 months if he left the State of origin between 6 months and a year ago, or (*c*) has been in the present State at least 6 months if he left the State of origin more than 1 year ago.

1b. A *recent long-duration migrant* is any *recent migrant* not classifiable as a *recent short-duration migrant*, defined above.

2. A *technical nonresident* is any transient who claims 1 year's continuous residence in the State in which he is interviewed, immediately preceding such interview.

3. An *itinerant* is any transient who has been away from his State of origin for 2 years or longer and does not claim 1 year's residence in the present State, as defined for *technical nonresident*, above.

It is evident from table 8 that itinerants, probably that group most nearly like "transients" as they are popularly imagined, constitute only an insignificant section of the population classified and treated as "transients" by the social and medical agencies. A more important section of the transient population seems to be those individuals who may be said to have "residence" in the State in which the Transient Case Study found them, in the sense that they have 1 year's continuous residence in that State. (It should be noted that 1 year's residence suffices in the majority of States for legal settlement purposes.) While these cases constitute only 4.8 percent of all unattached transients, they make up almost one-fifth of the family cases. As might be expected, the majority of these cases are the victims of the particularly stringent 3-year settlement laws that certain of the far western States have been led to adopt in recent years. A small minority of cases lack settlement owing to technicalities other than required duration of stay.

Three-quarters (76.7 percent) of all families and 83.9 percent of all unattached cases, however, may, with more or less justice, be called "recent migrants." In the time since they left their point of origin, a fraction of them have been more mobile than would seem necessary for purposes of relocation and are called here "recent migrants—long duration." It is reasonable to suppose that some of them have become part of the army of migratory, seasonal laborers in agriculture and elsewhere. However, more than two-thirds of

[26] Defined in "Place of Origin," page 24.

all transients are people who have recently left what may be considered their home States, have consumed only a reasonably short time in migration, but have not yet been long enough in the present State to acquire legal settlement.

TABLE 8.—*Distribution of a selected sample*[1] *of interstate transient families and of unattached interstate transients, according to migratory status*

Migratory status	Family attachment			
	Family		Unattached	
	Number	Percent	Number	Percent
Total	[3] 1,698	100.0	[4] 8,255	100.0
Recent migrants [2]	1,302	76.7	6,928	83.9
Short duration	1,175	69.2	5,680	68.8
Long duration	127	7.5	1,248	15.1
Technical nonresidents	327	19.3	398	4.8
Itinerants	69	4.1	929	11.3

[1] Selected from transients applying for public assistance in 20 cities covered by the Transient Case Study. The Study extended over a 6-week period between March 8, 1938, and May 7, 1938.
[2] For definition of "Recent migrants," etc., see p. 31 of text.
[3] Excluding 5 interstate transient families for whom migratory status was unknown.
[4] Excluding 33 unattached interstate transients for whom migratory status was unknown.

PART II

STATUTORY LIMITATIONS ON PUBLIC ASSISTANCE TO TRANSIENTS

It is not the intention in this chapter to attribute to statutory discrimination against the migrant the sole responsibility for his deprivation of certain social services. Instead of considering the law as the *cause* of the migrant's being deprived of these services, it is proposed to examine it as merely one of the *mechanisms* whereby he is thus deprived, leaving for discussion in a later chapter the question of why the migrant or the group of migrants thus adversely affected is penalized.

Of the various laws that provide for free medical care to the indigent population, the most important are the so-called "poor laws" of the various States, sometimes called "pauper" or "indigent" laws, or more recently "public welfare" or "public assistance" laws. One characteristic common to these laws is that in them the several States impose, upon either themselves or their political subdivisions, the obligation to relieve the destitute. Relief or medical care for the sick-poor is, therefore, part of the machinery for relieving destitution, by which, incidentally, ends more fundamental than the relief of destitution may also be accomplished. A certain measure of social quarantine, rehabilitation, or even prevention may thus be involved in the provision of medical care under the poor laws. The basic concept, however, remains that of relief of the poor.

Another concept common to most poor laws, however, is the provision that their benefits are to apply, with rare exceptions, only to needy persons whom the law considers residents of the State or its political subdivisions. Sometimes the poor law makes further provision for those who do not fall within its definition of residence, but in 39 States nonresidents are more or less explicitly excluded from its benefits.

That part of the poor law defining residence requirements and other conditions of eligibility for poor relief is commonly called "settlement law" and will be thus referred to in the discussion that follows. "Settlement" should be carefully distinguished from "residence" as it applies to eligibility for voting, certain licenses, or civil service appointment.

Certain other features of the poor law, relating to the relief of needy persons who do not qualify as residents, will be considered in this section, and there will be a short discussion on laws of the various States relating to the burial of needy persons who are not classified as residents.

SETTLEMENT LAW

History and development.—The history of settlement law extends beyond colonial times and the legal concepts brought to this country by the first settlers, to the time of feudalism. In many of the original poor laws of the Colonies there is a provision similar to that in the early law of Rhode Island, that it should be "Agreeable to the Statute of XLIII of Elizabeth." Thus, early poor laws in general, and settlement laws in particular, reveal notions and practices that are peculiarly English. States that did not derive their settlement laws directly from England frequently did so indirectly, although a few States, including Louisiana, whose early laws were derived largely from the French, have never had a settlement law.

The reason for the transfer of legal conceptions from England to America lies partly in the identity of the racial and cultural stock of the early settlers and the similarity of social and economic conditions in America and England at the time. The American colonies were predominantly agricultural so that here, as in England, the laboring classes were surrounded by a series of restrictions designed to attach them so far as possible to the soil or the villages and towns where they happened to be settled. In England these restrictions date back to 1350 when, in the towns, the scarcity of labor resulting from the Black Death led to the desertion of the feudal manors by the serfs.

So-called "vagrancy statutes," providing for flogging, branding, mutilation, and, after repeated offense, the death penalty, for "sturdy rogues and beggars," date from the latter part of the fourteenth century. Foremost among the laws, however, that impeded the laborers' freedom of movement in England was the "Law of Settlement and Removal," enacted in 1662.

In the American colonies one of the purposes of the early settlement laws was to restrict the movement of labor. Among other important functions which they served were the enforcement of religious conformity and homogeneity within the community and, most important, the protection of the individual towns and parishes from the intrusion of persons likely to become dependents. This is probably the most compelling consideration today.

It is within this framework, then, that early settlement legislation, and legislation about the poor generally, must be regarded. Early

settlement laws differed from those of the present in a number of ways. First of all, they made residence almost completely a matter of inhabitancy of a town or parish, rather than of the State, as is increasingly the trend today. Moreover, since the town or parish bore the sole financial responsibility for relieving the destitute, acceptance or nonacceptance of newcomers was dependent on whether or not they seemed likely to become public charges. In order to bar undesirable newcomers, colonial towns and parishes resorted to various practices and legal rulings. From the very first, newcomers to a community had to obtain approval from local authorities whether for the purpose of settlement or for only temporary stay. Even now in such States as Iowa, South Dakota, and Minnesota there are statutory provisions to the effect that persons coming into the State or going from one county to another, if they are, or are likely to become, county charges, may be prevented from acquiring settlement by the authorities of the county, township, or city in which they are found by the act of warning them to depart.

Approval by the town authorities and failure to be "warned out" were two of the usual requirements to be met before acquiring settlement under the old laws. A third requirement which the Colonies, and later the States and Territories, quite uniformly exacted in order to guarantee that "those likely to become chargeable" should not acquire inhabitance was the payment of taxes for a certain period of time. The period varied from 1 to 6 years. In Rhode Island the possession of property or payment of a stipulated rental was another basis for the acquisition of settlement. Connecticut and Rhode Island even today require a shorter period of residence for those possessed of property or an estate of freehold than for other persons. In the early laws citizenship was indispensable to the acquisition of settlement and is still in South Carolina and Anne Arundel County, Md.

Residence, as such, in a given locality and over a stipulated length of time—"commorancy" as it has been called by some legal authorities—did not become an important criterion for legal settlement until well within the nineteenth century. Even today there are few States whose statutes permit acquisition of legal settlement by residence alone. Nevertheless, in the discussion of the conditions of settlement under our present laws, residence must be assigned first place, since it is one of the few principles that the settlement laws of the various States have in common.[1] In other respects we find

[1] Connecticut is the only State in which the law waives residence if a town wishes to admit a person to settlement by the vote of its townsmen or by the consent of its selectmen and justices of the peace.

State laws differing to such an extent that not a few of the problems of settlement must be attributed to this mutual inconsistency. The "residence" principle, however, is marked by a complete lack of uniformity between States.

Acquisition of settlement.—Residence is a decisive factor in both acquisition and loss of settlement. Considering residence in relation to *acquisition of settlement*, the State laws are found to disagree on two questions: (1) Where must a person have resided in order to acquire settlement in a particular State? (2) How long must he have resided there? In reply to the first question, the 39 States that have settlement laws give 13 different replies, as shown in table 9.

TABLE 9.—*Distribution of States according to political unit in which residence is required for acquisition of legal settlement, August 1938*

State:
- California.
- Colorado.

State and county:
- Arizona.
- Delaware.
- Idaho.
- Montana.
- Nevada.
- Oregon.
- South Dakota.
- Texas.
- Wyoming.

State or county:
- North Dakota.

State, county, or town:
- Minnesota.

County:
- Alabama.
- Iowa.
- Kansas.
- Mississippi.
- Missouri.
- Oklahoma.
- South Carolina.
- Tennessee.
- West Virginia.

County and town:
- Ohio.

County or town:
- Illinois.
- Michigan.

Town:
- Connecticut.
- Indiana.
- Maine.
- Massachusetts.
- New Hampshire.
- New York.
- Rhode Island.
- Vermont.
- Wisconsin.

Other:
- Nebraska.[1]
- New Jersey.[2]
- North Carolina.[3]
- Pennsylvania.[4]
- Virginia.[5]

No settlement law:
- Arkansas.
- District of Columbia.
- Florida.[6]
- Georgia.
- Kentucky.
- Louisiana.
- Maryland.[7]
- New Mexico.
- Utah.
- Washington.

[1] In county for 1 year but failing that, in State 1 year and in one county 6 months.

[2] In State for 1 year if prior to May 4, 1936, but failing that, 5 years in State, county, or town.

[3] In county for 1 year, unless a migrant from out of State who at time of entrance into State was not able to maintain himself, in which case 3 years' residence in State is required in addition.

[4] In State 1 year if for purposes of relief from State; in institution district 1 year if for purposes of relief from institution district.

[5] In county or town for 1 year, unless a migrant from out of State who at time of entrance into State was not able to maintain himself, in which case 3 years' residence in State is required in addition.

[6] Except for two counties, one of which requires 2 years in State, 1 year in one county, and the second (only for purposes of hospital and clinic care) 1 year in county.

[7] Except for one county which requires 1 year of county residence.

The replies to the second question are equally varied. Most of the States whose settlement laws demand residence both in the State and a county, or in a county as well as a town, require a different period of residence in the larger political unit from that in the smaller. Idaho, for example, requires 1 year's residence in the State, 6 months of

which must be in 1 county; Ohio requires 1 year's residence in one county, 3 months of which must be in one town. A number of the States do not have residence provisions that apply uniformly to all cases. Colorado requires 1 year's residence in the State, if the person has been self-supporting during that time, but 3 years' if the person either has pulmonary tuberculosis or has not been self-supporting. Connecticut requires 4 years' residence in a town except that 1 year will suffice if the person owns property in the town for that period of time. Rhode Island and New York also have differential requirements that are applicable to different classes. The most important disparity, however, between residence requirements for legal settlement is between States. The range of time extends from 6 months to as much as 5 years. Table 10 illustrates these inequalities. It will be noted that, while a substantial number of States still prescribe 1 year's residence for all cases, 17 now have settlement laws that require a longer residence at least for some cases.

A definite trend is revealed if we compare the present requirements with those of 9 years ago. A digest of the settlement law in 1930 showed only 7 States requiring more than 1 year's residence. During the last 25 years, more than one-third of the States have made more stringent laws in respect to the length of residence necessary for settlement.

TABLE 10.—*Distribution of States according to length of residence required for acquisition of legal settlement, August 1938*

Six months:
- Alabama.
- Mississippi.
- Oklahoma.

One year:
- Idaho.
- Illinois.
- Indiana.
- Iowa.
- Kansas.
- Michigan.
- Minnesota.
- Missouri.
- Montana.
- Nebraska.
- New York.[1]
- North Dakota.
- Ohio.
- Pennsylvania.
- South Dakota.
- Tennessee.
- Texas.
- West Virginia.
- Wisconsin.
- Wyoming.

Two years:
- Delaware.

Three years:
- Arizona.
- California.
- Colorado.[2]
- Nevada.
- North Carolina.[3]
- Oregon.
- South Carolina.
- Vermont.
- Virginia.[3]

Four years:
- Connecticut.[4]

Five years:
- Maine.
- Massachusetts.
- New Hampshire.
- New Jersey.[5]
- Rhode Island.[6]

No settlement law:
- Arkansas.
- District of Columbia.
- Florida.[7]
- Georgia.
- Kentucky.
- Louisiana.
- Maryland.[8]
- New Mexico.
- Utah.
- Washington.

[1] Five years in certain counties if person came there with tuberculosis or for institutionalization, or members of his immediate family have done so.

[2] One year sufficent if person is self-supporting for that period.

[3] One year sufficient unless person is a migrant from out of State who was not able to support himself at time of entrance, in which case 3 years are required.

[4] One year sufficient if person is possessed of property for that period.

[5] One year sufficient, prior to May 4, 1936.

[6] Three years sufficient if person is possessed of estate of inheritance or freehold.

[7] Except for two counties, one of which requires 2 years and the other 1 year.

[8] Except for one county which requires 1 year.

All but 7 of the States that have settlement laws define residence for settlement in terms of its continuity or its chronological precedence of application for public support. Some States require that residence be "continuous," others that it be "without interruption," or over a number of "successive," "consecutive," or "whole" years or months, as the case may be. Residence may be required to be "prior to application," "immediately preceding application," "immediately preceding becoming chargeable," or various similar phrases. Table 11 shows the requirements of the several States in this respect.

TABLE 11.—*Distribution of States according to terms used in settlement laws to modify residence requirements for acquisition of legal settlement, in respect to continuity or chronological precedence before application for public support, August 1938*

Continuity

Continuous:
- California.
- Colorado.
- Connecticut.
- Iowa.
- Minnesota.
- Nebraska.
- North Carolina.
- North Dakota.
- Ohio.
- Oklahoma.
- Oregon.
- Pennsylvania.[1]
- Rhode Island.

Without interruption:
- Indiana.
- New Jersey.

Successive years:
- Delaware.
- Maine.
- South Carolina.

Consecutive years:
- Massachusetts.
- New Hampshire.
- Virginia.[2]

Whole year:
- Tennessee.
- Wisconsin.

Chronological precedence

Prior to application:
- Alabama.
- Mississippi.

Immediately preceding application:
- Arizona.
- Illinois.[3]
- Montana.
- Nevada.
- Pennsylvania.[4]

Next preceding application:
- Idaho.
- Missouri.[5]
- Tennessee.
- West Virginia.

No restrictions

- Kansas.
- Michigan.
- New York.
- South Dakota.
- Texas.
- Vermont.
- Wyoming.

No settlement law

- Arkansas.
- District of Columbia.
- Florida.[6]
- Georgia.
- Kentucky.
- Louisiana.
- Maryland.[7]
- New Mexico.
- Utah.
- Washington.

[1] "Continuous" used only in connection with law that applies to assistance from institution district.

[2] "Consecutive months" instead of "consecutive years."

[3] "Immediately preceding becoming chargeable" instead of "immediately preceding application."

[4] "Immediately preceding application" used only in connection with law that applies to assistance from State.

[5] "Next preceding order being made" instead of "next preceding application."

[6] One of the two counties having settlement laws uses term "next preceding application."

[7] The one county having settlement law uses term "immediately preceding application."

Thus far, only the application of the residence principle to acquisition of settlement has been considered. It should be borne in mind, however, that for acquisition of settlement there are limiting clauses in most of the laws. It has already been pointed out that 11 States require residence to precede application for public support, if

it is to be applicable toward legal settlement. Furthermore, 32 States that have settlement laws explicitly void residence for settlement purposes if the person concerned has been the beneficiary of some public or private agency. Self-support for a specified length of time in addition to residence is, therefore, another important principle involved in the acquisition of settlement. This requirement is in a sense the modern correlative of those earlier laws that made nonpayment of taxes or failure to own property or pay a stipulated rental a bar to the acquisition of settlement, and is, similarly, intended to prevent the acquisition of settlement by "those likely to become chargeable."

Loss of settlement.—Next in importance to the principles governing the acquisition of settlement are those that determine loss of settlement. These are of particular consequence when it becomes desirable to determine the place of legal settlement of a person who is known not to have settlement in the place where he is now living.

Only 21 of the 39 States with settlement laws have explicit provisions regarding the loss of legal settlement. In the remaining 18 States it has been necessary for the courts to decide when settlement is lost. Heisterman says: "The courts are divided upon the question of interstate settlement. The various court decisions in point, however, seem to establish, as the weight of judicial authority, that the original settlement is lost by removing to and obtaining a legal settlement in another State, unless the evidence shows that the person in question did not intend to relinquish his former settlement and acquire a new one." [2]

In contrast to this principle of recognizing a settlement as lost only upon acquisition of a new one, most of the States that have legal provisions for loss of settlement include in them considerations other than acquisition of a new settlement. Thus, in 18 States, settlement may be lost by absence from the place of settlement for a specified time, ranging from 30 days in South Dakota to 5 years in Maine, Massachusetts, New Hampshire, and Rhode Island. The same 18 States all make the additional stipulation that acquisition of a new settlement elsewhere nullifies the previous settlement; but 9 of these States interpret "new" to apply only within the State. New Hampshire alone stipulates that a settlement shall be void after 5 years' support as a pauper in that State. Table 12 lists the States according to their statutory provisions regarding loss of legal settlement.

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[2] See (57).

TABLE 12.—*Distribution of States according to statutory provisions relating to loss of settlement, August 1938*

SETTLEMENT LOST UPON		
Acquisition of new settlement	*Absence for specified period*	*No settlement law or no provision for loss of settlement*
Within State:	Equal to period required for acquisition of legal settlement:	Alabama.
Indiana.	Indiana.[2]	Arkansas.
Iowa.	Iowa.	Connecticut.
Kansas.	Maine.[3]	District of Columbia.
New Jersey.	Massachusetts.[4]	Florida.
New York.	Minnesota.[5 6]	Georgia.
North Carolina.	Nebraska.[5 6]	Illinois.
North Dakota.	New Hampshire.	Indiana.
South Dakota.	New York.	Kentucky.
Wisconsin.	North Dakota.[7]	Louisiana.
In another State:	Rhode Island.	Maryland.
Iowa.	Wisconsin.[4 5]	Michigan.
Minnesota.	Wyoming.	Mississippi.
Nebraska.	Less than period required for acquisition of legal settlement:	Missouri.
New Jersey.	Arizona.	Nevada.
North Carolina.	California.[8]	New Mexico.
Oregon.[1]	Colorado.[9]	Ohio.
Place not specified:	Kansas.[10]	Oklahoma.
Maine.	New Jersey.[11]	Pennsylvania.
Montana.	South Dakota.[10]	South Carolina.
Rhode Island.		Tennessee.
	Assistance as pauper for five years	Texas.
		Utah.
	New Hampshire.	Vermont.
		Virginia.
		Washington.
		West Virginia.

[1] Acquisition of a "residence in another State by living continuously therein for at least 1 year subsequent to his residence in this State."

[2] Absence must be willful and uninterrupted.

[3] Absence without receiving pauper supplies from within State.

[4] Time spent in certain institutions within State is not to be counted toward loss of settlement.

[5] Absence must be voluntary and uninterrupted.

[6] Absence must be with intent to abandon residence.

[7] Absence must be voluntary.

[8] Absence for labor or other temporary purpose does not occasion loss.

[9] The Colorado law by requiring 1 year's self-supporting residence and 350 days' physical presence or 3 years' residence and 30 months' physical presence in effect provides for loss of residence after 15 days' or 6 months' absence, respectively.

[10] Absence must be willful.

[11] For period of present economic emergency, period since January 5, 1935, spent in certain institution or in receipt of certain types of relief is not to be counted toward loss of settlement.

The number and complexity of statutes that field workers and interviewers would have been forced to use constantly made it impossible in the Transient Case Study to determine which transients had lost settlement in the States from which they had migrated. Quite apart from the fact that no compilation of statutory provisions on loss of settlement has ever been made, it is also true that some States follow practices that are at apparent variance with the law. In most States local authorities are responsible for the return of stranded transients. Whether or not there is a State loss-of-settlement law, the rulings of such local authorities are not necessarily

uniform throughout the State nor for all cases. Residents who weigh the desirability of granting settlement to a citizen immigrant also weigh, on an individual basis, the "worthiness" of an emigrant whom it is proposed to return from another State.

Many interstate migrants, therefore, find themselves without legal settlement in any State since acquisition of new settlement may require as long as 5 years' residence with additional requirements such as self-support; while the "old" settlement may have been lost by absence from another State for even 1 month. This paradox in which some citizens of the United States find themselves should be seriously considered by public welfare officials and legislative bodies.

STATUTORY PROVISIONS FOR RELIEF TO NONRESIDENTS

While the settlement laws of the States define principles by which nonresidents are excluded from the general benefits of the poor laws, the latter generally include further provisions regulating the administration of special forms of aid granted to nonresidents. Statutory provisions for relief to nonresidents, types of laws, responsible political units, types of care given, and restrictions on relief are shown in tables 13 and 14. It will be noted that, although 39 States provide for aid to nonresidents, they are not, in every instance, those that have settlement laws. Also, in making provision for aid to the "nonresident" most of the States do not specifically define the term to show whether or not it means a "nonresident of the community" who has residence in the State, or a "nonresident of the State" or both.

TABLE 13.—*Distribution of States with different statutory provisions for relief to nonresidents, according to type of law and responsible political unit, August 1938*

Type of law

Mandatory:
- Alabama.
- Arkansas.
- Colorado.
- Connecticut.
- Florida.
- Illinois.
- Indiana.
- Kansas.
- Maine.
- Michigan.
- Minnesota.
- Mississippi.
- Nebraska.
- Nevada.
- New Hampshire.
- New Jersey.
- New York.
- North Carolina.
- North Dakota.
- Ohio.
- Oklahoma.
- Oregon.
- Pennsylvania.
- Rhode Island.
- South Carolina.
- South Dakota.
- Utah.
- Vermont.
- Virginia.
- Washington.
- Wisconsin.
- Wyoming.

Permissive:
- Arizona.
- California.
- Delaware.
- Idaho.
- Massachusetts.[1]
- Montana.[2]
- West Virginia.

Responsible political unit

Local unit:
- Alabama.
- Arkansas.
- California.
- Colorado.
- Illinois.
- Indiana.
- Kansas.
- Michigan.
- Minnesota.
- Mississippi.
- Nebraska.
- Nevada.

[1] Permissive for all but residents of the State who are not residents of the town.
[2] Permissive for all but sick nonresidents.

TABLE 13.—*Distribution of States with different statutory provisions for relief to nonresidents, according to type of law and responsible political unit, August 1938*—Continued

Responsible political unit

Local unit—Continued.
- New Hampshire.
- North Carolina.
- North Dakota.
- Ohio.
- Oklahoma.
- Oregon.
- South Carolina.
- South Dakota.
- Virginia.
- Washington.
- Wisconsin.
- Wyoming.

Local unit and State:
- Connecticut.
- Maine.
- Massachusetts.
- Montana.
- New Jersey.
- New York.
- Pennsylvania.
- Rhode Island.
- Utah.
- Vermont.

State only:
- Delaware.
- Florida.
- West Virginia.

Not specified:
- Arizona.
- Idaho.

No provision

- District of Columbia.[3]
- Georgia.[3]
- Iowa.
- Kentucky.[3]
- Louisiana.[3]
- Maryland.[3]
- Missouri.
- New Mexico.[3]
- Tennessee.
- Texas.

[3] No settlement law.

TABLE 14.—*Distribution of States with different statutory provisions for relief to nonresidents according to specifications as to recipients and to types of care to be granted, August 1938*

Type of nonresident granted care

State transient:[1]
- Oregon.

Out-of-State transient:[2]
- West Virginia.

State and out-of-State transient:
- Connecticut.
- Maine.
- Massachusetts.
- Michigan.
- Montana.
- Nebraska.
- Nevada.
- New Jersey.
- New York.
- Pennsylvania.
- Vermont.
- Wisconsin.
- Wyoming.

Not specified:
- Alabama.
- Arizona.
- Arkansas.
- California.
- Colorado.
- Delaware.
- Florida.
- Idaho.
- Illinois.
- Indiana.
- Kansas.
- Minnesota.
- Mississippi.
- New Hampshire.
- North Carolina.
- North Dakota.
- Ohio.
- Oklahoma.
- Rhode Island.
- South Carolina.
- South Dakota.
- Utah.
- Virginia.
- Washington.

Health condition of nonresident granted care

Sick only:
- Arkansas.
- Colorado.
- Illinois.
- Minnesota.
- North Carolina.
- Virginia.
- Washington.

Sick and others:
- Kansas.
- Mississippi.
- Montana.
- Nebraska.
- Nevada.
- Oklahoma.
- Pennsylvania.
- South Dakota.
- Utah.
- Vermont.
- Wisconsin.

Not specified:
- Alabama.
- Arizona.
- California.
- Connecticut.
- Delaware.
- Florida.
- Idaho.
- Indiana.
- Maine.
- Massachusetts.
- Michigan.
- New Hampshire.
- New Jersey.
- New York.
- North Dakota.
- Ohio.
- Oregon.
- Rhode Island.
- South Carolina.
- West Virginia.
- Wyoming.

Type of care granted

Temporary only:
- Indiana.
- Kansas.
- Massachusetts.
- Mississippi.
- Montana.[3]
- Nevada.[3]
- New Jersey.
- Oklahoma.
- Pennsylvania.
- Rhode Island.
- South Carolina.
- South Dakota.
- Utah.
- Vermont.[4]
- Virginia.

Emergency only:
- Arizona.
- California.
- Delaware.
- Idaho.

[1] Nonresidents of the local political unit who are, however, residents of the State.
[2] Nonresidents of the State
[3] Temporary for all but sick nonresidents.
[4] Temporary for those not residents of town for 1 year.

TABLE 14.—*Distribution of States with different statutory provisions for relief to nonresidents according to specifications as to recipients and to types of care to be granted, August 1938*—Continued

Type of care granted		*No provision*
Not specified:	Nebraska.	District of Columbia.[5]
Alabama.	New Hampshire.	Georgia.[5]
Arkansas.	New York.	Iowa.
Colorado.	North Carolina.	Kentucky.[5]
Connecticut.	North Dakota.	Louisiana.[5]
Florida.	Ohio.	Maryland.[5]
Illinois.	Oregon.	Missouri.
Maine.	Washington.	New Mexico.[5]
Michigan.	West Virginia.	Tennessee.
Minnesota.	Wisconsin.	Texas.
	Wyoming.	

[5] No settlement law.

STATUTORY PROVISIONS FOR THE BURIAL OF NONRESIDENTS

In addition to the problem of public assistance and free medical care for persons adversely affected by the settlement legislation of the various States, there have been considerable difficulties involved in the disposal of the bodies of deceased nonresidents who leave neither resources of their own nor known relatives who are legally responsible. Table 15 shows the statutory provisions of the several States with relation to the disposal of the bodies of dead nonresidents.

TABLE 15.—*Distribution of States according to statutory provisions relating to burial of nonresidents, August 1938*

Explicit provision for nonresidents	Utah.	Oklahoma.
Alabama.	Vermont.	Pennsylvania.
Arkansas.	Washington.	West Virginia.
Colorado.	Wisconsin.	
Connecticut.		*Miscellaneous provisions*
Illinois.	*Provision relating only to burial of indigents generally*	Arizona.[3]
Kansas.		California.[4]
Maine.[1]	Delaware.	District of Columbia.[5]
Massachusetts.	Georgia.	Iowa.[6]
Michigan.[2]	Idaho.	Virginia.[6]
Minnesota.	Indiana.	
Mississippi.	Louisiana.	*No provision*
Nevada.	Missouri.	Florida.
North Carolina.	New Hampshire.	Kentucky.
Montana.	New Jersey.	Maryland.
Nebraska.	New Mexico.	Oregon.
Rhode Island.	New York.	Tennessee.
South Carolina.	North Dakota.	Texas.
South Dakota.	Ohio.	Wyoming.

[1] Relates only to nonresidents of the township who are residents of the State.

[2] Relates only to nonresidents of the State.

[3] Only provision in the law is that bodies of deceased indigents are to be delivered to various medical schools for dissection, etc.

[4] Only provision in the law is concerned with notification of State Board of Health regarding bodies that have to be buried at public expense.

[5] Only provision in the law is one authorizing and directing the operation of a crematorium for bodies that cannot be disposed of except at public expense.

[6] Only provision in the law is that the bodies of persons dying in certain institutions are to be delivered to various medical schools for dissection, etc.

Part III

ADMINISTRATIVE PRACTICES OF AGENCIES GIVING PUBLIC ASSISTANCE TO TRANSIENTS

It has been noted that the States and their constituent political units make limited free medical care available to certain groups of the population as part of their program for relieving destitution. In Part II were examined the laws under which such medical care and the other forms of public assistance are provided. It was found that these laws assign to the transient a status significantly different from that of the resident. It now remains to be seen to what extent the transient is actually deprived of the benefits of the above-mentioned social services as a consequence of those laws.

Some light on this problem is furnished by data from the Study of Agency Practice. Since the findings of this part of the study are related only to agencies that do give free care to transients, they will necessarily reveal policies more generous toward transients than would be the case if the agencies refusing care had been included. This should be borne in mind in drawing conclusions as to the extent of restriction against the transient.

AGENCIES GIVING PUBLIC ASSISTANCE TO TRANSIENTS

The distribution of agencies giving care to transients and the number of transients interviewed in the 20 cities under consideration are shown in table 16. The proportion of agencies in each city seems to bear a close relationship to the relative size of the transient problem of the city, as the problem existed during the study period and was revealed by the number of applications for some form of public assistance. However, apart from the situation in certain cities where the similarity is not shown, no measure of the adequacy of facilities for transients in the respective communities is revealed by these data. Even though, generally, one city has about the same proportion of agencies in relation to its transient "case load" as has another, whether these facilities are adequate for the care of the transient problem is quite a different question.

TABLE 16.—*Distribution of transients applying for public assistance during a 6-week period between March 8 and May 7, 1938, and of agencies receiving applications, according to city covered by Transient Case Study*

City	Transients		Agencies	
	Number	Percent	Number	Percent
Total	27,866	100.0	432	100.0
Los Angeles, Calif.	4,863	17.5	80	18.5
Phoenix, Ariz.	3,332	12.0	21	4.9
Philadelphia, Pa.	3,130	11.2	45	10.4
Cincinnati, Ohio	2,634	9.5	26	6.0
Denver, Colo.	2,078	7.5	33	7.6
Minneapolis, Minn.	1,710	6.1	16	3.7
Atlanta, Ga.	1,453	5.2	15	3.5
Seattle, Wash.	1,452	5.2	30	7.0
San Antonio, Tex.	1,138	4.1	35	8.1
Stockton, Calif.	941	3.4	15	3.5
Ogden, Utah	806	2.9	10	2.3
Jacksonville, Fla.	738	2.6	14	3.2
New Orleans, La.	707	2.5	23	5.3
Boise, Idaho	699	2.5	14	3.2
Albuquerque, N. Mex.	571	2.0	9	2.1
El Paso, Tex.	428	1.5	13	3.0
Roswell, N. Mex.	390	1.4	12	2.8
El Centro, Calif.	349	1.3	9	2.1
Hot Springs, Ark.	258	.9	10	2.3
Tucson, Ariz.	189	.7	2	.5

General function.—Agencies giving public assistance to transients may be roughly divided into two categories, according to the type of assistance they dispense primarily. Those agencies whose primary function is to provide medical care[1] or whose provision of material aid (i. e., food, clothing, or shelter) is only incidental to the provision of free medical care have in this study been called medical agencies; those whose primary function is to distribute general relief, some part of which may be free medical care, have been called social agencies.[2]

As shown in table 17, there were exactly three times as many social agencies as there were medical agencies giving some sort of assistance to transients in the 20 cities. Although 25 percent of all agencies giving public assistance to transients were medical agencies, the percentage of transient applicants that they handled was substantially smaller. One factor among others that operated to reduce the percentage of cases handled by medical agencies was the inclusion among the 20 cities studied of the city of Phoenix which was at the time coping with an extraordinary influx of stranded migratory agri-

[1] "Medical care" is used throughout this discussion to denote "free medical care."

[2] There were only a few borderline cases under these definitions. Three hospitals were found which made a practice of distributing food at their doors to transients who applied there. These were nevertheless classified as medical institutions. One county welfare department in one of the States refused all material aid to transients, acting only as an intake center for the county hospital, so far as sick transients were concerned. In its primary function, it acted as the general public welfare agency for all indigents in that community, and was, therefore, treated as a social, rather than a medical agency. With these exceptions, the definitions set forth above were easily applicable.

cultural workers' families.[3] In the throes of material distress, these families applied to the local public welfare agency and consequently lowered the total representation of applications to medical agencies. Leaving Phoenix out of consideration, the percentage of transient applicants handled by medical agencies in the remaining 19 study cities becomes 21.6 in the case of families and 7.3 for the unattached.

TABLE 17.—*Distribution of agencies*[1] *giving public assistance to transients and of transient cases*[2] *handled thereby, according to general function of agency*

General function of agency	All agencies	Cases handled		
		Total	Family	Unattached
	Number			
Total	432	27,866	5,598	22,268
Medical	108	2,300	732	1,568
Social	324	25,566	4,866	20,700
	Percent			
Total	100.0	100.0	100.0	100.0
Medical	25.0	8.3	13.1	7.0
Social	75.0	91.7	86.9	93.0

[1] Located in 20 cities covered by the Transient Case Study.
[2] Transient families and unattached transients applying for assistance during a 6-week period between March 8, 1938, and May 7, 1938.

Another consideration bearing on the proportion of applicants for free medical care is that those agencies called medical agencies are not the only ones that actually give such care to transients. On the contrary, in addition to the 108 medical agencies, 98 social agencies, or a total of 206 agencies, were found providing free medical care to transients in certain instances. It should be pointed out, however, that the proportion of agencies providing for free medical care to transients, 206 out of 432, is not in any sense a measure of the availability of such care to them. The distribution of all agencies by function is shown in table 18.

With regard to social agencies providing medical care to transients in certain instances, the question arose as to how many applications for free medical care they actually receive. A tabulation of the objects sought in all transient applications during one week, in 15 of the 20 cities, indicated that, in addition to applications for medical care at medical agencies, 2.7 percent of applications at social agencies were also for medical care.

[3] See (27).

TABLE 18.—*Distribution of agencies[1] with different policies in provision of medical care giving public assistance to transients, according to general function of agency*

General function of agency	All agencies	Agencies providing medical care	Agencies not providing medical care
	Number		
Total	432	206	226
Medical	108	108	
Social	324	98	226
	Percent		
Total	100.0	100.0	100.00
Medical	25.0	52.4	0
Social	75.0	47.6	100.0

[1] Located in 20 cities covered by the Transient Case Study.

Table 19 presents a classification of medical agencies giving free medical care to transients in the 20 cities. Among them there are as many hospitals as there are out-patient departments of hospitals and clinics, and the two groups make up over nine-tenths (94.4 percent) of the total. Sixty-three percent of the hospitals are general hospitals, and among the remainder, half are maternity hospitals.

TABLE 19.—*Distribution of medical agencies[1] giving free medical care to transients, according to type of agency*

Type of agency	Medical agencies	
	Number	Percent
Total	108	100.0
Hospitals	51	47.2
General	32	29.6
Maternity	10	9.3
Children's	3	2.8
Emergency	2	1.9
Venereal disease	1	.9
Tuberculosis	1	.9
Nose and throat	1	.9
Chronic invalidism	1	.9
Clinics and out-patient departments	51	47.2
Other medical agencies	6	5.6
Visiting nurse associations	2	1.9
Tuberculosis associations	2	1.9
Milk fund associations	1	.9
First aid stations	1	.9

[1] Located in 20 cities covered by the Transient Case Study.

Social agencies do not lend themselves to classification as easily as do medical agencies. However, since one of the main purposes of this study was to determine the type of care available to transients, they were classified according to the intensity and the amount of personal attention with which the individual agencies treat each transient case. Some of the criteria used were these: Is so-called case

work treatment available for the transient? How is shelter provided? Is it provided to each case individually by the disbursing of case or rent orders, or on a congregate basis in the form of mass shelter? How is food provided—to each case according to individual need by the disbursing of cash or grocery orders, by feeding all comers on the premises, or by the more or less indiscriminate distribution of food baskets? When transportation is provided for the transient, is this done with his ultimate welfare in mind or merely to get him out of town?

With these criteria as a background, all social agencies were readily grouped into "case-work agencies" and "mass-care agencies" so far as their treatment of transients is concerned. Local public welfare departments, family welfare societies, travelers' aid agencies, and the like, generally belong in the case-work category, while so-called "mission" agencies, "flop-houses," public shelters, and jails or police stations (if they provide food or shelter to transients) are typically mass-care institutions.

As shown in table 20, mass-care agencies, representing less than three-fifths of all social agencies, were found to handle two-thirds of all applications and more than three-fourths of the unattached cases. It might also be noted that, considering the individual person as the unit, almost one-fifth of all persons for whom application was made to mass-care agencies belonged to families.

TABLE 20.—*Distribution of social agencies*[1] *giving public assistance to transients and of transient cases*[2] *handled thereby, according to type of services*

Type of service	All agencies	Cases handled		
		Total	Family	Unattached
	Number			
Total	324	25,566	4,866	20,700
Mass-care	184	16,954	935	16,019
Case-work	140	8,612	3,931	4,681
	Percent			
Total	100.0	100.0	100.0	100.0
Mass-care	56.8	66.3	19.2	77.4
Case-work	43.2	33.7	80.8	22.6

[1] Located in 20 cities covered by the Transient Case Study.
[2] A selected sample of transient families and unattached transients applying for assistance during a 6-week period between March 8, 1938, and May 7, 1938.

Agency control.—For a period of approximately 2 years (August 1933 to September 1935) the bulk of public assistance to transients was

dispensed by one agency, the Federal Transient Bureau of the Federal Emergency Relief Administration. When, in September 1935, this program was ordered liquidated, the official responsibility for relief to transients was returned to the States, where it has since remained.[4]

How have the States met this responsibility? The data in tables 21 and 22 seem to suggest that, generally, they have not met it. Neither State nor local public agencies carry the burden of relief in the 20 cities studied, since 77.8 percent of the agencies providing any sort of material or medical relief to transients are nongovernmental agencies and these handle 63 percent of all transient cases applying for public assistance.

However, the governmental agencies seem to be carrying a relatively greater share of the burden of medical relief for transients than they do of material relief. This is suggested by the proportion of governmental agencies providing for medical care to transients as well as the number of transient cases making application to them. With the exception of a small number of "other" hospitals, all agencies that do provide medical care to transients are represented a great deal more heavily among governmental agencies than are those agencies that do not provide for such care.

TABLE 21.—*Distribution of agencies*[1] *under different control giving public assistance to transients, according to provision of medical care*

Provision of medical care	All agencies	Control of agency	
		Governmental	Nongovernmental
	Number		
Total	432	96	336
Agencies providing medical care	206	66	140
Medical agencies	108	44	64
General hospitals	32	14	18
Other hospitals	19	3	16
Clinics and out-patient departments	51	25	26
Other medical agencies	6	2	4
Social agencies	98	22	76
Agencies not providing medical care	226	30	196
	Percent		
Total	100.0	22.2	77.8
Agencies providing medical care	100.0	32.0	68.0
Medical agencies	100.0	40.7	59.3
General hospitals	100.0	43.8	56.2
Other hospitals	100.0	15.8	84.2
Clinics and out-patient departments	100.0	49.0	51.0
Other medical agencies	100.0	33.3	66.7
Social agencies	100.0	22.4	77.6
Agencies not providing medical care	100.0	13.3	86.7

[1] Located in 20 cities covered by the Transient Case Study.

[4] See (27).

TABLE 22.—*Distribution of transient cases*[1] *handled by agencies*[2] *under different control giving public assistance to transients, according to general function of agency*

General function of agency	All agencies	Cases handled								
		Total			Family			Unattached		
		Total	Governmental agency	Nongovernmental agency	Total	Governmental agency	Nongovernmental agency	Total	Governmental agency	Nongovernmental agency
	Number									
Total	432	27,866	10,299	17,567	5,598	4,186	1,412	22,268	6,190	16,078
Medical	108	2,300	1,734	566	732	449	283	1,568	1,284	284
Social	324	25,566	8,565	17,001	4,866	3,737	1,129	20,700	4,906	15,794
	Percent									
Total	100.0	100.0	37.0	63.0	100.0	74.8	25.2	100.0	27.8	72.2
Medical	25.0	100.0	75.4	24.6	100.0	61.3	38.7	100.0	81.9	18.1
Social	75.0	100.0	33.5	66.5	100.0	76.8	23.2	100.0	23.7	76.3

[1] Transient families and unattached transients applying for assistance during a 6-week period between March 8, 1938, and May 7, 1938.
[2] Located in 20 cities covered by the Transient Case Study.

RESTRICTIONS ON THE TYPE OF MEDICAL CARE AVAILABLE TO TRANSIENTS

To gauge the availability of medical care to the transient, it is not enough to show that there are certain agencies giving such care. One must determine further what sort of medical care is made available to the transient and under what conditions it is administered to him. Data on this subject are presented in table 23. The fact that the type of medical care available to the transient is greatly restricted stands out immediately in the table. Only 50 of the 196 agencies that give transients any type of medical care do so on the same basis as to residents. The remaining agencies are approximately equally divided between those that grant the transient only emergency care and those that grant ordinary care but do so only for selected cases. It is interesting to note that governmentally controlled agencies as a group seem to be more stringent in their restrictions than are those not so controlled.

As shown in table 24, only 8 out of 95 social agencies that provide for medical care to transients do so without restricting it to emergency care or to ordinary care in selected cases. Thirty out of 50 mass-care agencies and 20 out of 45 case-work agencies limit their provisions to emergency medical service. The least restricted type of care seems to be given by medical agencies other than general hospitals, that is, largely by clinics and out-patient departments, a few maternity hospitals, and a few other agencies that do not lend themselves readily

to classification. Of the 72 agencies falling into this group, 35 accord their particular type of treatment to all transients on the same basis as to residents and only 14 limit their care to emergency treatment.

TABLE 23.—*Distribution of agencies[1] under different control giving medical care to transients, according to type of care provided*

Type of medical care provided	All agencies	Control of agency	
		Governmental	Nongovernmental
	Number		
Total	[2] 196	63	133
Emergency care only	74	23	51
Ordinary care for selected cases only	72	30	42
Unrestricted care	50	10	40
	Percent		
Total	100.0	100.0	100.0
Emergency care only	37.7	36.5	38.3
Ordinary care for selected cases only	36.7	47.6	31.6
Unrestricted care	25.5	15.9	30.1

[1] Located in 20 cities covered by the Transient Case Study.
[2] Excluding 10 agencies for which the type of medical care provided was unknown.

TABLE 24.—*Distribution of agencies[1] of different general function giving medical care to transients, according to type of care provided*

Type of medical care provided	All agencies	General function of agency			
		Medical		Social	
		General hospitals	Other	Mass-care	Case-work
	Number				
Total	[2] 196	29	72	50	45
Emergency care only	74	[3] 10	14	30	20
Ordinary care for selected cases only	72	[3] 12	23	16	21
Unrestricted care	50	7	35	4	4
	Percent				
Total	100.0	100.0	100.0	100.0	100.0
Emergency care only	37.8	34.5	19.4	60.0	44.4
Ordinary care for selected cases only	36.7	41.4	31.9	32.0	46.7
Unrestricted care	25.5	24.1	48.6	8.0	8.9

[1] Located in 20 cities covered by the Transient Case Study.
[2] Excluding 10 agencies for which the type of medical care provided was unknown.
[3] One not registered by the American Medical Association.

Possibly the most decisive index of the nonavailability of medical care to transients is shown in the data on general hospitals presented in table 25. The availability of treatment in general hospitals is most

important since, in contrast to treatment in agencies other than hospitals, it is more elaborate and, in most cases, more intensive. However, only 30 of the 146 registered general hospitals (exclusive of Federal general hospitals) in 20 cities studied have any sort of free medical care available for the transient. The care, moreover, is restricted in the majority of these institutions. As shown in table 24, 9 hospitals grant only emergency care to transients, 11 grant ordinary care, but only to selected cases, and only 7 general hospitals in the 20 cities grant ordinary medical care to all transients on the same basis as to residents.

TABLE 25.—*Distribution of general hospitals*[1] *under different control registered by the American Medical Association, according to provision of free care for transients*[2]

Provision of free care	All hospitals	Control of hospital		
		Governmental[3]	Nonprofit	Proprietary
	Number			
Total	[4] 146	17	106	23
Hospitals providing free care	30	13	17	0
Hospitals not providing free care	116	4	89	23
	Percent			
Total	100.0	100.0	100.0	100.0
Hospitals providing free care	20.5	76.5	16.0	----
Hospitals not providing free care	79.5	23.5	84.0	100.0

[1] Located in 20 cities covered by the Transient Case Study.
[2] Data from Hospital Number, Journal of the American Medical Association, March 1938.
[3] Excluding hospitals under Federal control.
[4] Including 9 hospitals classified as "General-Tuberculosis."

That medical care to transients is, on the whole, limited to emergency cases is also indicated by the records of Louisville (Kentucky) City Hospital's disposition of transient cases applying for hospitalization during the period from September 1935 to April 1938, inclusive. This hospital defines settlement (in reference to eligibility for bed care) as continuous residence in Louisville for 6 months. Furthermore, in the process of admitting patients, the determination of eligibility is made subsequent to the determination, by a physician of the hospital staff, of the need for bed care. Nevertheless, 650, or 44 percent, of the 1,488 transients who made application were admitted as bed patients. That the majority of them were suffering from more or less emergency conditions for which immediate medical or surgical attention was needed is borne out by the provisional diagnoses made in the admitting wards.[5]

[5] See Part V.

The remaining 838, or 56 percent of the transient cases, although judged by a physician to be in need of bed care, were not accepted for in-patient care at the City Hospital. Inasmuch as the only reason for accepting transient cases in this hospital is that the nature of the conditions from which they are suffering is such that if they were not accepted undue suffering or death might ensue, it follows that the cases rejected, although they needed bed care, were not immediate emergencies, or that the Department of Admissions was able to make arrangements that the patient or some agency would pay for the hospitalization in some other hospital. One hundred and seventy-three, or 12 percent, of the cases were referred to other hospitals in this manner.

In the study of transient applicants for medical care covering 16 Los Angeles (California) medical agencies[6] it was shown that, out of 1,011 applicants, 84 percent were admitted to the various medical facilities, although the established policy of the majority of the medical agencies was not to care for transients. The report of the Los Angeles study emphasized that the high percentage of admissions indicated the emergency nature of the medical conditions for which care was sought.

USE OF SETTLEMENT RESTRICTIONS AGAINST THE TRANSIENT

The method whereby the transient is accorded different treatment from that accorded the resident in a community's program of material aid and free medical care consists in the application against him of certain residence and technically related requirements which were referred to in a previous chapter as "settlement restrictions." In 39 States this discrimination between transient and resident has been crystallized in the form of legal enactment; in 9 States and the District of Columbia it has no such form. However, regardless of the existence of a settlement law, settlement restrictions against the transient are resorted to in practice by numerous communities in their administration of social services.

In this sense, as has previously been said, discrimination against the transient is the primary factor and its embodiment in legal form is only secondary. Even if States repeal or nullify their settlement laws they may, nevertheless, make regulations as strict as the original statutes. For example, chapter 90, Laws of Utah, 1937, provides that the State and county welfare departments may grant assistance and relief to persons in "necessitous circumstances," regardless of age and settlement. The amount of such assistance is to be determined by

[6] See (25).

the Welfare Board after taking into consideration all of the facts surrounding the case. As of January 1938, the welfare boards had not promulgated any rules or regulations but had adopted the practice of refusing aid to transients except on rare occasions of actual need, and even then the practice seems to have been to get them out of the State of Utah as soon as possible. It is emphasized, however, that so far as settlement or residence is concerned the State has no legal requirements when granting general relief. The rules and regulations in use by this State are the same as those embodied in the settlement statute in operation before the passage of the superseding law.

Similarly, in the State of Washington in 1938, the rules and regulations of the State Department of Social Security required for purposes of general public assistance 1 year's presence in the State to gain residence and 1 year out of the State to lose residence. Moreover, in 1937 the old poor law which required only a 6-month residence in each county and made no mention of State residence had been repealed and no new statute had been enacted to replace it.

That the existence of a settlement law is not *per se* the determining factor in restriction against the transient is further indicated by the findings of the Transient Case Study in 20 cities. Twelve of the cities studied are located in States that have settlement laws, 8 in States that do not. Nevertheless, 38.5 percent of all agencies apply settlement restrictions against transients in the cities where there is no settlement law, while in the cities governed by such a law only 33.4 percent do so. The complete tabulation is shown in table 26.

Moreover, as shown in table 27, in the States that have settlement laws, only 24 of the 100 agencies that resort to settlement restrictions govern themselves by the State law. Of the remainder 49 were stricter than the law and 27 more lenient. Governmental agencies conformed to the letter of the law in more than one-third of all cases (13 out of 37), while only half that proportion (11 out of 63) did so among other agencies.

Agencies in States that do not have settlement laws usually follow the 1-year rule of residence in the State, or in a specified political unit within the State, when they make settlement restrictions. However, as in the States that do have settlement laws, they add further restrictions, the most important of which is requiring self-support during the period of residence. This was found to be true in approximately one-third of the agencies making restrictions, with governmental agencies displaying greater stringency in this regard than the nongovernmental agencies, as shown in table 28.

The relative stringency of governmentally controlled agencies in applying settlement restrictions against the transient has already been a subject of comment. Table 29 summarizes the situation.

Among governmental agencies, the percentage applying settlement restrictions is twice as large (58.9) as it is among nongovernmental agencies (27.9). This fact has great bearing on the availability of medical care to transients because more than three-fourths of all applications to medical agencies are directed to governmentally controlled agencies.

TABLE 26.—*Distribution of agencies[1] in States with settlement laws and without settlement laws giving public assistance to transients, according to use of settlement restrictions*

Use of settlement restrictions	All agencies	Location of agency	
		In States with settlement laws	In States without settlement laws
	Number		
Total	[2] 421	299	122
Agencies using settlement restrictions	147	100	47
Agencies not using settlement restrictions	274	199	75
	Percent		
Total	100.0	100.0	100.0
Agencies using settlement restrictions	34.9	33.4	38.5
Agencies not using settlement restrictions	65.1	66.6	61.5

[1] Located in 20 cities covered by the Transient Case Study.
[2] Excluding 11 agencies for which the practice of using settlement restrictions was unknown.

TABLE 27.—*Distribution in States with settlement laws of agencies[1] under different control giving public assistance to transients, according to degree of adherence to settlement laws*

Adherence to settlement laws	All agencies	Control of agency	
		Governmental	Nongovernmental
	Number		
Total	100	37	63
Agencies adhering to restrictions in settlement laws	24	13	11
Agencies exceeding restrictions in settlement laws	49	18	31
Agencies not meeting restrictions in settlement laws	27	6	21
	Percent		
Total	100.0	100.0	100.0
Agencies adhering to restrictions in settlement laws	24.0	35.0	17.5
Agencies exceeding restrictions in settlement laws	49.0	48.7	49.2
Agencies not meeting restrictions in settlement laws	27.0	16.2	33.3

[1] Located in 12 of the 20 cities covered by the Transient Case Study.

TABLE 28.—*Distribution in States without settlement laws of agencies[1] under different control giving public assistance to transients, according to type of settlement restrictions made*

Type of settlement restrictions made	All agencies	Control of agency	
		Governmental	Nongovernmental
	Number		
Total	47	19	28
Residential restrictions only	32	11	21
Residential and other restrictions	15	8	7
	Percent		
Total	100.0	100.0	100.0
Residential restrictions only	68.1	57.9	75.0
Residential and other restrictions	31.9	42.1	25.0

[1] Located in 8 of the 20 cities covered by the Transient Case Study.

TABLE 29.—*Distribution of agencies[1] under different control giving public assistance to transients, according to use of settlement restrictions*

Use of settlement restrictions	All agencies	Control of agency	
		Governmental	Nongovernmental
	Number		
Total	[2] 421	95	326
Agencies using settlement restrictions	147	56	91
Agencies not using settlement restrictions	274	39	235
	Percent		
Total	100.0	100.0	100.0
Agencies using settlement restrictions	34.9	58.9	27.9
Agencies not using settlement restrictions	65.1	41.1	72.1

[1] Located in 20 cities covered by the Transient Case Study.
[2] Exclusive of 11 agencies whose use of settlement restriction is unknown.

Greater stringency in applying settlement restrictions against transients is also indicated in the agencies set up to offer the more elaborate or the more universal types of care. Table 30 shows that, while half the case-work agencies include residence restrictions in their eligibility requirements, only one-fifth of the mass-care agencies do so. Similarly, the general hospital is stricter in exacting settlement qualifications than are other medical agencies. More than half the general hospitals make such requirements, while less than one-third of other medical agencies do so. Among governmental agencies the degree to which restrictions are imposed is even greater. All the governmentally controlled general hospitals and 24 out of 26 case-work agencies discriminate against the transient on a settlement

basis. Other social and medical agencies do so in approximately one-third of the cases. Table 31 shows the detailed tabulation.

TABLE 30.—*Distribution of agencies*[1] *of different general function giving public assistance to transients, according to use of settlement restrictions*

Use of settlement restrictions	All agencies	General function of agency			
		Medical		Social	
		General hospitals	Other	Mass-care	Case-work
	Number				
Total	421	28	75	180	138
Agencies using settlement restrictions	147	16	23	39	69
Agencies not using settlement restrictions	274	12	52	141	69
	Percent				
Total	100.0	100.0	100.0	100.0	100.0
Agencies using settlement restrictions	34.9	57.1	30.7	21.7	50.0
Agencies not using settlement restrictions	65.1	42.9	69.3	78.3	50.0

[1] Located in 20 cities covered by the Transient Case Study.

TABLE 31.—*Distribution of governmental agencies*[1] *of different general function giving public assistance to transients, according to use of settlement restrictions*

Use of settlement restrictions	All agencies	General function of agency			
		Medical		Social	
		General hospitals	Other	Mass-care	Case-work
	Number				
Total	95	13	30	26	26
Agencies using settlement restrictions	56	13	11	8	24
Agencies not using settlement restrictions	39	0	19	18	2
	Percent				
Total	100.0	100.0	100.0	100.0	100.0
Agencies using settlement restrictions	58.9	100.0	36.7	30.8	92.3
Agencies not using settlement restrictions	41.1		63.3	69.2	7.7

[1] Located in 20 cities covered by the Transient Case Study.

Data thus far presented have shown in general the restrictions on the types of medical care available to transients and the dependence of these restrictions on settlement requirements. Unfortunately these data have two limitations. First of all, they describe agencies selected because they do give medical care to transients. With agencies refusing care to transients thus explicitly excluded, the policies

revealed are more generous to transients than if the agencies refusing care had been included. Among general hospitals, the one class of agency in which all were considered regardless of policy toward transients, it was found that only 7 out of 146, or less than 5 percent, give ordinary medical care to transients without restrictions other than those also imposed on residents. If one considers only the general hospitals that actually give some sort of care to transients, the proportion that give ordinary care without restriction appears much higher (7 out of 30). A second limitation of the data is the smaliness of the sample, confined as it was to 20 cities and not permitting a detailed breakdown of medical agencies so that restrictions as they apply to individual types might be observed.

Fortunately, two other bodies of data with neither of the above limitations are available. Each consists of an enumeration of all the medical agencies of a given type throughout the United States. The two types of agencies represented are (*a*) out-patient departments of hospitals, and (*b*) tuberculosis hospitals and sanatoria.

Out-patient departments.—The only data available on settlement restrictions for purposes of eligibility for care at the out-patient departments of hospitals relate to *residence* requirements which, as pointed out elsewhere, are the most important part of settlement requirements. (See Part II.) These data are presented in table 32 and are a part of the analysis made by Margaret L. Plumley of data from the National Health Inventory collected by the Division of Public Health Methods of the United States Public Health Service. They apply to all out-patient departments irrespective of whether the care offered is free. The tabulation consequently tends to show greater leniency on the part of the whole group of institutions than if only the free out-patient departments had been represented.

TABLE 32.—*Percentage distribution of out-patient departments in the United States under different control, according to residential requirements for admission of patients* [1]

Political unit in which residence is required for admission	All out-patient departments [2]	Control of out-patient department			
		Governmental		Nongovernmental	
		Local	State	Church and fraternal	Other nonprofit
Total	100	100	100	100	100
State	6	1	53	3	2
Local political unit	48	90	20	35	41
No residence requirement	46	9	27	62	57
Number of out-patient departments	729	149	56	141	383

[1] Data from Admission Policies for Out-patient Departments by M. L. Plumley. Hospital Management, 5: 20–22 (February 1938).

[2] Including only out-patient departments that reported satisfactory data in the study of out-patient departments conducted as part of the National Health Inventory, 1935–36.

It will be noted that, while 54 percent of all out-patient departments made admission to their services conditional upon a residence requirement of some sort, 91 percent of local governmental (i. e., city, city-county, or county) out-patient departments and 73 percent of State controlled out-patient departments do so. In all but 1 percent of local governmental agencies the residence required is local.

Nongovernmental out-patient departments are less stringent in their residence requirements. Only 38 percent of those controlled by church and fraternal societies and 43 percent of those controlled by other nonprofit associations make such stipulations. However, as indicated elsewhere in the National Health Inventory data,[7] the proportion of nongovernmental out-patient departments offering free care is very small (23 percent of those controlled by church and fraternal organizations and 15 percent of those run by other nonprofit organizations) as contrasted with that of governmental out-patient departments (72 percent of local and 56 percent of State agencies). In other words, wherever residence requirements do not prevent the transient from obtaining service, the much more effective restriction of a fee requirement will probably do so, although this latter situation would not affect transients in a manner different from that in which it would residents of the same economic level.

Tuberculosis hospitals.—It has already been noted that generally the more elaborate the care offered by a medical agency, the more stringent is its application of settlement restrictions against transients. It would, therefore, be expected that the admission policies of tuberculosis hospitals would be stricter than those observed for out-patient departments. This is found to be true. The 507 tuberculosis hospitals and sanatoria registered by the American Medical Association are tabulated in table 33 by type of control and admission policies. Considering them irrespective of whether they have free care available, it is found that 62.1 percent make residential restrictions. If proprietary and Federal institutions are omitted, as they were in the case of out-patient departments, the percentage becomes 72.2 percent, whereas in the case of out-patient departments it was only 54 percent.

As in the case of out-patient departments, governmentally controlled institutions are substantially more stringent in making residence stipulations than are the nongovernmental agencies. The chief reason why nongovernmental hospitals resort less to residential restrictions than the governmental ones do, is, as in the case of out-patient

[7] See (93).

departments, the fact that the nongovernmental agencies seldom furnish free care [8] to the general population, as shown in table 34.

TABLE 33.—*Distribution of tuberculosis hospitals in the United States under different control, according to residential requirements for admission of patients* [1]

Political unit in which residence is required for admission	All hospitals	Control of hospital				
		Governmental			Nongovernmental	
		Federal	State	Local	Nonprofit	Proprietary
	Number					
Total	507	16	70	241	120	60
State	105	0	65	21	17	2
Local political unit	210	0	1	183	24	2
No known residence requirement	192	16	4	37	79	56
	Percent					
Total	100.0	100.0	100.0	100.0	100.0	100.0
State	20.7	----	92.9	8.7	14.2	3.3
Local political unit	41.4	----	1.4	75.9	20.0	3.3
No known residence requirement	37.9	100.0	5.7	15.4	65.8	93.4

[1] Data from National Tuberculosis Association, Tuberculosis Hospital and Sanatorium Directory, 1938. Only hospitals and sanatoria registered by the American Medical Association are included.

The close relationship existing between the availability of free care and the making of residential restrictions in tuberculosis hospitals is illustrated trenchantly in table 35. Practically all of the agencies listed in the Tuberculosis Hospital and Sanatorium Directory [9] as having free care available to indigents or to all persons irrespective of their economic status make some sort of residence requirement.

Unfortunately also, it is the larger institutions that restrict admission on the basis of residence. The larger the bed capacity of a tuberculosis hospital, the greater the likelihood that nonresidents will be excluded. Classifying these hospitals according to bed capacity, one finds in table 36 that very small hospitals, those having less than 25 beds, limit admission in the above fashion in 10 out of 34 cases, while large hospitals, those with 150 beds or more, do so in 120 out of 155 (77.4 percent) cases. Hospitals of intermediate size range between these two extremes.

[8] "Free care," as used in this connection, does not include the care available to beneficiaries of organizations such as the U. S. Public Health Service and U. S. Veterans' Administration; or to those of certain trade unions, benefit societies, or church groups; or to Indians.

[9] See (87).

TABLE 34.—*Distribution of tuberculosis hospitals in the United States under different control, according to beneficiaries for free care*[1]

Beneficiaries for free care	All hospitals	Control of hospital				
		Governmental			Nongovernmental	
		Federal	State	Local	Nonprofit	Proprietary
	Number					
Total	[2] 492	16	69	233	117	57
All persons	82	0	11	63	8	0
Indigents only	121	0	18	83	20	0
Beneficiaries of specific organizations	36	16	1	0	19	0
None	253	0	39	87	70	57
	Percent					
Total	100.0	100.0	100.0	100.0	100.0	100.0
All persons	16.7	----	15.9	27.0	6.8	----
Indigents only	24.6	----	26.1	35.6	17.1	----
Beneficiaries of specific organizations	7.3	100.0	1.4	----	16.2	----
None	51.4	----	56.5	37.3	59.8	100.0

[1] Data from National Tuberculosis Association, Tuberculosis Hospital and Sanatorium Directory, 1938. Only hospitals and sanatoria registered by the American Medical Association are included.
[2] Excluding 15 hospitals for which the policy of selecting beneficiaries for free care was unknown.

TABLE 35.—*Distribution of tuberculosis hospitals in the United States with different residential requirements for admission, according to beneficiaries for free care*[1]

Beneficiaries for free care	All hospitals	Political unit in which residence is required for admission		
		State	Local political unit	No known residence requirement
	Number			
Total	[2] 492	105	210	177
All persons	82	15	65	2
Indigents only	121	25	88	8
Beneficiaries of specific organizations	36	4	1	31
None	253	61	56	136
	Percent			
Total	100.0	20.7	41.4	37.9
All persons	100.0	18.3	79.3	2.4
Indigents only	100.0	20.7	72.7	6.6
Beneficiaries of specific organizations	100.0	11.1	2.8	86.1
None	100.0	24.1	22.1	53.8

[1] Data from National Tuberculosis Association, Tuberculosis Hospital and Sanatorium Directory, 1938. Only hospitals and sanatoria registered by the American Medical Association are included.
[2] Excluding 15 hospitals for which the policy of selecting beneficiaries for free care was unknown.

TABLE 36.—*Distribution of tuberculosis hospitals in the United States with different residential requirements for admission, according to size of hospital*[1]

Size of hospital	All hospitals	Political unit in which residence is required for admission		
		State	Local political unit	No known residence requirement
	Number			
Total	507	105	210	192
Very small (less than 25 beds)	34	3	7	24
Small (25–49 beds)	90	12	35	43
Medium (50–149 beds)	228	34	104	90
Large (150 beds and over)	155	56	64	35
	Percent			
Total	100.0	20.7	41.4	37.9
Very small (less than 25 beds)	100.0	8.8	20.6	70.6
Small (25–49 beds)	100.0	13.3	38.9	47.8
Medium (50–149 beds)	100.0	14.9	45.6	39.5
Large (150 beds and over)	100.0	36.1	41.3	22.6

[1] Data from National Tuberculosis Association, Tuberculosis Hospital and Sanatorium Directory, 1938. Only hospitals and sanatoria registered by the American Medical Association are included.

Part IV

ILLNESS AND MEDICAL CARE

The first three parts of this report have described how transiency results from unsuccessful and misdirected migration and have analyzed the methods by which communities discriminate against this class of needy persons. It has been shown that the barriers set up against transients by authorities responsible for public assistance are usually successful not only in excluding transients from the receipt of material aid on the same basis as needy residents but also in closing generally the doors of public medical agencies to them for all conditions except emergencies.

The latter type of discrimination, while serious enough in principle to merit concern, becomes more important as the group toward which it is directed exhibits a relatively higher rate of illness. If transients were extremely "healthy," if their need for public medical care were almost negligible, this type of discrimination would be of no particular importance.

It becomes imperative then to measure the unmet medical needs of these individuals in terms of illness and medical care received.

Data on disabling illness and medical care were collected during the course of the Transient Case Study and will be presented in such form as to facilitate comparisons with data on similar resident groups. Disabling illness was defined as one that prevented the person from following his usual occupation for as much as 1 day.

Disabling illness rates in each case are expressed as the number of such illnesses per 1,000 individuals during a 3-month period. Interviewing in each of 19 cities was begun during March 1938 [1] and continued for exactly 6 weeks, so that the 3-month survey period prior to interview, in individual cases, began as early as December 1937, and in others ended as late as May 1938. Each interview was with an unattached transient or one member of a transient family applying for public assistance. The informants were the heads of families in 83 percent of all family cases on which data were secured.

[1] The survey in Los Angeles was delayed to April 1, 1938, by flood conditions.

More than one-eighth (13.6 percent) of the 9,040 unattached transients interviewed and 21.7 percent of the 7,105 individuals in interviewed transient family cases had had at least 1 disabling illness during the 3-month survey period. That these rates are not comparable should be obvious since the unattached group is made up principally of young male adults who would be expected to have less disability than a group of adults and children, the age composition of which is more like that in the general population.

The resident group with which interstate transients may be compared most logically is that group of persons included in the Health and Depression Study of the United States Public Health Service and the Milbank Memorial Fund [2] embracing some 7,000 families in 8 cities and considering health in its relation to income and income change. The group included in the Health and Depression Study was not intended to represent a true sample of the whole population of the surveyed cities but rather the plan was to include sections having families that in normal times were in moderate circumstances but that in large numbers had been reduced to poverty during the depression. Slum areas and the best residential sections were avoided. About one-third of the families included had a total income in 1932 of less than $600, roughly two-thirds had incomes of less than $1,200, and only one-tenth had annual incomes as great as $2,000 in that year. The survey period of the Health and Depression Study was of the same length, occurring in approximately the same season as that of the present study, and the definitions of terms used in the two studies are practically identical. That one study was made in 1932 and the other in 1938 is not believed to prejudice the results of comparisons.

Table 37 shows a comparison between the disabling illness rates of the two populations. It will be noted that both in the total and in each age group transients had a considerably higher disability rate than did the resident population [3] studied in 1932. This finding is entirely in accord with the many estimates and statements made as to the relatively high incidence of illness among transients. It will be further noted that adjusting the resident population rates to the age distribution of the transient group made practically no difference in the total rate. This must not be construed to mean that there is no difference between the age distribution of the two groups. Table 37 and figure 1 show that the transient group contains a rela-

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[2] For a full report on this group refer to (*89*).

[3] Throughout this discussion "residents" will be used to designate that portion of the population of 8 cities studied in the Health and Depression Studies. See (*59*), (*89*), and (*90*).

tively higher proportion of individuals under 5 years of age and a smaller proportion of persons 45 years of age and over than does the resident group.

TABLE 37.—*Disabling illness rates [1] for interstate family transients [2] and for residents,[3] according to age of individual*

Age group	Disabling illness rate		Number of persons observed	
	Interstate family transients	Residents	Interstate family transients	Residents
Total, adjusted [4]	239	137		
Total, crude	239	138	[5] 6,395	31,630
Under 5	299	185	913	2,486
5–9	258	196	802	3,641
10–14	195	115	738	3,716
15–19	185	87	643	3,306
20–24	216	88	640	2,538
25–34	217	121	1,153	4,646
35–44	240	132	814	4,678
45–54	286	141	462	3,515
55 and over	291	183	230	3,104
Number of disabling illnesses, all ages			1,525	4,358

[1] Per 1,000 persons for a 3-month period.
[2] Persons included in the selected sample of transients applying for public assistance in 20 cities covered by the Transient Case Study. The Study extended over a 6-week period between March 8, 1938, and May 7, 1938. The interval for which disabling illnesses were reported by transients includes the 3 months preceding the date of interview.
[3] Persons constituting the sample described in Health and Depression Studies. See (*89*) and (*90*).
[4] Adjusted to age distribution of all transients in family cases.
[5] Excluding 10 of unknown age.

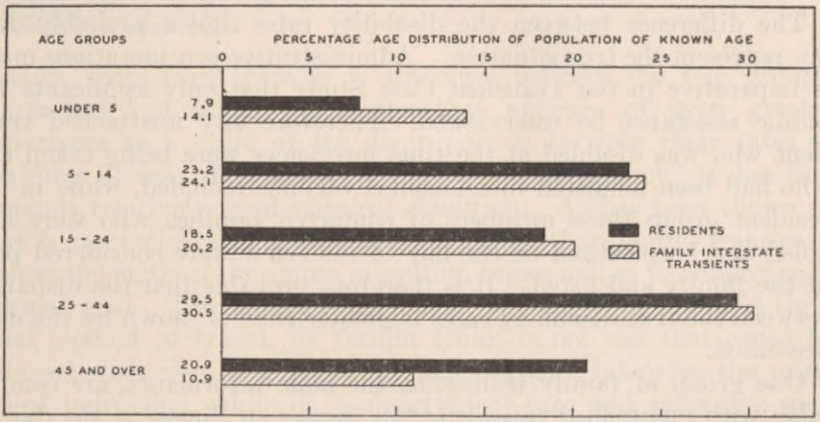

FIGURE 1.—Percentage age distribution of population of known age.

In table 38 is shown a comparison of disability rates for unattached interstate transients [4] and for resident males of comparable age. It

[4] Among the unattached were 241 females who had 82 disabilities. If these are eliminated, the rate is reduced, but not materially. It is thought that a comparison of all unattached with resident males is therefore justified.

will be noted that, as in the case of transients traveling in family groups, among interstate unattached transients higher rates of disabling illness occur in each age group (except 10–14, with only 13 individuals) than among males in resident families.

TABLE 38.—*Disabling illness rates*[1] *for unattached interstate transients*[2] *and for resident males*,[3] *according to age of individual*

Age group	Disabling illness rate		Number of persons observed	
	Unattached interstate transients[4]	Resident males	Unattached interstate transients	Resident males
Total, adjusted[5]	145	100		
Total, crude	144	107	[6] 8,286	12,650
10–14	0	108	13	1,838
15–19	102	73	706	1,666
20–24	88	73	1,781	1,272
25–34	127	86	2,470	2,220
35–44	180	121	1,818	2,343
45–54	214	122	1,004	1,850
55 and over	207	166	494	1,461
Number of disabling illnesses, all ages			1,065	1,356

[1] Per 1,000 persons for a 3-month period.
[2] Persons included in the selected sample of transients applying for public assistance in 20 cities covered by the Transient Case Study. The Study extended over a 6-week period between March 8, 1938, and May 7, 1938. The interval for which disabling illnesses were reported by transients includes the 3 months preceding the date of interview.
[3] Persons included in the sample described in Health and Depression Studies. See (*89*) and (*90*).
[4] Rates adjusted for sampling errors in agencies, by type of care furnished.
[5] Adjusted to age distribution of all unattached transients.
[6] Excluding 2 of unknown age.

The difference between the disability rates shown probably does not represent the true situation. Administrative considerations made it imperative in the Transient Case Study that only applicants for public assistance be interviewed. Therefore any unattached transient who was disabled at the time interviews were being taken and who had been admitted to a hospital was not included, while in the resident group those members of contacted families who were disabled and hospitalized on the day of interview were considered part of the family and listed. It is therefore probable that the disparity between the true disability rates is greater than is shown by the data presented.

One group of family transients, the male informants, are comparable with unattached transients[5] in respect to illness on the day of interview. In table 39 the disabling illness rates of three groups of male interstate transients—unattached, informants in family cases, and all males 10 years of age and over in family cases—are shown

[5] Of all interstate unattached transients 2.9 percent were female. This small fraction is disregarded in the present comparison of male groups.

by age groups. Male informants show a consistently lower rate of disabling illness than do all males in family cases. It is believed that this difference represents family transients disabled and hospitalized at the time of interview.

TABLE 39.—*Disabling illness rates* [1] *for unattached interstate transients, for male informants in family cases, and for all males over 10 years of age in family cases, according to age of individual* [2]

Age group	Disabling illness rate			Number of persons observed		
	Unattached interstate transients [3]	Male informants in family cases	All males [4] in family cases	Unattached interstate transients	Male informants in family cases	All males [4] in family cases
Total, adjusted [5]	145	167	187			
Total, crude	144	178	187	[6] 8,286	1,303	[7] 2,408
10–14	0	500	184	13	6	391
15–19	102	100	103	706	20	311
20–24	88	136	118	1,781	167	280
25–34	127	158	189	2,470	443	555
35–44	180	174	203	1,818	356	459
45–54	214	202	265	1,004	208	268
55 and over	207	291	299	494	103	144
Number of disabling illnesses, all ages				1,065	232	451

[1] Per 1,000 persons for a 3-month period.
[2] Persons included in the selected sample of transients applying for public assistance in 20 cities covered by the Transient Case Study. The Study extended over a 6-week period between March 8, 1938, and May 7, 1938. The interval for which disabling illnesses were reported by transients includes the 3 months preceding the date of interview.
[3] Rates adjusted for sampling errors in agencies, by type of care furnished.
[4] Excluding those under 10.
[5] Adjusted to age distribution of all unattached transients.
[6] Excluding 2 of unknown age.
[7] Excluding 3 of unknown age.

Aside from this, there is a difference between the two groups, unattached and male informants, that appears of even greater importance as a cause of the disproportion between their rates of disabling illness. The state of "unattached transiency" is one that demands relatively good physical condition. As has been shown in Part I, unattached transients are more mobile than family transients, both as to length of time since migration began and as to adherence to original goal. The unattached lead a very rigorous life and their usual method of travel, by freight train, is not one that could be followed with ease by a person chronically ill. Likewise, the unattached individual, while ill, is deprived of care and assistance such as is ordinarily received only from members of one's immediate family. For these reasons it is believed that unattached transients as a class are more highly selected as healthy individuals than are family transients.

It has been mentioned previously that the residents included in the Health and Depression Study were not confined to any one economic

group, but rather the sampling was by area within the cities, and analyses of illness were made by economic status. The results of these analyses as well as the findings of a subsequent study, the National Health Survey, show that the frequency of all illness and of disabling illness is highest among the poor.

Since it has been shown here that transients experienced more disabling illness per unit than did the residents described in the Health and Depression Study, it is believed useful to compare their rates with those of the three economic groups of residents. This comparison is shown in table 40. It is seen that again, in the total adjusted for age differences and in each age group, transients suffer a higher rate of disabling illness than any economic class of residents—even considerably higher than those classified as "poor" in the Health and Depression Study, with whom they are most comparable in economic status.

TABLE 40.—*Disabling illness rates*[1] *for interstate family transients*[2] *and for residents*[3] *classified as to economic status,*[4] *according to age of individual*

Age group	Disabling illness rate				Number of persons observed			
	Interstate family transients	Residents			Interstate family transients	Residents		
		Comfortable	Moderate	Poor		Comfortable	Moderate	Poor
Total, adjusted[5]	239	126	128	154				
Total, crude	239	119	128	152	[6] 6,395	4,451	13,001	14,178
Under 5	299	173	172	195	913	162	913	1,411
5–9	258	231	185	198	802	186	1,259	2,196
10–14	195	137	116	113	738	204	1,317	2,195
15–19	185	78	79	95	643	243	1,351	1,712
20–24	216	84	89	89	640	383	1,148	1,007
25–34	217	78	98	171	1,153	821	2,163	1,662
35–44	240	89	123	160	814	827	1,938	1,913
45–54	286	130	129	162	462	729	1,499	1,287
55 and over	291	165	192	189	230	896	1,413	795
Number of disabling illnesses, all ages					1,525	531	1,666	2,161

[1] Per 1,000 persons for a 3-month period.
[2] Persons included in the selected sample of transients applying for public assistance in 20 cities covered by the Transient Case Study. The Study extended over a 6-week period between March 8, 1938, and May 7, 1938. The interval for which disabling illnesses were reported by transients includes the 3 months preceding the date of interview.
[3] Persons constituting the sample described in Health and Depression Studies. See (*89*) and (*90*).
[4] For explanation of income range used, see (*89*).
[5] Adjusted to age distribution of all transients in family cases.
[6] Excluding 10 of unknown age.

Another important differential of disabling illness seems to be the pattern of migration. Students of this subject believe that there is a definite selection of the more healthy for migration from overcrowded areas or areas of economic distress. A correlative is the principle that mobility is restricted by illness. Data related to this principle are presented in table 41 for two types of interstate tran-

sients, unattached and heads of families. Health migrants, persons who began migration because of ill health in themselves or members of their families, are not included. As was pointed out in Part I, health migrants cannot be expected to be as mobile, once they have reached their goal, as are economic migrants. The former, expecting benefit from the salubrious climate only after a considerable period of residence, tend to settle down for a stay of months or years; while the latter, usually seeking employment, will know after a relatively short time whether or not the goal lives up to expectations and, in the event of disappointment, will probably move on.

TABLE 41.—*Disabling illness rates*[1] *for heads of interstate transient families and for unattached interstate transients*[2] *interviewed in medical agencies, according to time since migration began and time in State of interview*

Time since migration began and time in State of interview	Family heads				Unattached			
	Disabling illness rate[3]		Number of persons observed[5]	Number of disabling illnesses	Disabling illness rate[3]		Number of persons observed[5]	Number of disabling illnesses
	Crude	Adjusted[4]			Crude	Adjusted[4]		
Less than 2 years since migration began	102	106	6,958	711	177	179	1,342	238
In this State less than 1 year	97	100	6,582	638	169	175	1,079	182
In this State 1 year or more	194	194	376	73	213	182	263	56
2 years or more since migration began	161	141	893	144	183	191	60	11

[1] Per 1,000 persons for a 3-month period.
[2] Persons included in the selected sample of transients applying for public assistance in 20 cities covered by the Transient Case Study. The Study extended over a 6-week period between March 8, 1938, and May 7, 1938. The interval for which disabling illnesses were reported by transients includes the 3 months preceding the date of interview.
[3] Adjusted for sampling errors in agencies, by type of care furnished.
[4] Adjusted to age distributuion of all unattached transients.
[5] Excluding 29 unattached transients and 3 transient family heads for whom migration history was unknown.

In table 41, individuals are classified by degrees of mobility measured in two ways, length of time since migration began, and length of residence in the State of interview. The groupings are believed to represent three degrees of mobility. It will be noted that for both unattached individuals and family heads those who have been migrants for the longer period have the higher rate of disability. That this does not indicate a greater mobility of the sick is shown by the disabling illness rate of those who have been migrants less than 2 years and in the State of interview more than 1 year. The rate for the latter group is higher than that for persons in the State less than 1 year, considering either the unattached or the family heads.

The pattern suggested by these rates is: (*a*) Migrants are relatively healthy at the beginning of migration; (*b*) illness strikes them more frequently as the period of migration increases; and (*c*) those suffer-

ing most from sickness and disability tend to settle down and fuse into the resident population.

TABLE 42.—*Disabling illness rates [1] for transients [2] interviewed in medical and in nonmedical agencies, according to family and settlement status*

Family and settlement status	Disabling illness rate [3]			Percent of total applications made to medical agencies
	All transients	Transients interviewed in medical agencies	Transients interviewed in nonmedical agencies	
Unattached transients:				
Interstate	138	926	115	6.6
Intrastate	189	960	113	10.9
All family transients:				
Interstate	237	379	230	12.1
Intrastate	204	360	167	20.7
Informant in transient families:				
Interstate	200	556	182	12.4
Intrastate	225	672	104	22.1

[1] Per 1,000 persons for a 3-month period.
[2] Persons included in the selected sample of transients applying for public assistance in 20 cities covered by the Transient Case Study. The Study extended over a 6-week period between March 8, 1938, and May 7, 1938. The interval for which disabling illnesses were reported by transients includes the 3 months preceding the date of interview.
[3] Adjusted to total age distribution of each group and for sampling differences between interstate and intrastate categories in medical agencies.

It must be remembered that the "transient" population, as it is commonly spoken of, includes not only interstate transients but also intrastate transients [6] and the local homeless.[7] The sample of intrastate transients secured along with the interstate transients makes possible a comparison of disability rates between the two groups. In table 42 these are shown for the totals and by type of agency to which the interviewed case was applying for assistance. This latter break-down is essential to a complete understanding of the rates since it is obvious that persons applying for medical care are more likely to have had disabling illness during the 3 months prior to interview than are those found applying only for food, clothing, or shelter. The rates are presented for all transient individuals by family attachment and for informants in family cases. While the rates for all transient family persons are necessary for an estimation of the illness suffered by the whole group, the informant in medical agencies has a rate so unique that to fail to show it separately would create an impression that is false.

It will be noted that among all unattached transients intrastate cases had a higher disability rate than did interstate cases. This difference is supported by the fact that 10.9 percent of all applications made by intrastate transients were to medical agencies while

[6] Persons with legal settlement in some locality of the State other than that of interview.
[7] Persons with legal settlement in the place of interview but called "transients" principally because they are homeless or without families and are most conveniently cared for in the congregate type of shelter.

among interstate cases only 6.6 percent of applications were thus made. The difference between the disability rates is believed to indicate that in medical agencies the intrastate unattached transient appears relatively more frequently than in social agencies, and that this, in turn, is due to the higher proportion of intrastate unattached transients who have very recently migrated to the cities specifically for medical aid. In nonmedical agencies interstate and intrastate unattached disabling illness rates are practically identical.

The relationship shown between the rates for interstate and intrastate unattached transients is changed in the case of families. The disabling illness rates of the two family transient groups in medical agencies are not materially different. However, in nonmedical agencies the interstate transients have rates sufficiently in excess of those for intrastate transients to determine the relationship between the rates for all family transients.

The rates for informants in transient family cases give still another picture. There is a higher rate of disabling illness for either interstate or intrastate informants than among the corresponding unattached whom they resemble in that in each case the person concerned is the one who is seeking the medical or material aid. Among informants, those with legal settlement in the State of interview also had a higher disability rate than did those without it.

It may be said that, exclusive of those applying to medical agencies, interstate transient cases had more disabling illness in the 3-month survey period than did intrastate cases. But when one includes those applying for medical care, many of whom were ill on the day of interview, the intrastate group appears less healthy since it is made up, in addition to persons who happened to be in the cities when they became ill, of a greater proportion of persons who came to the cities because they were ill.

DISABLING ILLNESS BY DIAGNOSIS GROUPS

Table 43 and figures 2 and 3 show the rates of disabling illness, by certain broad diagnosis groups, for interstate transients and residents. Family transients show consistently higher rates in all the broad diagnosis groups except the one called "degenerative, etc." which includes the majority of the chronic diseases such as rheumatism, malignancies, tumors, diabetes mellitus, and pellagra. These are chronic conditions, and it is not surprising that transients show fewer disabling illnesses from them than do residents. It is extremely unlikely that persons with chronic conditions, such as might reasonably be expected to recur, would be taken along with the family when migration began, inasmuch as most migration is started to improve the economic status of the family. Persons not expected to work

with regularity would quite logically be left behind with relatives or friends.

TABLE 43.—*Disabling illness rates* [1] *for interstate transients* [2] *and for residents* [3] *of different family attachment, according to certain broad diagnosis groups*

Diagnosis group	Family		Unattached	
	Transients	Residents	Transients	Residents [4]
Respiratory:				
Crude	83.7	62.9	39.8	62.9
Adjusted [5]		65.4		55.1
Epidemic:				
Crude	41.4	17.7	17.7	17.7
Adjusted [5]		22.7		2.4
Digestive:				
Crude	23.0	10.9	16.8	10.9
Adjusted [5]		9.5		11.9
Degenerative, nervous, and rheumatic:				
Crude	14.5	24.6	14.7	24.6
Adjusted [5]		18.5		25.8
Accidents:				
Crude	12.8	5.5	26.0	5.5
Adjusted [5]		4.9		5.6
Puerperal: [6]				
Crude	25.1	13.7	18.4	13.7
Adjusted [5]		14.2		19.6
All other:				
Crude	51.2	9.2	27.5	9.2
Adjusted [5]		8.8		7.8

[1] Per 1,000 persons for a 3-month period.
[2] Persons included in the selected sample of transients applying for public assistance in 20 cities covered by the Transient Case Study. The Study extended over a 6-week period between March 8, 1938, and May 7, 1938. The interval for which disabling illnesses were reported by transients includes the 3 months preceding the date of interview.
[3] Persons included in the sample described in Health and Depression Studies. See (*89*) and (*90*).
[4] Resident males of same age distribution as unattached transients.
[5] Adjusted to age distribution of total transient population of group by family attachment.
[6] Per 1,000 females.

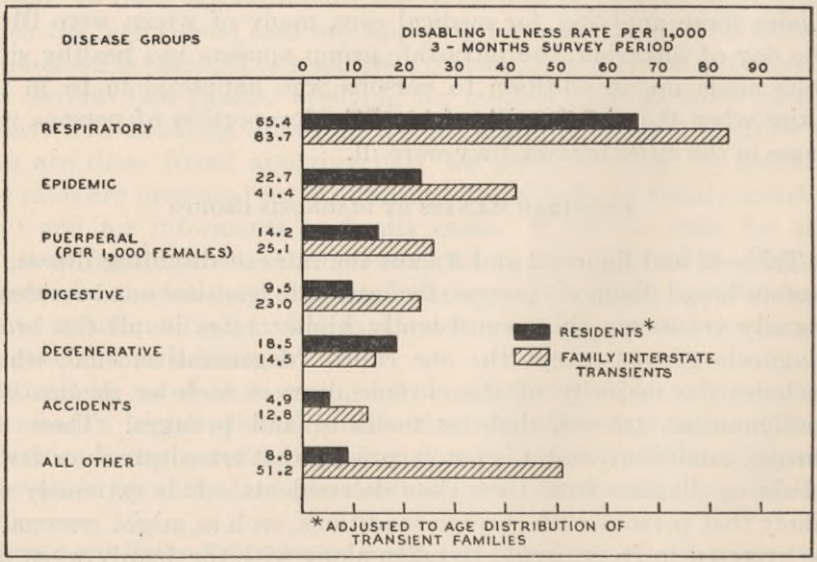

FIGURE 2.—Rate, during a 3-month period, of disabling illness, classified by broad diagnosis groups, interstate family transients, and residents.

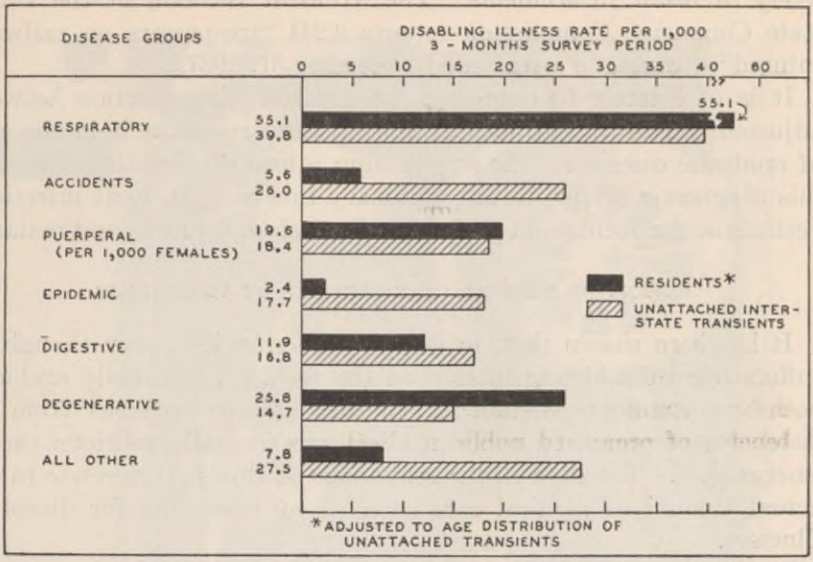

FIGURE 3.—Rate, during a 3-month period, of disabling illness, classified by broad diagnosis groups, unattached transients and residents.

Among all age-adjusted illness rates for defined diagnosis groups, family transients show the greatest proportionate excess over comparable residents in the accident rate. Progressively smaller differences are shown in the rates for digestive, epidemic, puerperal, and respiratory diseases in the order named.

It is thought that the relatively high rate of digestive disease among transients is significant. A description of the conditions under which many transient or migratory agricultural workers live will be given in Part V of this report. Many camps not only have unsatisfactory facilities for sewage disposal but lack even a water supply that is fairly safe from human fecal contamination. A high rate of digestive diseases is normally found among persons living under such conditions.

The situation among the unattached differs somewhat from that among families. For epidemic and digestive diseases and for accidents, transients continue to have higher rates. Significantly, the excess illness shown by unattached transients from accidents is still greater than that shown by family transients. If, as stated above, the excess of accidents among transients above those experienced by residents is due largely to conditions under which the former live and travel, unattached transients should have a still higher rate. Whereas the majority of family transients move by automobile, the unattached commonly travel on freight trains, a mode of travel most

likely to result in accidents. The Accident Bulletin of the Interstate Commerce Commission reports 2,241 "trespassers on railways injured" during the year ended December 31, 1937.[8]

It is of interest to note that the greatest disproportion between adjusted rates for unattached transients and residents is in the case of epidemic diseases. The five leading causes of disabling illness in this diagnostic group were: pulmonary tuberculosis, local infections (cellulitis, furuncles, and so forth), gonorrhea, syphilis, and malaria.

EXTENT OF MEDICAL CARE RECEIVED BY TRANSIENTS

It has been shown that, in general, the transient, even though he suffers more disabling illness than the resident, is usually excluded both by statutory provisions and in administrative practice from the benefits of organized public medical care for all conditions except emergencies. The data in the remainder of this section relate to the actual amount of medical care received by transients for disabling illnesses.

Inasmuch as data on residents are being presented for comparison, it should be noted that the consequences of lack of early medical care may be more serious for transients than for residents. When it is remembered that 16.3 percent of the interstate family cases and 70.6 percent of the interstate unattached had been in the State less than 16 days when interviewed, it becomes apparent that a considerable proportion of all interstate transients are actually "homeless," and consequently present different medical problems from those presented by residents, even for the same illness.

Living in a camp, jungle, mission, and other temporary quarters, lacking even facilities for self-medication or continuous rest in a comfortable bed, a disabled transient who cannot secure medical attention not only is subjected to a much more miserable experience than is a resident ill of the same condition but he is also much more likely to have serious complications. It is apparent, therefore, that in order to give a transient homeless person an opportunity equal to that of a resident to recover from illness and maintain his independence and self-sufficiency, not only is earlier admission to care required, but also a longer period under medical care is necessary than for the resident with a comparable illness. Homeless individuals in free hospitals are known to average longer periods of hospitalization per case than do residents in similar hospitals.

In the Transient Case Study, 11.3 percent (1,026 persons) of the unattached transient group and 10.3 percent (195 persons) of heads

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[8] See (*63*).

FIGURE 4.—A transient family arrives at the California border.

FIGURE 5.—Crippled child of a transient agricultural worker.

of transient families were entitled as United States veterans to medical care and hospitalization by the Veterans' Administration. An additional 304 unattached transients (3.4 percent of the total) and 5 family heads were eligible for medical care by the United States Public Health Service as merchant seamen. These groups bulk large enough in the transient population observed to merit separate study.

Over half (57.8 percent) of the disabling illnesses of family transients received no medical attention at all, while among residents the proportion was only one-third. Family transients were able to secure the services of a physician [9] for 31.2 percent of their disabling illnesses, residents for 52.6 percent. Hospitalization occurred in 11.0 percent of the illnesses among family transients, in 14.2 percent among residents. Residents were able, therefore, to secure at least the attendance of a physician in two-thirds of all instances of disabling illness; family transients succeeded in only slightly over two-fifths (42.2 percent) of such instances over a 3-month period.

Among interstate family transients, duration of migration appears to have a significant relationship to both total amount of medical service secured and number of disabling illnesses attended by a physician. Family transients in the State where interviewed less than 3 months had no service in 47.9 percent of disabling illnesses, attendance by a physician in 37.7 percent, and hospitalization in 14.4 percent. Those in the State 3 months or more had no service in 59.3 percent of cases reported, physician only in 30.3 percent, and hospitalization in 10.4 percent. The discrepancies in favor of recent arrivals may be due to hospitalization and physician's attendance reported as occurring within the 3-month survey period, but before migration began.

Table 44 shows the proportion of disabling illnesses receiving specified services among unattached interstate transients and contrasts that received by special groups of Federal beneficiaries, family transient adults, and the resident poor of similar age distribution.

Only 3.6 percent of the disabilities reported for merchant seamen were unattended by a physician. Contrast this with 17.0 percent for veterans, 33.8 percent for other unattached, and 53.0 percent for family adults. That seamen and veterans should receive medical care for a higher proportion of their disabilities than do others in general is to be expected since rather extensive medical services are provided for them by the Federal Government.

[9] "Services of a physician" or "physician's attendance" is used to mean such service alone, exclusive of hospitalization.

TABLE 44.—*Percentage of all disabling illnesses experienced by interstate transients [1] and residents [2] for a 3-month period receiving specified service, according to class of individual disabled*

Classification of individuals disabled	No service	Physician's attendance	Hospitalization
Unattached transients	28.8	37.7	33.6
Veterans [3]	17.0	32.8	50.2
Merchant seamen [3]	3.6	56.1	40.3
Others	33.8	37.9	28.3
Family transient adults [4]	53.0	33.3	13.7
"Poor" resident adults	([5])	([5])	19.3

[1] Persons included in the selected sample of transients applying for public assistance in 20 cities covered by the Transient Case Study. The Study extended over a 6-week period between March 8, 1938, and May 7, 1938. The interval for which disabling illnesses were reported by transients includes the 3 months preceding the date of interview.
[2] Persons included in the sample described in Health and Depression Studies. See (*89*) and (*90*).
[3] Beneficiaries of Federal hospitals.
[4] 15 years of age and over.
[5] Not available by age.

That merchant seamen seem to have fared better in total medical care than did veterans is probably due to the fact that seamen become migrants in the course of their occupation and that marine hospitals or medical relief stations for seamen are located in most of the cities which seamen frequent in any considerable numbers. Of the seamen interviewed, 85 percent were in cities having marine hospitals or other relief stations. Among veterans the case is quite different. Eligibility for Federal medical care as a veteran is based on past service, and present migrations, chiefly for the purpose of finding work, have no significant relationship to location of Veterans' Administration facilities.

The relation shown between disabilities of seamen and veterans in the total of medical attendance is not true for hospitalization, half the disabilities of veterans having been hospitalized as compared to two-fifths of those of seamen.

The real test of the relative amount of service received by unattached transients for reported disabilities lies in the findings for unattached persons not eligible for Federal hospitalization and classified in table 44 as "others." Compared with family transient adults these unattached individuals have a considerably smaller proportion of disabling illnesses unattended by a physician, a slightly larger percentage seen by a physician but not hospitalized, and a greater percentage hospitalized. It is also seen that these "other" unattached transients receive more hospitalization per reported disabling illness than do resident adults. Although this is an apparent contradiction to statements previously made in discussing availability of medical care to transients, its significance is explained by the fact that most

hospitals and clinics do accept transients for "emergency conditions." It would be very difficult to define the term in accordance with practice of the various hospitals and clinics but, in general, "emergency conditions" is accepted to mean "any condition which demands immediate medical attention to prevent death, undue suffering, or permanent injury to the patient." If the proportion of such conditions to all disabling illnesses reported were known for transients and residents, it is believed the explanation for the high rate of hospitalization would be at hand. Unfortunately, reported diagnoses cannot be classified as emergency or nonemergency without all the other data for the case. For example, an acute attack of appendicitis requiring an emergency operation and a mild attack of chronic appendicitis preventing a child from attending school for only 1 day will both be reported 2 months later as "appendicitis" with no further details.

The proportion of accidents among all disabling illnesses gives some indication of a higher proportion of emergencies in the unattached transients. Of all disabling illnesses the percentages due to accidents and external violence are among unattached interstate transients, 18.2 percent, family interstate transients, 5.4 percent, and residents, 4.0 percent. Since it is known that a high proportion of disabilities from accidents are emergency conditions, these differences may well explain some of the excess hospitalization received by the unattached.

Another reason for the apparent excess of hospitalization for the unattached may lie in the fact that these persons require "in-patient" treatment for relatively less serious disabilities than do either adult family transients or adult residents. Without relatives or a home, the unattached should be hospitalized for any condition in which travel is impossible or contraindicated.

Table 45 shows the volume of hospital service received by the several classes of interstate transients and residents. Unattached interstate transients eligible for hospitalization by the Veterans' Administration led all others in volume of service received, with merchant seamen ranking second. Of all the groups, family transients received the least hospitalization on the basis either of the number of persons or number of disabling illnesses. Again unattached transients not eligible for Federal hospitalization as veterans or merchant seamen present a unique picture. While they receive less hospitalization per person than the resident poor, they receive more days of hospitalization per disabling illness.

TABLE 45.—*Days of hospital care per 1,000 persons and per 1,000 disabling illnesses received by interstate transients*[1] *and residents*[2] *during a 3-month period, according to class of individual hospitalized*

Classification of individuals hospitalized	Days of hospital care	
	Per 1,000 persons	Per 1,000 disabling illnesses
Unattached transients	1,060	8,246
Veterans[3]	5,042	22,852
Merchant seamen[3]	2,630	8,247
Others	490	4,454
Family transients	362	1,515
"Poor" residents	575	3,710

[1] Persons included in the selected sample of transients applying for public assistance in 20 cities covered by the Transient Case Study. The Study extended over a 6-week period between March 8, 1938, and May 7, 1938. The interval for which disabling illnesses were reported by transients includes the 3 months preceding the date of interview.
[2] Persons included in the sample described in Health and Depression Studies. See (*89*) and (*90*).
[3] Beneficiaries of Federal hospitals.

The problem of the amount of medical care and hospitalization received by transients has been studied from the viewpoint of the record of physician's attendance and hospitalization for disabling illnesses occurring during a 3-month survey period. An equally enlightening approach to the subject of hospitalization of transients is a study of transients who apply for admission as bed patients at a large charity hospital. Louisville (Ky.) City Hospital was chosen for this study principally because of availability of records.[10]

The records of nonresident applicants for 32 months, September 1935 to April 1938, totaling 1,444 cases, are summarized in table 46 to show age, sex, and race characteristics of applicants by State of residence.[11] More than half the applicants of all ages were found to have residence in Kentucky outside of Louisville. Three-fourths of the total group were white, and there was an almost equal division between the sexes. As would be expected, there was a slightly higher proportion of individuals 25–44 years of age (the period during which travel on business or for medical care is most easily done) among nonresidents of the State than among Kentuckians, and correspondingly lower proportions of those younger and older.

[10] See Introduction.
[11] Those not having residence in Louisville were assigned to present or last State of residence, and county of residence if in Kentucky.

TABLE 46.—*Distribution of 1,444 nonresident applicants for in-patient care at Louisville (Ky.) City Hospital, September 1935–April 1938, of different residence, race, and sex, according to age of applicant*

Age group	All applicants	Residence		Race		Sex	
		Kentucky	Other	White	Colored	Male	Female
	Number						
Total	[1] 1,444	823	621	1,082	362	694	750
Under 5	94	57	37	82	12	52	42
5–9	40	24	16	33	7	22	18
10–14	62	36	26	46	16	26	36
15–19	225	143	82	169	56	61	164
20–24	262	142	120	203	59	99	163
25–34	313	164	149	220	93	153	160
35–44	194	95	99	141	53	113	81
45–54	110	68	42	78	32	68	42
55 and over	144	94	50	110	34	100	44
	Percent						
Total	100.0	57.0	43.0	74.9	25.1	48.1	51.9
Under 5	6.5	3.9	2.6	5.7	.8	3.6	2.9
5–9	2.8	1.7	1.1	2.3	.5	1.5	1.2
10–14	4.3	2.5	1.8	3.2	1.1	1.8	2.5
15–19	15.6	9.9	5.7	11.7	3.9	4.2	11.4
20–24	18.1	9.8	8.3	14.0	4.1	6.8	11.3
25–34	21.7	11.4	10.3	15.2	6.5	10.6	11.1
35–44	13.4	6.6	6.8	9.8	3.6	7.8	5.6
45–54	7.6	4.7	2.9	5.4	2.2	4.7	2.9
55 and over	10.0	6.5	3.5	7.6	2.4	6.9	3.1

[1] Excluding 44 of unknown age.

The greatest age differential was found between males and females. Although there were fewer females under the age of 10, there was a great excess of females over males in the ages from 15 to 24. The reason for this will be discussed in connection with diagnoses.

The Department of Admissions of this hospital, if it refuses admission to nonresidents, makes every effort to secure adequate medical care for each person applying. Sometimes the patient is able to pay all or part of the cost of needed hospitalization in another institution. At times private hospitals will take charity patients referred from Louisville City Hospital and, at other times, arrangements for medical attention can be made through the local official and nonofficial health agencies. If it appears that hospitalization is not imperative, the Department may refer the patient to any one of a panel of physicians from the Jefferson County (Louisville City) Medical Association. It is important to note that in most of the referrals the Department makes definite appointments for the patient with other hospitals or private physicians.

Table 47 shows the immediate disposition of the 1,488 cases included in this Study. It is interesting to note that, in addition to the 650 persons hospitalized in Louisville City Hospital, arrangements for admission to other hospitals were made for another 173 cases. Thus, a total of 823, or 55.3 percent of all applicants, are

known to have been hospitalized immediately. Forty-one percent show no record of hospitalization or medical attention after being refused admission to Louisville City Hospital.

TABLE 47.—*Distribution of 1,488 nonresident applicants for in-patient care at Louisville (Ky.) City Hospital, September 1935–April 1938, according to immediate disposition of applicant*

Disposition of applicant	Number	Percent
Total	1,488	100.0
Hospitalized in Louisville City Hospital	650	43.7
Referred to other hospitals	173	11.6
Referred to private physicians	53	3.6
Refused admission, further course unknown	612	41.1

Table 48 shows the number of applications and disposition of applicants by geographical divisions of place of residence. For purposes of analysis, Kentucky outside Louisville has been divided into tiers of counties by contiguity as follows: Jefferson County, in which Louisville lies, is designated "Tier 1"; all counties touching Jefferson County are called "Tier 2"; counties touching those in Tier 2, except Jefferson, are called "Tier 3", and so on through "Tier 5"; all other counties of the State are designated as "Tier 6". This method of classification is neither an exact measure of distance from Louisville nor an equal division of population, but it is believed to be a satisfactory index for the purpose of this analysis.[12]

It has already been noted that almost three-fifths of all applicants had residence in Kentucky. In the terminology used in this Study, these will be called intrastate transients and those with residence out of the State, interstate transients. It will be seen that among intrastate transients, the largest percentage came from Tier 3, in spite of the fact that Tier 4 had almost twice the population. The counties in Tier 3 are roughly 50 miles from Louisville.

Perhaps a better index of the load in Louisville City Hospital by place of residence in Kentucky is the number of applicants in relation to the population of the tiers of counties, respectively. It will be seen that with the exception of Tier 1, which is the county in which Louisville lies, the number of applicants in relation to population decreases as the distance from Louisville increases. The numbers of accepted cases in relation to population show the same relation by tiers of counties except that, whereas Tier 1 furnished only a few less applicants per 10,000 population than did Tiers 2 and 3, it furnished a much smaller number of accepted cases in relation to population than did Tiers 2, 3, or 4, and is only slightly higher than the average for the State.

[12] The number of counties in each tier is as follows: Tier 1, 1; Tier 2, 4; Tier 3, 6; Tier 4, 12; Tier 5, 17; and Tier 6, 80.

TABLE 48.—*Distribution of 1,488 nonresident applicants and of 650 accepted cases for in-patient care at Louisville (Ky.) City Hospital, September 1935–April 1938, according to place of residence*

Place of residence	Population 1930	Applicants			Accepted cases		
		Number	Percent of total	Per 10,000 population 1930	Number	Percent of applicants	Per 10,000 population 1930
Total [1]	----	1,488	100.0	----	650	43.7	----
Kentucky [1]	2,306,844	851	57.2	3.7	345	40.5	1.5
Tier 1 [2]	47,605	93	6.2	19.5	8	8.6	1.7
Tier 2	40,555	108	7.3	26.6	54	50.0	13.3
Tier 3	84,934	202	13.6	23.8	89	44.0	10.5
Tier 4	154,566	160	10.8	10.4	67	41.9	4.3
Tier 5	286,173	100	6.7	3.5	44	44.0	1.5
Tier 6	1,693,011	188	12.6	1.1	83	44.1	.5
Outside of Kentucky	----	637	42.8	----	305	47.9	----

[1] Excluding Louisville.

[2] All the area of Kentucky was arbitrarily divided into mutually exclusive tiers of counties, as follows: Tier 1 includes all of Jefferson County except Louisville; Tier 2 includes the Kentucky counties that touch Jefferson County; Tier 3 includes the Kentucky counties that touch Tier 2; Tier 4 includes the Kentucky counties that touch Tier 3; Tier 5 includes the Kentucky counties that touch Tier 4; Tier 6 includes all other Kentucky counties.

The reason for these exceptions in the case of Jefferson County probably lies in the disposition of cases rejected and in the availability of other resources. The City Hospital is forced to take certain types of cases if no other provision can be made for them. Cases diagnosed as, or suspected of being, quarantinable diseases or frank psychoses are accepted *ipso facto*. Similarly, nonresident applicants with emergency conditions are admitted to the hospital if refusing admission might endanger the life of the person, increase the probability of permanent disability, or unduly prolong his suffering. The disproportion in the percentage of applicants accepted from Tier 1 as compared with applicants from the rest of Kentucky probably occurs in this latter category of cases. The fiscal authorities and public agencies that administer free medical care to residents of Jefferson County are located in Louisville and consequently can be easily reached. Indigent residents of this county, if they require immediate hospitalization and appear at Louisville City Hospital, may be referred to the proper authorities and provision made for admission to private institutions in a relatively short time. This cannot be done so easily for patients from other counties, partly because of the relatively greater distance involved. Louisville City Hospital must accept these cases.

Forty percent of the intrastate transients and almost 48 percent of the interstate transients were accepted. That the latter fared slightly better may again be due to the relatively greater distance to proper and responsible authorities.

Table 49 shows the number of nonresident applicants at this hospital and the number hospitalized there and at other hospitals by broad diagnosis groups in order of descending frequency of occurrence.

Conditions resulting from accidents and violence were more numerous than any other diagnosis group, with puerperal conditions ranking next. It is of interest to note that of the 214 puerperal conditions, 170 were pregnancies at term and 44 were complications of the puerperal state.

TABLE 49.—*Distribution of 823 hospitalized and 665 nonhospitalized applicants for in-patient care at Louisville (Ky.) City Hospital, September 1935–April 1938, according to provisional diagnosis group*

Diagnosis group	All applicants	Hospitalized			Nonhospitalized
		Total	In Louisville City Hospital	In other hospitals	
	Number				
Total	1,488	823	650	173	665
Conditions resulting from accidents	269	205	162	43	64
Puerperal	214	123	106	17	91
Respiratory	168	62	57	5	106
Digestive	144	73	49	24	71
Communicable	134	96	92	4	38
General	108	34	26	8	74
Other and ill-defined	102	52	33	19	50
Nonvenereal, genital	83	30	16	14	53
Circulatory	76	49	40	9	27
Nervous	58	34	30	4	24
Skin and cellular	39	18	9	9	21
Urinary	37	24	16	8	13
Eyes	19	10	7	3	9
Ears—mastoid	15	7	4	3	8
Congenital malformations	11	3	1	2	8
Orthopedic	6	1	0	1	5
Impairments	5	2	2	0	3
	Percent				
Total	100.0	55.3	43.7	11.6	44.7
Conditions resulting from accidents	100.0	76.2	60.2	16.0	23.8
Puerperal	100.0	57.5	49.5	8.0	42.5
Respiratory	100.0	37.0	34.0	3.0	63.0
Digestive	100.0	50.7	34.0	16.7	49.3
Communicable	100.0	71.6	68.6	3.0	28.4
General	100.0	31.5	24.1	7.4	68.5
Other and ill-defined	100.0	51.0	32.4	18.6	49.0
Nonvenereal, genital	100.0	36.1	19.3	16.8	63.9
Circulatory	100.0	64.5	52.7	11.8	35.5
Nervous	100.0	58.6	51.7	6.9	41.4
Skin and cellular	100.0	46.2	23.1	23.1	53.8
Urinary	100.0	64.9	43.3	21.6	35.1
Eyes	100.0	52.6	36.8	15.8	47.4
Ears—mastoid	100.0	46.7	26.7	20.0	53.3
Congenital malformations	100.0	27.3	9.1	18.2	72.7
Orthopedic	100.0	16.7	0	16.7	83.3
Impairments	100.0	40.0	40.0	0	60.0

The data on percentage of all patients hospitalized by diagnosis groups give an indication of the types of conditions for which transient patients are accepted in this hospital. This is shown graphically in figure 6. As in total number of applicants, accidents lead all other diagnosis groups in percentage of hospitalization. However, communicable diseases rank second in percentage of hospitalization as compared to a rank of fifth in total number of cases.

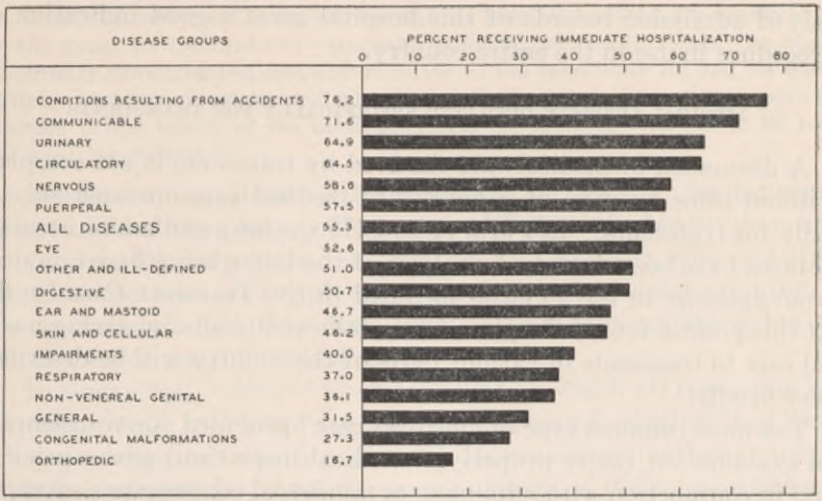

FIGURE 6.—Percentage of nonresident applicants for in-patient care receiving hospitalization, by disease groups, Louisville City Hospital, September 1935–April 1938.

Although it was not possible, from the recorded provisional diagnosis, to separate the cases into emergency and nonemergency categories, some of the diagnosis groups obviously contain a relatively high proportion of emergency conditions, and it is probably for these that hospitalization is secured.

The 1,488 transients included in this study from Louisville City Hospital records are probably not typical of transient applicants for in-patient care at hospitals in all parts of the country in three respects. First, the transient problem in Louisville is relatively small in volume as compared to that in cities of comparable size in the Southwest. Second, whereas the majority of the Louisville transients studied were intrastate, in only two of the Transient Case Study cities did the number of intrastate applicants to medical agencies exceed the number of similar interstate transient applicants, while for the total in 20 cities only 14.3 percent of the applications to medical agencies were made by individuals with legal settlement in the State of application. Third, the Louisville transients had been judged by staff physicians of the hospital to be in need of hospitalization, whereas transients found applying for hospitalization during the Transient Case Study had not at the time of interview been seen by a physician of the hospital staff.

In other respects, however, the two groups are believed to be similar. Each is made up of sick and needy individuals who are the object of certain discriminatory practices set up by communities. While the individuals may differ as noted above, these factors are not involved in the decision as to whether a transient needing hospitalization shall be admitted to any particular hospital, and it is believed that the anal-

ysis of admission records of this hospital gives a good indication of procedure in use in the entire country.

MEDICAL SERVICES OPERATED SPECIFICALLY FOR TRANSIENTS

A discussion of medical care received by transients is not complete without some mention of programs of medical care operated specifically for transients. In Parts II and III the laws and administrative policies have been discussed, analysis of the latter being based on data from agencies in the 20 cities included in the Transient Case Study. At this point a few of the plans being followed in administering medical care to transients in various parts of the country will be described very briefly.

The most common type of "medical care" provided for transients is an examination (more properly, a medical inspection) given prior to and in conjunction with admission to municipal congregate shelters or governmental camps. Such procedures as are found in a number of cities are not in reality medical care but principally an attempt to isolate persons suffering from easily recognizable communicable diseases. If serious conditions are found, the patients are usually sent to a public hospital, if one is available. A description of such facilities furnished by a "Committee on the Health Problem of Transients" in one large city is quoted in full below. It illustrates admirably this type of medical facility.

> Contact with the unattached transient male is established when he applies for relief or shelter. He is sheltered for no more than 24 hours after which he must move on. No money is provided for transportation. The inspection which he receives at the Shelter Clinic is not a complete medical or physical examination, but is sufficient to indicate infectious conditions. A nose and throat examination is included. The Shelter Clinic attempts to protect the community from infectious diseases by discovering and isolating them, but about all it is able to do for the individual himself is to give him such treatment as to prevent his becoming acutely ill while in Cincinnati. Acutely ill transients are sent to the General Hospital. Men who are subacutely ill and who need infirmary care receive bed rest at the Shelter's Infirmary until they are able to travel. Those who need clinic care but not bed rest receive it in the Shelter's Clinic. All treatments are given only for the period necessary during the transient's stay. For example, transients suffering from acute gonorrhea, the most frequent condition requiring medical care, are given one treatment and sent on their way elsewhere. In 1938 the Clinic reported 539 acute gonorrheal infections and 9 chronic cases among transients. Syphilis is treated in the same manner, but at the Health Center, through Federal funds. Tuberculous patients not requiring immediate hospitalization are isolated overnight before moving on. No medical care for transients, with cure or correction as its object, is attempted or can be with present facilities. In addition, it is believed that medical care with cure or correction as a purpose would create an attraction and would increase the problem of transiency, unless facilities were available on a nation-wide basis. Similarly, no immunization is attempted against any diseases.

It may be said that Cincinnati, through its hospital facilities for emergent and acute cases, its treatment of venereal disease at the Health Center, its Shelter Infirmary providing bed rest and isolation to the subacutely ill, and its Shelter Clinic providing overnight medical treatment and advice, is furnishing more protection to the health of the community and the transient than is to be found in most large cities.[13]

Needless to say, these facilities and the service they render cannot be considered complete medical care. While undoubtedly they serve a very useful purpose in the isolation of transients with infectious disease and even in supplying a modicum of medical attention, it is not believed that they were planned to supply anything but the most meager sort of medical care.

In some cities, "clinics" are established to which all transients who request public assistance are sent, regardless of whether they think they need medical attention or not. Here an examination or inspection is conducted for about the same purposes as those connected with the shelter described above. In a few communities a card from such a clinic is a prerequisite to any kind of public assistance.

In a very few States intrastate transients fare better, at least theoretically, as a result of the fact that those States maintain general charity hospitals. Any resident of those States is entitled to complete medical care in his own State when it is proved that he is needy.

The largest organization formed specifically for the purpose of supplying emergency medical care to transients is a Federally supported organization called the Agricultural Workers Health and Medical Association, operating in the Southwest. This is an independent corporation, organized in May 1938, with a Board of Directors consisting of four officials of the Farm Security Administration, and three physicians, one representing the California Relief Administration, another representing the California State Board of Health, and the third representing the California State Medical Association.[14] Since the inception of this program it has been expanded to include beneficiaries of the Farm Security Administration in Arizona. Grants to the corporation are made by the Farm Security Administration.[15] Only emergency medical care is furnished by this Association and then only migratory agricultural workers who have been in California less than 1 year are eligible. During the summer of 1938 the Association handled about 4,000 cases a month through 10 offices at a cost of $20 to $30 per person per year. During 1938 the Association handled approximately 15,000 patients through 18 offices in California and Arizona at an expense of $400,000, or an average

[13] See (28).
[14] See (42).
[15] See (43).

cost of $26.67 per patient per year. About 10 percent of the total was charged to administration.[16]

The method of handling cases is as follows: Any eligible person desiring medical care applies to the nearest Association office. He is then referred to any physician he may select from a panel of local doctors. The physicians submit their bills directly to the Association, which audits them to make sure the charges are reasonable.[17] This organization is supplying a service vitally needed by migratory agricultural workers and has done much to relieve the deplorable conditions existing among these people because of lack of medical care.

One large clinic is operated by the Federal Government. Any indigent citizen of the United States with infectious venereal disease, regardless of residence status, is entitled to treatment for the condition at the Venereal Disease Medical Center, Hot Springs National Park, Ark., which is operated by the United States Public Health Service in cooperation with the National Park Service. The Medical Center is divided into two parts, an out-patient clinic and an infirmary operated for patients who are totally indigent. The out-patient clinic was organized in 1921. The infirmary was turned over to the Public Health Service in 1937, having formerly been a camp of the Transient Division of the Federal Emergency Relief Administration.

During the fiscal year 1938, 6,486 indigent persons were treated at the Center.[18] Applicants came from every State except New Hampshire and Vermont and received 108,337 treatments. During the year 2,231 indigent persons were afforded infirmary care at the Medical Center. Nine hundred and five persons were given hospitalization for certain complications of venereal disease or for serious reactions from treatment. Twenty-two infants were delivered from syphilitic mothers. Only one infant, whose mother registered at the Center 2 weeks before the child was born, showed evidence of prenatal syphilis.

The majority of medical services operated specifically for transients meet, in some measure, at least the emergency medical needs of this group of persons. The most unfortunate aspect of this form of public assistance, other than its frequent inadequacy, is that the service is supplied to "indigents with venereal disease," "migratory agricultural workers," "transients," "nonresidents," or to some other special group of beneficiaries. Programs with such restrictions cannot be expected to erase the differentials between the adequacy of service received by residents and transients, and they may actually furnish the incentive for misrepresentation of resident status.

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[16] See (*54*).
[17] See (*43*).
[18] For a detailed report see (*116*).

PART V

INFLUENCE OF TRANSIENTS ON COMMUNITY HEALTH

Transients influence community health significantly only when they exhibit characteristics of disease different from those of the general population. Some of the more important causes of differentiation between groups of individuals in the matter of illness incidence are: Previous experience with communicable disease, economic status, occupation, diet, and the hygienic conditions under which they live.

SANITATION AND HOUSING

Hygiene, or sanitation, and housing are so pertinent to a consideration of the influence of transients on community health that they will be discussed in some detail. It is with respect to these factors that there is the greatest difference, in many areas, between transients and residents of the communities in which the transients are found.

Transients are not a homogeneous group with respect to the sanitary conditions under which they live. Living conditions of individual transients may vary within the widest limits. For example, transients are found living in well-ordered homes in large cities with all the protections of a safe water, milk, and food supply, and with the most scientific methods of sewage and garbage disposal available and compulsory. Under such conditions, transients will probably exhibit the same characteristics of disease, as they are determined by hygiene, that are found among residents of the same cities exposed to the same environment.

However, the preponderant majority of transients are not found living under such conditions. From this high standard, homes (or, perhaps more accurately, temporary abodes) of transients range downward in the scale of sanitation to the flophouse and jungle level for the unattached and the squatter camp or temporary migratory labor camp level for families. It is in shelters, jungles, and migratory labor camps that the worst sanitary conditions of transient life are epitomized; thus this discussion will be concerned with their effect on the incidence and spread of disease.

No other phase of the transient problem has been so thoroughly investigated or so frequently discussed as this one. As early as 1912 attention was focused on the problem of sanitation in labor camps in California. At that time about half the migratory agri-

cultural workers in that State were immigrants and for this reason the Commission of Immigration and Housing was originated in 1913 for the purpose of ascertaining the condition, welfare, and opportunities of all immigrants making their homes within the State. After it was found that fully half the employees residing in labor camps were aliens, the duty of improving conditions and maintaining set standards in these camps, through the medium of the Labor Camp Sanitation Act, developed upon the Commission.[1]

Since the formation of this Commission, it has made annual reports of the conditions found in inspected work camps throughout the State and has advised and consulted with various interested groups. The 1930–32 report states that 3,941 labor camps were inspected in 56 counties of the State, housing a total of 145,474 persons. It is pertinent to this discussion to note that the report stated that because of general economic conditions little in the way of permanent improvement could be sought in labor camp betterment. This was thought particularly true in dealing with agricultural camps. Of the camps inspected, 536 are classified as "good," 432 as "bad," and 1,036 as "fair."[2]

A great number of surveys and studies of transients and migratory labor have recognized the bad hygienic conditions of the camps throughout the country, and a multitude of articles on the subject have appeared in official publications and the lay press. Even the picture weeklies have given attention to this phase of American life.[3] Out of this variety of data and description a few have been chosen to illustrate some of the worst conditions under which transients live.

The State Relief Administration of California, speaking in 1935 of unattached transients prior to the Federal Transient Bureau program, considered that conditions in general were wretched. Flophouses were overcrowded, food was poor, and sanitary facilities for the use of these people were inadequate. Transients and local homeless were all treated alike in the shelters, men and boys were mingled, and there was no separation of the diseased from the healthy. Those not accommodated in the shelters often found a night's lodging in the city jails or a longer residence in the shanty towns and jungles that sprang up on the outskirts of the cities. These conditions were considered ameliorated during the Federal program, but after it was discontinued in September 1935, jungles and shanty towns were once more in evidence. Health problems were thought to have been persistent among transients largely because of exposure and insanitary living conditions during migration.

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[1] See (*31*).
[2] See (*31*).
[3] E. g., see *Life* magazine, November 29, 1937.

FIGURE 7.—Home of a transient family.

FIGURE 8.—A transient camp in the Southwest.

FIGURE 9.—The drinking water supply for 40 transient families.

FIGURE 10.—A poorly protected public water supply in a transient camp.

This report also states that of 6,392 cases of communicable disease found among transient unattached males in California between February and August 1935, 80.5 percent were venereal diseases, 4.5 percent were pediculosis, 3.8 percent were scabies, and 2.8 percent were tuberculosis. These conditions were found in a transient population that varied during the period from 25,000 to 17,000.[4]

Dr. Anita Faverman of the California State Department of Public Health made a study of the health of 1,000 children of migratory agricultural workers in 1936–1937. She notes that "crowding, and in many cases, lack of adequate sanitary facilities are notable." Where housing is not provided "the workers live at nearby auto camps or 'squat' along ditch banks by the roadside. These * * * obviously constitute a health menace to the entire community."[5]

The report of the National Labor Board in 1934, speaking of Imperial Valley (Calif.), stated: "We found filth, squalor, an entire lack of sanitation, and a crowding of human beings into totally inadequate tents or crude structures built of boards, weeds, and anything that was found at hand to give a pitiful semblance of a home at its worst. Words cannot describe some of the conditions we saw."[6]

In the migratory history of one California family, given in a report on migratory labor by the State Relief Administration of California, it is stated that "The Hillis clan found available sanitary facilities consistently bad. This was true both when they camped and when they lived in a nearby town. Camping, however, was much worse. The water was frequently poor, even when they were living on the property of growers. When camping on the bank of a river or irrigation ditch the water was often polluted. Privies were badly constructed and devoid of proper safeguards."[7]

In the same report the State Relief Administration states: "One of the worst features of the migratory labor situation has been the housing of the laborer * * *. Only a fraction of the growers provide housing to migratories. The standards of the agricultural labor camps have declined steeply in the last years * * *. When the Marysville [Resettlement] Camp was started in August 1935, nearly 900 persons were camped on the site. Sanitary facilities were lacking. Some families had no shelter of any sort. One family consisting of husband, wife, and a 3-year-old child possessed neither shelter nor bedding and slept on newspapers spread upon the ground."[8]

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[4] See (*107*) for the full report.
[5] See (*46*), pp. 35–36.
[6] See (*105*), p. 62.
[7] See (*106*), p. 197.
[8] Op. cit., p. 207.

A study of transients in California by the State Relief Administration describes in even more detail the conditions under which transients live. The following excerpts from the report illustrate the lack of satisfactory hygiene prevalent in camps: "* * * in Watsonville, 500 men were living in the jungles or passing through * * *; 1,000 men sleeping out near Sacramento and 800 near Stockton; * * * a toilet had been constructed by thrusting four tree branches in the ground and lapping burlap around; during irrigation periods water could be secured from the pump 500 feet away but for the rest of the time it was necessary to haul it * * * from a pump 2 miles away; a family of 5 in a tent 9 feet wide by 15 feet long; many of the [railway] cars were left in such filthy condition by the men who had lived in them for several days without any sanitary facilities that it was almost impossible to clean them decently again; health officials * * * refused to allow 20 cars to be loaded with oranges until properly cleaned and disinfected; health officials in Chicago have dumped carloads of oranges into the lake * * * because transients had made the cars filthy, according to Santa Fe [R. R.] officials." [9]

The State Department of Public Health of California says, "There are * * * large numbers of squatter and trailer camps, the housing facilities of which are deplorable and whose sanitary conditions are not conducive to health." This official health agency, speaking of "hygienic habits" (of transients), says further: "Gross ignorance of personal hygiene is found among individuals in the migratory group. On the larger ranches new houses, with water-flush toilets, painted walls and floors, adequate light and ventilation, have been provided. Within a week after occupancy these places will be dilapidated * * * garbage thrown in the toilet causing stoppage, screen doors on the outhouses torn off, shower baths used as toilets and, very often, sanitary equipment will not be used at all." [10]

Nor have the local health departments been silent on this subject. Dr. Lee A. Stone, Director, Madera County (Calif.) Health Department, tells of "the Dozier clan * * * all 42 of them were discovered in a two-room cabin living under almost unbelievable conditions." Dr. Stone goes on to discuss excellent camps that had been provided for migratory labor in his county: "Recently I made a trip of inspection into this (formerly excellent) camp * * *. I found the cabins in an unbelievable condition; partitions had been torn out and used for firewood, filth of all kinds, including human excreta, was found on the floors * * *. Public health officials

[9] See (*108*), pp. 235 ff.
[10] See (*32*), p. 126.

and welfare workers are doing all in their power to point out to these people the advantages of sanitation, cleanliness, and disease-control measures, but to no apparent avail * * *. Public health problems are presenting themselves to a degree that is appalling * * *. Malaria, pellagra, conditions simulating scurvy, trachoma, and others too numerous to mention, are offering themselves for attention." [11]

Dr. Joe Smith, Health Officer of Kern County (Calif.), has given considerable attention to this problem. His department has made special investigations of the labor camp situation in Kern County and estimates that "for * * * 2,000 agricultural workers and their families (in Kern County) no housing facilities and no safe sanitary camp site * * * exists." [12] The Sanitary Division's survey of the problem in Kern County not only describes conditions but makes recommendations as to location, type, and number of camps needed.[13]

Another excellent study of conditions under which transients or migratory laborers live is that of the Department of Labor published in 1938. Two field workers describe conditions found on an extensive trip throughout the Southwest. A few pertinent sentences from the report follow: "During this study, family groups, including many children, were observed camping out along the roadside or perhaps just off the road along an irrigation ditch * * *. As a rule sanitation facilities and drinking water are not easily accessible in these mesa camp sites * * *. Low standards of housing and sanitation prevailed, on the whole, in the class of tourist camps being used by migrant families." [14] The report not only describes general conditions but specifically mentions many individual camps as completely unhygienic.

Studies have not been confined to California. At least four studies of child labor have been made by the United States Children's Bureau in areas outside California, i. e., in Texas,[15] Maryland,[16] Colorado, and Michigan,[17] and the northern Pacific coast.[18] In each of these studies the unhygienic conditions of labor camps are described.

A study of conditions in the hop industry by the Agricultural Experiment Station, State College of Washington, in 1938, says: "The conditions under which the transient workers lived in hop camps

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[11] See (*109*), pp. 3, 7, 8, 18.
[12] See (*71*), p. 37.
[13] See (*5*).
[14] See (*74*), p. 136.
[15] See (*24*).
[16] See (*21*).
[17] See (*23*).
[18] See (*22*).

on the average were unsanitary and inadequate for health and decency standards." [19]

One of the most recent studies is that made by the Work Projects Administration of the migratory cotton pickers in Arizona. In speaking of living conditions the report states: "Arizona cotton pickers' camps conform to the 'rural-slum' pattern of western migratory workers' camps * * *. The usual run consists of a crowded, filthy, makeshift collection of shelters. Although some of the camps house as many as 1,000 people during the picking season, even elementary sanitation provisions are frequently lacking." [20]

Speaking of these same cotton camps in March 1938, the Arizona State Board of Health says: "Their [labor contractors'] camps are of a temporary nature with no provision for proper water supply or sewage disposal and to operate under such conditions should be prohibited by law in the interest of public health and common humanity." [21]

It is not intended to imply in the present study that nothing is being done to better the sanitary facilities of these camps and the condition of the individuals living in them. Where organized full-time local health departments exist and the problems of migratory labor have been acute, considerable improvement has been made in the type of camp furnished by the growers and a great deal of effort directed toward preventive health measures and health education of these transients. In several of the reports quoted, more particularly those from health agencies, the measures intended to eradicate such conditions are cited.

Dr. Walter M. Dickie, Director, California State Department of Public Health, says: "Acting together, local, State, and Federal authorities have surmounted legal, financial, and other obstacles and today, regardless of citizenship, legal residence, race, or color, adequate provision is made for safeguarding the health of migrants and for providing health protection for local residents * * *. The California State Department of Public Health recognized this fact (the public health problem of unhygienic conditions in migratory labor camps) and local health officers became particularly aware of it, as did also growers of cotton, fruits, and vegetables. A sincere attempt to provide suitable housing for these refugees was made by large numbers of landowners but their efforts were applicable to relatively few, because of the magnitude of the migration." [22]

The Arizona State Board of Health has much the same to say: "As the conditions described (bad housing and sanitation in cotton

[19] See (*122*), p. 18.
[20] See (*11*), p. 24.
[21] See (*2*), p. 2.
[22] See (*34*), p. 764.

camps) have developed with the industry and the seasonal influx of itinerant labor, health workers have been constantly on the alert to provide adequate preventive measures and sanitary environment for the occupants of the labor camps. The larger camps * * * have been very cooperative with these efforts—with the result that better water supply, sewage disposal, and refuse collection methods have been introduced. In the 55 camps mentioned, 365 sanitary toilets have been installed. All water supplies have been examined for possible sources of pollution, and corrections made where indicated. Sanitary inspections have been made in every camp once monthly * * *." [23]

The most direct approach to the problem of housing migratory agricultural workers is that of the Farm Security Administration. This Federal agency has attacked the problem by the construction of camps at strategic points throughout the West, so that migratory agricultural families may have decent camps with sanitary facilities at nominal cost. The camps established are at points where there have been the greatest concentration of people and the greatest need for such facilities.

Each camp provides a number of tent platforms arranged usually 30 feet apart and often in groups of 40 about a community facility building. Sanitary flush toilets are provided. Imhoff tanks for the treatment of sewage have been placed in nearly all camps. Garbage is collected and burned in camp incinerators. Pure water usually from wells is supplied in every camp. Shower baths and laundry tubs with plenty of hot water are located in the community facilities buildings.

Eleven of these camps with about 2,000 tent platforms are in operation in California and three additional camps in California and one in Arizona are under construction (April 1939). Because of the need and demand, 11 additional camps in 6 other States are now proposed. One mobile camp, in which the sanitary facilities and tent platforms may be moved by truck as the workers migrate from one crop to another, is now being constructed for trial.

These camps undoubtedly have been and are a great improvement and have aided considerably in the betterment of the living conditions of the migratory families whom they serve. A brief summary of the program given in the annual report on activities of the Farm Security Administration for the fiscal year 1937–38 states:

> The increasing mechanization of farm production is changing many former tenants into migrant farm laborers. The problems of this group * * * have not as yet found a satisfactory answer. On the Pacific coast * * * the camps of the Farm Security Administration have continued in operation. They furnish temporary residence and sanitary facilities to the migrants.

[23] See (2), p. 1 ff.

The camps, however, can by no means be termed a complete solution for the problems of this group of landless farmers. Some of the health aspects of the problem have been made less threatening; but little permanent security can be attained by migrant families through the camp program. Rehabilitation and security for these and other stranded groups are yet to be approached on a basis leading toward a permanent solution.[24]

Despite the excellence of the camps, only a fraction of the families following this type of existence are housed in them. The Farm Security Administration estimates that there are 50,000 to 75,000 families following the crops along the Pacific coast. The number afforded the opportunity to live under the sanitary conditions supplied by the Farm Security Administration is not great enough to effect a change in the mass health status of migratory workers.

DIET AND MALNUTRITION

Although dietary deficiencies and malnutrition in transients probably do not have a great deal of direct effect on the health of residents, the subject deserves some attention for its effects on the health of transients themselves. Any residue of ill health in transients must eventually be reflected in the health status of the whole community.

No detailed study of the diets of transients in terms of vitamins, calcium, iron, protein, or total calories has been made. In one study of the health of migratory agricultural workers which recorded the average milk consumption of 1,000 children, it was found that "18.6 percent (of the children) were getting one and one-half to two pints of milk daily. Thirty percent were getting a pint or less; 34.8 percent got less than half a pint; 4.1 percent got milk occasionally or irregularly; and 12.4 percent got no milk." [25]

Among reasons given for low milk consumption, the most common were that the family could not afford to buy fresh milk and that it was not available. An interesting comment by the manager of a migratory agricultural workers' camp in California, quoted in the study referred to above, was that "18 cases of soda pop were consumed a day by the 100 inhabitants of the camp * * * this in spite of the fact that milk was also available here." [26]

Aside from milk, the diet of transients who are also migratory agricultural workers is, as one would expect, the diet of the rural population of the areas from which they have migrated, worsened by the financial distress in which the families find themselves. Such diets often fall far short of minimum requirements as to calories, vitamin or mineral content, and digestibility. The entire solution

[24] See (*41*), p. 13.
[25] See (*46*), p. 30.
[26] Op. cit., p. 35.

FIGURE 11.—Migrant camp operated by Farm Security Administration, Kern County, Calif.

FIGURE 12.—In a Farm Security Administration migrant camp.

probably does not lie in raising the economic status of the transients. Reeducation to more varied and more adequate diets would also be necessary.

The record of disabling illnesses of a group of individuals is an inadequate measure of the diseases and conditions due to diet deficiencies, in that it misses not only such recognizable states of ill health as rickets, scurvy, and pellagra, unless they are disabling, but also those subclinical or "subrecognizable" states due to diet deficiency. Despite this and despite the fact that the disabling illnesses from dietary deficiency are usually only a small fraction of the conditions of ill health due to this cause, the Transient Case Study found 6 transients who had been disabled during the 3-month survey period by pellagra.

Two studies have been made of the nutritional status of the children of migratory agricultural workers. The study mentioned in connection with diets found that 27.9 percent of all the children had nutritional and dietary defects. This did not include dental caries and decalcification. Dietary defects found in the group of 1,002 children numbered 117 and nutritional defects 167, the latter classified as: Malnutrition, 62; overweight, 4; rickets, 24; underweight, 25; and flabby turgor, 52.[27]

In another study of the children of migratory agricultural workers in cotton camps it was found that "14 percent (of the interstate transient children) had rickets and 13 percent * * * had malnutrition." Of the 43 "nutrition defects" recorded for 122 interstate transient children, 2 were "old rickets, severe," 15 were "rickets," 2 were "malnutrition, severe," 14 "malnutrition," and 10 "underweight."[28] These two studies, particularly the former, have been widely quoted. It is this study that has given rise to statements such as: "One-fourth (or 27 percent) of the children of transients (or of migratory workers) suffer from malnutrition."

It is doubted whether or not much reliance can be placed on the percentage of children classified as "malnourished" in routine physical examination without the use of tests for specific nutritional deficiencies. It has been shown by a number of studies[29] that in such examinations physicians vary within wide limits in their judgment of the nutritional status of children. One study concluded that "The differences in judgments are so great that estimates based on a single examination are of little value in determining the amount of malnutrition among any group of children at any one time * * *. Neither

[27] See (*46*), data from table IX.
[28] See (*115*), p. 10 ff.
[29] E. g. (*48*), (*33*).

are these nutritional estimates reliable bases for determining which children of a group are malnourished." [30]

However, the facts thus brought out and the resultant doubts cast on any estimate of the *percentage* of transient children who are malnourished have no bearing on the known fact that many transient children do have deficiencies in quality and quantity of diet and that such deficiencies will result in retarded growth, malformation of parts of the body, or even frank, clinical cases of deficiency diseases. Whether a higher rate of malnutrition is found among transient or resident children of similar economic status cannot be determined and is relatively unimportant.

Other causes which may be fairly important in differentiating transients from residents on the basis of disease incidence are health selection for migration, the hazards of travel, and low economic status. They will be discussed in connection with particular diseases later in this report. The discussion thus far has had to do with the causes for differentiation of transients and residents in their exhibition of disease. The remainder of this part will consider the effects on community health brought about by mingling populations with dissimilar health characteristics.

EFFECT OF TRANSIENTS ON EXISTING COMMUNICABLE DISEASE

The propagation of an existing communicable disease depends on several interrelated factors. These factors, any or all of which may be so altered as to increase or decrease the morbidity from a particular existing communicable disease, are: (1) The susceptibility of the population; (2) the virulence of the causative organism; (3) the rate of transfer of infection per case; (4) the incidence of infectious disease; and (5) the period of infectiousness per case.

The influence that a change in any one of these factors may have on the propagation of a particular disease in a community depends both on the nature of the disease and on the other factors, since they are interrelated. The result on the incidence of any single communicable disease depends entirely on the causative agent of that disease, its modes of transmission, and the susceptibility of the potential victims, so that in a discussion of this sort it is imperative that the various diseases be discussed individually or by specific groups. Since it is not within the scope of this study to discuss in detail the epidemiology of all communicable diseases as they are influenced by the presence of transients in a community, data on the incidence of existing communicable disease in transients and its influence on the general incidence will be presented for only a few diseases.

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[30] See (*33*), p. 6.

FIGURE 13.—The child of a transient.

Tuberculosis.[31]—It is believed that the factor of susceptibility of the population may be disregarded in the discussion of tuberculosis, since there is no reason to assume that transients affect this factor. The influence of racial susceptibility may also be disregarded since in none of the survey cities had the addition of transients materially changed the racial composition of the total population. It will also be assumed that the virulence of tubercle bacilli carried by tuberculous transients does not differ from that found in the resident population.

Whether tubercle bacilli are transferred more rapidly or less rapidly from a transient with infectious tuberculosis to other persons than from a similar resident case cannot be answered. Proof for either contention would require types of data such as are not available; and, still more important, there would need to be some general agreement as to the role these matters play in the propagation of tuberculosis.

In order to measure the effect of a disparity between the incidence rate of infectious tuberculosis among transients and that among residents, it is imperative that the rates for the two groups, respectively, be known within reasonable limits of accuracy. Further, the rates should be based not on the total number of infectious cases per unit of population but rather on the number of infectious cases outside of institutions for the tuberculous. It would not be justifiable to measure the probability of contact with an infectious case of tuberculosis in a community containing a large tuberculosis sanatorium by including as infectious cases those in the sanatorium.

The incidence rate of infectious tuberculosis outside institutions could probably be computed for States that have a reasonably effective tuberculosis control program. The consensus of estimates of the incidence of active tuberculosis in the general population of such States is 1.0 to 1.5 percent. By eliminating from the calculation institutionalized cases of active tuberculosis and making the necessary adjustment for the proportion of active cases that are infectious, a fairly satisfactory rate could be established.

But, unfortunately, it is in States in which such data are not available that there appears to be a problem of tuberculosis control arising from transients. All evidence seems to indicate that Arizona, Colorado, and New Mexico are the States in which is found the unhappy combination of a relatively sparse population and a comparatively large number of transients, some of whom have migrated to those States because of tuberculosis or other respiratory conditions.[32] How-

[31] "Tuberculosis" is used throughout to mean "pulmonary tuberculosis," unless otherwise stated.

[32] See (*75*), (*110*), (*129*), and (*130*).

ever, the knowledge of the incidence of tuberculosis even among residents of these States is not satisfactory. In a survey of health in New Mexico in 1933, Buck,[33] using the best available data, estimated that there were 10,000 to 22,000 cases of definite or suspicious tuberculosis among adults in the State. Such an estimate in a State with a relatively small population does not permit computation of a rate of tuberculosis sufficiently exact for useful comparison in this study. Dunshee, speaking only of Arizona, described what is believed to be the situation in the southwestern resort States.[34] He said, "Without a careful study it is impossible from the usually accepted figures to estimate the number of new or living cases (of pulmonary tuberculosis) as there are 1,428 beds for the care of tuberculosis cases in the State (Arizona) many of which are undoubtedly filled with patients not having contact relatives in the State." [35]

Despite lack of definite data on the amount of tuberculosis among either residents or the total population of the resort States, the value of available data on the amount of tuberculosis among transients in the same area is not lost. It has already been pointed out in this discussion that the five factors on which the propagation of existing communicable disease depends are interrelated. It is through this interdependence with the factor next to be discussed that the incidence of tuberculosis among transients becomes useful.

The presence in a community of a considerable number of tuberculous transients probably increases the prevalence of the disease because tuberculous transients have a longer period of infectiousness per case than similar residents do. By this, it is not meant that tuberculous transients become sputum positive earlier or remain sputum positive longer without treatment. The statement is based on community practice in admitting cases of tuberculosis to hospitals or sanatoria.

Institutionalization of the tuberculous accomplishes a dual purpose. The open case is isolated from the nontuberculous population and the tuberculosis case fatality rate is decreased by giving to the isolated cases a specialized and adequate type of medical and nursing care. Both objectives are desirable from the public health viewpoint, but there can be little doubt that isolation of open cases is the more important in reducing morbidity and mortality. In summarizing activities designed to continue the present downward trend of tuberculosis, Frost cited as most important "the isolation in sanatoria of all known open cases of pulmonary tuberculosis, continuing isolation so long as the cases remain open." [36] However, admission policies of practically

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[33] See (*15*).

[34] "Resort States" will be used throughout to designate Arizona, Colorado, and New Mexico.

[35] See (*39*), p. 39.

[36] See (*49*).

all tuberculosis institutions are such as partially to defeat this important purpose.

TABLE 50.—*Distribution of tuberculosis hospitals in the United States with known admission policies and with free beds for the general population, according to use of restrictions for admission* [1]

Restriction by financial status	All hospitals	Restriction by residence					
		Restricted to residents of specified political unit			Not restricted to residents		
		Total	City or county	State	Total	25–49 beds	50–149 beds
Total	[2] 203	193	153	40	10	3	7
Only indigents admitted	121	113	88	25	8	2	6
All persons admitted	82	80	65	15	2	1	1

[1] Data from National Tuberculosis Association, Tuberculosis Hospital and Sanatorium Directory, 1938. Only hospitals and sanatoria registered by the American Medical Association are included.
[2] Hospitals controlled by Federal, fraternal, and proprietary agencies are omitted.

Table 50 classifies tuberculosis institutions registered with the American Medical Association [37] to show those into which transients might be admitted for isolation. It will be noted that there are in the United States 203 tuberculosis hospitals and sanatoria of known admission policy, each of which has one or more beds. However, all but 10 of these are restricted to residents of the State or locality in or near which they are located. Since the distinguishing characteristic of transients is nonresidence, it appears that these 10 hospitals theoretically are the only ones that will admit transients to free beds—within the limits of availability of empty beds. The maximum number of beds, for which transients must still compete with residents, is only 1,190. Bearing in mind that the majority of public tuberculosis hospitals have a long waiting list of residents, it is obvious that transients are seldom admitted to such institutions.

There are undoubtedly many other hospitals to which patients are admitted at no cost to themselves. But in practically all such cases limitation to specified types of beneficiaries or limitations imposed by appropriating bodies exclude transients as such. It is true that transients with tuberculosis are known to die in general hospitals. But it is believed that very few tuberculous transients occupy beds in general hospitals long enough to affect materially their chances of recovery or their period of contact with the general public.

Both objectives of hospitalization of the tuberculous (and the admission policy which tends to defeat one of them) are stated in the law relating to public assistance to the tuberculous in one of the western States. It reads:

Objects and purposes of the act.—The People * * * hereby declare that tuberculosis is a communicable disease, that it endangers the lives

[37] See (87).

of the entire population of the State and that the treatment and control thereof is the responsibility of the States; and to the end that said disease may be better brought under control, it is further hereby declared that it is the duty of the State to provide treatment and care for indigent residents suffering from said disease. (Colorado Session Laws, 1937, ch. 216.)

The law cited defines "resident" as a person who has actually resided in the State for 3 or more years at the time of application, although for other types of public assistance only 1 year's residence is required.

Thus this State, in common with most political jurisdictions that use public funds to support hospital beds for the tuberculous, declares ineligible for isolation one class of persons dangerous to the health of the general population. In such jurisdictions it is apparent that the period during which each case could infect and reinfect the nontuberculous is consequently prolonged. The result must influence unfavorably general morbidity and mortality from tuberculosis in those areas.

In this connection it might well be noted again that a "transient" may not necessarily be merely a sojourner in the community. In several States failure to maintain a domicile continuously in the State for as long as 5 years makes an unattached person, or a family head, a "nonresident," and in the case of the family head, all his dependents, including children born in the State, are similarly affected. The point should also be emphasized that an individual need not be obviously indigent to require public assistance in hospitalization for tuberculosis. The Interdepartmental Committee to Coordinate Health and Welfare has estimated that "there are in the United States today probably 40 million persons * * * living in families with annual incomes of less than $800." [38] It is known that the average annual cost per patient in private tuberculosis institutions is approximately $1,000.[39] If approximately one-third of our population live in families whose income is less than the cost of maintaining one person in a private tuberculosis institution, the group of families that would require public assistance, if it became necessary to hospitalize a tuberculous member, reaches well into the income bracket for the middle third of the population.

It must be kept in mind that the importance of any difference in period of infectiousness per case between transient and resident applies only when the community in which both are found has an effective program of isolation of resident cases. In communities with no such program a transient with tuberculosis cannot, with justice, be said to constitute a menace to the health of the community on the basis of his greater period of infectiousness.

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[38] See (62), p. 42.
[39] See (68).

Since the cumulative influence of this factor depends directly on the number of tuberculous transients, available data are presented on the size of the tuberculosis problem in transients. The data are all concerned with the incidence of active tuberculosis, and since there is no reason to assume that tuberculous transients have an unusual rate of infectiousness, it is believed that information on activity is sufficiently precise for this purpose.

In 1921 a study of the indigent migratory consumptive problem in 6 cities of the Southwest was made by Whitney.[40] Questionnaires were sent to all social and medical agencies in the 6 cities and data compiled from those returned. The information requested was on indigent migratory consumptives cared for during the year 1920. An "indigent" tuberculous person was defined as one who did not finance himself completely during the period of his care. The "care" was not necessarily medical since data were compiled from all types of public and semipublic agencies, including many that probably did not dispense medical care. Duplication of persons was eliminated within each city; hence the data presented in the report represented the number of individuals and not the number of successful applications. In the published reports persons reporting that they had lived in the city less than 2 years were treated separately as "migratory." Table 51 summarizes certain data from a report of this study.

TABLE 51.—*Distribution of total indigent consumptives, and of number that were nonresidents, cared for during 1920 by public assistance agencies in 6 cities, according to city in which agency was located* [1]

City	Number of indigent consumptives cared for	Nonresidents in the group		Population 1920 (in thousands)	Number of persons in whole resident population to each nonresident tuberculosis case
		Number	Percent of total		
Colorado Springs, Colo	385	[2] 281	73	30	107
Denver, Colo	1,635	1,112	68	256	230
El Paso, Tex	1,086	510	47	78	153
Phoenix, Ariz	499	414	83	29	70
Los Angeles, Calif	3,103	1,986	64	577	290
San Antonio, Tex	611	220	36	161	732

[1] Data from (*129*).
[2] Estimated. Only those with less than 1 year's residence in Colorado Springs are reported in data on length of residence.

There are two points of especial interest in the table. First, there was a high proportion of nonresidents, if one accepts the residence definition used, among all indigent consumptives cared for during this period. The second point is the small resident population in relation to one indigent nonresident tuberculous person. The proper care of tuberculous patients is expensive, and it may be doubted

[40] See (*129*) and (*130*).

whether the residents of these cities, even if they were willing, could easily bear the cost of complete medical care, including institutionalization, for the large number of nonresident indigent tuberculous. It has been stated frequently that the complete care even of resident cases of tuberculosis in these cities would be a considerable financial burden, especially since, as the report emphasizes, the tuberculous person is not the only one requiring assistance.

Among nonresidents many patients' families accompany them, and the other members, even if not frankly tuberculous, often require material aid and preventive medical services during the period of the patient's cure. There is little wonder therefore that considerable public funds and efforts are expended in attempting to return such patients to their place of legal settlement.

In 1936 the Maricopa County (Ariz.) Welfare Board analyzed data on transient family cases that applied and were accepted for relief during the year 1935 in Phoenix. This study showed that of a total of 686 such cases, 101 families, or 14.7 percent, gave as their reason for coming to Phoenix the fact that at least one member of the family had tuberculosis. Assuming one case per family and the same size of family (3.7 persons) in the nontuberculous as in the tuberculous, the minimal incidence of tuberculosis among family transients was 4.0 percent.[41]

In the same study it is stated that "from February 1, 1935, to October 1, 1935, 6,031 unattached male transients registered at the Phoenix Camp. Of this number * * * 81 were diagnosed as having tuberculosis,"[41] an incidence rate of 1.34 percent.

It is believed that the results of this study have been misinterpreted by many persons. The statement that *14.7 percent of these families gave tuberculosis as their reason for coming to Arizona*, while undoubtedly true, does not justify an assumption that 14.7 percent of all persons in the families had tuberculosis, although such an assumption has seemingly been made by some who have written on the problem. There were probably only a few of the 101 families with more than one case of tuberculosis each. If a true rate were derived, these few would more than likely be offset by persons counted as tuberculous, but having only related pulmonary conditions. Therefore, the computed incidence rate of 4.0 percent is near the true rate for all members of the families.

The results of this study have also been used as an indication of the incidence of tuberculosis in all family transients in Phoenix at that time. There is no evidence that this is the case. The study was of "transient family cases that applied and *were accepted for relief*" [italics supplied] by the County Welfare Board, and of "unattached

[41] See (82).

male transients (*registered*) at the Phoenix [Transient] Camp." County welfare departments almost universally (that of Maricopa County, Ariz., is no exception) are public, social, case-work agencies. In such an agency, before a case is "accepted for relief," the need of the particular case is thoroughly established by a social worker. It is to be expected therefore that the incidence of need and, further, of disease would be higher in the accepted cases or those under care than in those who applied and were not accepted for relief. In fact, the welfare departments of Arizona are prohibited by law from giving care to nonresidents except in emergency cases. That persons with conditions classified as "emergencies" are most needy, requires no proof. It was, then, in a group of selected cases that a tuberculosis rate of 4.0 percent was found. The sample was in no sense a random sample of the family transient population.

The unattached transients discussed in the same study were "registered" at a transient camp. It is well known that the only requisites to such registration were application and a statement that the transient had not resided in that particular State for as long as 1 year. Need was not determined before registration. In this group the incidence of tuberculosis was found to be 1.34 percent. It is believed that the unattached transients registered at the Phoenix Camp were probably a fairly satisfactory sample of the entire unattached transient population registered at transient camps in Arizona during that time and the data are of value in estimating the amount of tuberculosis in that group.

Another indication of the size of the tuberculosis problem among transients in the resort States during 1935–36, as they were represented in Tucson, Ariz., is found in the record of transient cases handled by the Pima County Welfare Board in the period from November 1935 to February 1936.[42] A summary of these cases is given in table 52.

In studying this table it must be kept in mind that all these cases were "handled" by the Pima County Welfare Board and, like the cases "accepted" by the Maricopa County Board, they were cases under care in which a comparatively high incidence of disability is expected. Consequently, they do not constitute a true sample of the transient population.

Two-thirds of all transients handled by this agency during the 4-month period gave "health" as the reason for coming to Arizona. This cannot be interpreted to mean that the health of each individual transient was such that he thought a move to Arizona was justified. These data included many who were, at the time of their contact with the Welfare Board, members of families in which only one

[42] See (*91*).

person was actually ill of a condition that caused the migration. While in the broadest sense all members of those families did come to Arizona because of health, the ill health was usually in only one person per family. The purpose of migration of the other members of the family is best described as "to accompany an ill relative."

TABLE 52.—*Distribution of interstate transients handled by the Pima County (Ariz.) Welfare Board, November 1935–February 1936, classified as to reason for coming to Arizona and as to major disability found, according to family attachment* [1]

Family attachment	Reason for coming to Arizona			Found with major disabilities on examination		
	Total	Health	Other	Total	Tuberculosis	Other
	Number					
Total persons	254	172	82	100	55	45
Unattached transients	65	46	19	58	31	27
Family transients	189	126	63	42	[2]24	18
Total family cases	41	28	13	38	24	14
	Percent					
Total persons	100.0	67.7	32.3	39.4	21.7	17.7
Unattached transients	100.0	70.8	29.2	89.2	47.7	41.5
Family transients	100.0	66.7	33.3	22.2	12.7	9.5
Total family cases	100.0	68.3	31.7	92.7	58.5	34.2

[1] Data from (*91*).
[2] Minimal number, based on one case per family, as indicated by "Summary" accompanying data.

The importance of these data lies in the fact that they show that during a 4-month period a minimum of 55 emergency cases of tuberculosis in transients applied for assistance to the County Welfare Board in Tucson, a city of approximately 30,000 population, and that these 55 tuberculous persons brought with them to Tucson approximately 85 other indigent persons—members of their immediate families.

C. Edgar Goyette, Director, has furnished an analysis of the transient family case load of the Pima County Welfare Board for a 30-month period, March 1936 to August 1938, showing that, of 1,189 transient family cases given emergency assistance, 509 (42.8 percent) were families having at least one case of tuberculosis. During 1937, the only year for which complete data are available, 190 tuberculous families were given assistance, one tuberculous transient family for each 170 persons in the resident population. It cannot be doubted that this constituted an enormous load on the resources of that small city. It will be shown that even this figure probably does not represent the entire problem arising from the tuberculous transient.

A study of the migratory tuberculosis problem in the Southwest was conducted by the United States Public Health Service in 1915.[43]

[43] See (*75*), (*110*), and (*19*).

While the investigation was not concerned primarily with the indigency of the group studied, some data were recorded on migratory tuberculous persons whom the present study would call transients.

Lanza concluded that about 400 indigent tuberculous persons migrated to Denver annually. Records of the Municipal Dispensary of Denver showed that 342 tuberculosis patients were treated there in approximately 10 months in 1914. Of this number 118, or 34.5 percent, had resided in Colorado less than 1 year.[44] Sweet found that of 428 "consumptive paupers" cared for in San Antonio, over the 4-year period 1910–13, 128, or 30.0 percent, were persons who had been in the State less than 1 year at the time of application for assistance. It is further shown that in 3 years, 1911–13, in the same city the Associated Charities furnished assistance to 1,646 cases of all types, 125, or 7.59 percent, of whom were "transient consumptives."[45]

Data from the Transient Case Study, extending over a 6-week period in each city, February to April 1938, include information on past tuberculosis history for each person on the family roster of cases studied. The exact question asked about each person was, "Has anyone, including yourself (informant) ever thought that (name of person under consideration) had tuberculosis or consumption?" Replies to this question by the case informant, in every instance a member of the immediate family, were recorded as "yes," "no," or "unknown." In table 53 the number of persons with such a history of tuberculosis in the cities of the resort area and in the rest of the United States is presented. While the coverage was not complete for either area and the data are not presented as a direct measure of the amount of tuberculosis in transients in the two areas, it is believed they do give an indication of the size of the problem and of the comparative incidence of tuberculosis among transients in the two areas.

Comparison between rates for unattached transients and those for persons in family cases is not justified, because of the age distributions involved, but rates for unattached transients for the two areas may be compared. It will be noted that the rate for the unattached in the resort States is one-third higher than that in the rest of the United States.

Table 54 shows similar data for transient adults (15 years and older) in family cases and unattached transient adults. It will be seen that there is a significantly higher percentage of tuberculosis history among transient persons in interviewed cases in the cities of the resort States than in other cities.

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[44] See (*75*).
[45] See (*110*).

TABLE 53.—*Distribution of a selected sample*[1] *of interstate transients with history of tuberculosis, according to area of interview and family attachment*

Area of interview and family attachment	All persons in cases interviewed	Persons with history of tuberculosis	
		Number	Percent of total persons in cases interviewed
Total	14,693	295	2.0
Resort area[2]	4,223	95	2.2
Family transients	2,773	55	2.0
Unattached transients	1,450	40	2.8
Rest of United States	10,470	200	1.9
Family transients	3,632	56	1.5
Unattached transients	6,838	144	2.1

[1] Persons included in the selected sample of transients applying for public assistance in 20 cities covered by the Transient Case Study. The Study extended over a 6-week period between March 8, 1938, and May 7, 1938.
[2] The Southwestern resort States include Arizona, Colorado, and New Mexico.

TABLE 54.—*Distribution of a selected sample*[1] *of unattached interstate transients and of adults in interstate transient families with history of tuberculosis, according to area of interview and family attachment*

Area of interview and family attachment	All persons in cases interviewed	Persons with history of tuberculosis	
		Number	Percent of total persons in cases interviewed
Total	12,182	284	2.3
Resort area[2]	3,064	90	2.9
Adult family transients	1,614	50	3.1
Unattached transients	1,450	40	2.8
Rest of United States	9,118	194	2.1
Adult family transients	2,280	50	2.2
Unattached transients	6,838	144	2.1

[1] Persons included in the selected sample of transients applying for public assistance in 20 cities covered by the Transient Case Study. The Study extended over a 6-week period between March 8, 1938, and May 7, 1938.
[2] The Southwestern resort States include Arizona, Colorado, and New Mexico.

Considering the difference between the percentages of all transients with a history of tuberculosis in the two areas, as shown in table 53, and the size of the transient population in relation to the total population of the two areas, it is apparent that the load from tuberculosis in transients falls much more heavily on the cities of the resort States. In table 55 this unequal distribution is shown on an annual basis in terms of transients with a history of tuberculosis per 100,000 population.

Still another way of showing the proportion of tuberculous persons among transients in the cities of the Southwest is illustrated by table 56 which lists certain causes of migration. It will be seen that more than 1 percent of all unattached transients started migration specifi-

cally because of tuberculosis. When asthma, hay fever, chronic bronchitis, and other pulmonary conditions are included, the figure for "pulmonary migrants" becomes 3.8 percent. The corresponding rates for family interstate transients (based on one possible case to the family) are 0.9 percent and 2.2 percent.

TABLE 55.—*Distribution of total transients[1] applying for public assistance in 20 cities and of transients with history of tuberculosis, according to location of city*

Location of city	Estimated annual number of transients in all cases applying to all agencies [1]	Estimated annual number of transients with history of tuberculosis	Population 1930 (in thousands)	Number of transients with history of tuberculosis per 100,000 population
Total	348,000	7,000	6,213	113
Cities in resort area [2]	113,000	2,500	406	616
Cities in rest of United States	235,000	4,500	5,807	77

[1] Estimated for 1 year. In arriving at the estimated number of transient applications for the entire year, use was made of data from the records of the Federal Emergency Relief Administration Transient Bureau in 1935 on the flow of transients by month by States, and of data from the Transient Case Study. This method is believed to be sufficiently accurate for an estimate of the total annual transient flow. The seasonal fluctuations in the size of the transient population in the Southwest are influenced largely by the maturing date of the local crops and by prevailing weather conditions, neither of which have changed materially during the 3-year interval, 1935-38.

[2] Southwestern resort States include Arizona, Colorado, and New Mexico.

TABLE 56.—*Distribution of a selected sample[1] of interstate transients in the resort States[2] with different motives for migration, according to family attachment*

Family attachment	All transients	Motive for migration					
		Health					Non-health
		Total [3]	Condition for which migration began				
			Pulmonary			Other	
			Total	Tuberculosis	Other pulmonary		
	Number						
Total	3,865	173	102	37	65	71	3,692
Family transients [2]	2,772	105	61	25	36	44	2,667
Unattached transients	1,093	68	41	12	29	27	1,025
	Percent						
Total	100.0	4.5	2.6	1.0	1.6	1.8	95.5
Family transients	100.0	3.8	2.2	.9	1.3	1.6	96.2
Unattached transients	100.0	6.2	3.8	1.1	2.7	2.5	93.8

[1] Persons included in the selected sample of transients applying for public assistance in 20 cities covered by the Transient Case Study. The Study extended over a 6-week period between March 8, 1938, and May 7, 1938.

[2] The Southwestern resort States include Arizona, Colorado, and New Mexico.

[3] Data on health migrants and health conditions in family cases relate to only one person per family.

The validity of these rates is supported by the results of X-ray examinations of a number of adult migratory cotton workers[46] in Maricopa County, Ariz., carried out in the spring of 1938. Table 57 shows the results of interpretation of the films.

TABLE 57.—*Distribution of a selected sample*[1] *of adult migratory cotton workers examined by X-ray, according to interpretation of roentgenograms for active tuberculosis*

Interpretation of roentgenograms	Workers examined	
	Number	Percent
Total	583	100.0
Negative	566	97.1
Suspicious	8	1.4
Positive	9	1.5

[1] The study was carried out by the Arizona State Board of Health in cooperation with the U. S. Public Health Service during the late winter and spring of 1938 in 19 cotton camps in Maricopa County, Ariz.

The incidence of definite active tuberculosis in this group was found to be 1.5 percent. The group was not transient in the sense used in the Transient Case Study, inasmuch as the persons concerned were not, at the time of examination, applying for public assistance. They were, however, migrants and probably had not acquired legal settlement under Arizona's 3-year residence ruling inasmuch as they were selected because of residence in cotton camps. Brown,[47] who studied the same group of people at the same time, has shown them to be "needy."

California does not have a particularly acute problem from tuberculosis among transients, as indicated by the relative incidence of the disease among transients and residents, according to the Department of Public Health of the State. In July 1937, the Department began a statistical study of "the incidence of positive tuberculins and active tuberculosis among * * * the migratory population of the State."[48] A summary of the results of tuberculin tests is shown in table 58. The Department comments on the findings of the study to the effect that it was of particular interest to note that the total percentage of positive tuberculin tests among whites was 26.9 and only 18.2 among adolescent (ages 15 to 19) whites. It was noted that among California residents in comparable age groups about 32 percent show positive tuberculin tests. In all, 1,808 X-rays were made. Of all migrants examined, less than 1 percent showed active tuberculosis.[49]

[46] See "Tuberculosis Study," in the Introduction.
[47] See (*11*).
[48] From (*44*).
[49] From (*44*).

FIGURE 14.—Tuberculous daughter of a transient living in a camp near Sacramento, Calif.

FIGURE 15.—A transient with tuberculosis "takes the cure" in a southwestern State.

TABLE 58.—*Distribution of tuberculin tests given migratory agricultural workers of specified race, according to results of tests* [1]

Results of tests	All tests	Tests given workers of specified race				
		White	Mexican	Japanese	Filipino	Negro
Total tests given	2,511	1,526	806	60	98	21
Number read	2,324	1,410	735	60	98	21
Number positive	798	380	338	19	48	13
Percent positive	34.3	26.9	45.9	31.6	49.0	62.0

[1] Data supplied by Dr. S. F. Farnsworth of the California Department of Public Health.

By way of summary, it may be said that in the resort States the incidence of pulmonary tuberculosis among transients is very probably 2 to 3 percent. There are approximately 3,000 tuberculous transient persons annually requesting public assistance in the procurement of the ordinary necessities of life in the 5 study cities of these States. If all the towns and cities of these States are included, the number requesting public assistance during 1 year would be nearer 5,000.

A considerable number of tuberculous transients have undoubtedly not been included in any of the data presented. The Transient Case Study was concerned only with persons applying for public assistance; therefore, the whole group of nonresident tuberculous persons able to secure ordinary necessities but unable to secure institutional care were not appreciably sampled in the Study. Because of various factors tending to keep tuberculous persons who need assistance only in securing hospitalization from applying for it, the proportion of tuberculous transients among applicants for public assistance must be lower than that among the entire transient population. In the absence of more definite data, it is estimated that the resort area contains 10,000 needy tuberculous persons who have not fulfilled the requirements for legal settlement in the respective States.

Syphilis.—In the discussion of tuberculosis the theoretical approach of estimating and evaluating dilution effects, that is, the effect of mixing two populations with dissimilar incidence rates of tuberculosis, was given consideration. This approach was appropriate in connection with tuberculosis inasmuch as the disease is often, perhaps most often, transferred from one person to another without physical contact and without knowledge of the transfer. The tuberculous parent with a positive sputum usually cannot prevent infecting and reinfecting his children so long as he remains in the household with them, since he cannot easily avoid the dissemination of tubercle bacilli in conversation, sneezing, or coughing, nor can he avoid some transfer of infection as he mingles with his fellow townsmen and neighbors. Society has recognized the probability of effective contact of the

tuberculous with other persons through the necessary activities of ordinary life and has endorsed isolation of the tuberculous in hospitals.

The situation is not the same with respect to syphilis. Effective contact in syphilis is, in most cases, the result of sexual or erotic physical contact. There is not an intermingling of all persons within a community in such a manner that syphilis transfer might be as likely from one person as another. Environmental influences, such as education, social and economic status, moral views, and personal habits, are so important that there is a decided tendency for syphilis in a given social or economic group to spread within that group more rapidly than into others. The theoretical approach of evaluating dilution effects on the general population would have little meaning in a discussion of syphilis. The important consideration in a discussion of syphilis seems to be the extent of the danger to resident contacts from transients with infectious syphilis and how it compares with the similar danger from residents who are likely to have the same contacts.

The data on syphilis incidence to be presented in this section relate to unattached male transients. The resident group most likely to have the same sexual contacts as male unattached transients are the local homeless males who most nearly resemble them so far as social, economic, and habit patterns are concerned.

Several factors on which the propagation of existing communicable disease depends may be disregarded in this discussion. Factors which in syphilis are probably not significantly influenced in a community by the presence of transients are: The susceptibility of the population, the virulence of the organism, and the rate of transfer of infection per case.

A careful study of the incidence of syphilis among indigent transient men applying for residence in camps under the Federal Emergency Relief Administration Transient Program in Minnesota in 1934–35 has been made by Dukelow. The examinations comprising the study were made in conjunction with the routine physical examination required of all such applicants and were made on 6,534 white men and 728 Negro men. Data presented include history of syphilis, evidence of congenital syphilis, primary syphilis, or secondary syphilis, and serological reactions by the Kline and Kolmer techniques.[50]

Three out of 2,419 white and 2 out of 350 Negro transient men were diagnosed as having either primary or secondary syphilis, a rate for the two groups of 0.124 percent and 0.571 percent respectively.[51] Although these examinations were carefully done on a comparatively large number of transient men, the rates established are not significantly above zero and, accordingly, are of limited usefulness. In order to overcome this objection it would be necessary to examine a much

[50] See (*37*) and (*38*).
[51] See (*37*) and (*38*).

larger group than was done under the Federal Emergency Relief Administration Transient Program or was possible during the present study. A great deal of data on this subject can be compiled from the records of routine examinations of transients during 1934–35, but in almost no instances, other than the study in Minnesota, was the work done with sufficient exactitude for the results to have statistical value.

Syphilis incidence will be discussed as determined by serological reactions. In table 59 are shown percentages of the 6,508 white transient men and 727 Negro transient men, over 15 years of age, by 10-year age groups, whose tests were interpreted as "serological reaction positive" in the study by Dukelow. It will be seen that among Negro transients there were higher percentages of tests in all ages interpreted as "positive" than among white transients, but the greatest difference occurs in the two youngest groups, and differences decrease as the age of those tested increases.

TABLE 59.—*Distribution of positive serological reactions of 6,508 white and 727 Negro transients*[1] *examined in Minnesota in 1934–35, according to the age of the individuals*[2]

Age group	White		Negro	
	Total examined	Percent serological reaction positive	Total examined	Percent serological reaction positive
Total	[3] 6,508	7.4	[4] 727	18.8
15–24	1,233	2.11	235	14.0
25–34	1,707	6.80	241	25.3
35–44	1,578	8.81	168	17.9
45–54	1,225	9.88	56	17.9
55–64	565	11.86	[5] 27	11.1
65 and over	200	7.00		

[1] According to Federal Emergency Relief Administration definition of the term.
[2] Data from (38).
[3] Excluding 26 of unknown age.
[4] Excluding 1 of unknown age.
[5] Including all of known age, 55 years of age and over.

Because of the very common practice of using the designations "local homeless," "intrastate transients," and "interstate transients," it was believed important in the present study to compare syphilis incidence among these three classes of homeless persons. An opportunity to make such a study was offered in the Cincinnati Shelter Care Division Hospital which serves all three types of homeless persons and, furthermore, has both the medical and social facilities necessary for such a study.[52]

Table 60 shows the results of the serological tests on white interstate transients in this institution, with the combined interpretation of the

[52] Refer to the Introduction for further description of the study.

two tests by the Kahn and Kolmer techniques.[53] It will be noted that, while 7.9 percent of the total had serology positive for syphilis, the percentage varied from 3.5 percent in the age group 15–24 to 11.1 percent in the age groups 55–64 and 65 and over. This seems to indicate a direct relationship in these transients between age and probability of having positive serology. There is also a remarkable similarity between the rates determined in Minnesota in 1934–35 and those found in Cincinnati 3 years later.

TABLE 60.—*Distribution of 596 white interstate transient males of different age groups examined by serological reaction, according to technique of test and interpretation of combined results* [1]

Technique of test and interpretation of combined results		All transients	Age group					
			15–24	25–34	35–44	45–54	55–64	65 and over
Kahn	Kolmer	Number						
Total		596	173	173	139	75	27	
Serology negative		540	167	154	123	64	24	8
Negative	Negative	535	167	152	122	63	23	8
Negative	Doubtful	1	0	1	0	0	0	0
Doubtful	Negative	4	0	1	1	1	1	0
Serology doubtful		9	0	3	3	3	0	0
Negative	Positive	5	0	3	1	1	0	0
Positive	Negative	4	0	0	2	2	0	0
Doubtful	Doubtful	0	0	0	0	0	0	0
Serology positive		47	6	16	13	8	3	1
Positive	Doubtful	0	0	0	0	0	0	0
Positive	Positive	39	6	15	10	5	2	1
Doubtful	Positive	8	0	1	3	3	1	0
		Percent						
Total		100.0	100.0	100.0	100.0	100.0	100.0	100.0
Serology negative		90.6	96.5	89.0	88.5	85.3	88.9	88.9
Negative	Negative	89.8	96.5	87.9	87.8	84.0	85.2	88.9
Negative	Doubtful	.2	-------	.6	-------	-------	-------	-------
Doubtful	Negative	.7	-------	.6	.7	1.3	3.7	-------
Serology doubtful		1.5	-------	1.7	2.2	4.0	-------	-------
Negative	Positive	.8	-------	1.7	.7	1.3	-------	-------
Positive	Negative	.7	-------	-------	1.4	2.7	-------	-------
Doubtful	Doubtful	-------	-------	-------	-------	-------	-------	-------
Serology positive		7.9	3.5	9.2	9.3	10.7	11.1	11.1
Positive	Doubtful	-------	-------	-------	-------	-------	-------	-------
Positive	Positive	6.5	3.5	8.7	7.2	6.7	7.4	11.1
Doubtful	Positive	1.3	-------	.6	2.2	4.0	3.7	-------

[1] The blood specimens were collected in the spring of 1938 at the Cincinnati, Ohio, Shelter Care Division Hospital of the Department of Safety, under the direction of Dr. E. B. Brandes. The serological examinations were made at the U. S. Public Health Service Venereal Disease Research Laboratory, Stapleton, N. Y.

Tables 61 and 62 present data on the percentage of positive serological reactions in the homeless men studied in Cincinnati by race,

[53] Similar tables for the two other classes of white cases and all classes of Negro cases are on file in the Division of Public Health Methods, National Institute of Health.

age group, and legal settlement status. Since there was considerable difference in the age distribution of those tests in the three categories by legal settlement status, adjustment to a standard population within each race has been made so that a comparison between the groups is more meaningful. There was no particular difference between the age distribution of white and Negro homeless males in the same legal settlement groups; hence age adjustment was made within the two races and not between them.

TABLE 61.—*Distribution of 914 homeless white men of different settlement status according to age, and percentage of each group serologically positive for syphilis* [1]

Age group	All men examined				Percent serologically positive		
	Total	Local homeless	Intrastate transients	Interstate transients	Local homeless	Intrastate transients	Interstate transients
Total	914	195	123	596	13.3	8.1	7.9
15–24	207	6	28	173	----------	3.6	3.5
25–34	232	25	34	173	12.0	17.6	9.2
35–44	217	45	33	139	17.8	3.0	9.3
45–54	151	52	24	75	5.8	8.3	10.7
55–64	82	51	4	27	13.7	----------	11.1
65 and over	25	16	0	9	31.2	----------	11.1

[1] The blood specimens were collected in the spring of 1938 at the Cincinnati, Ohio, Shelter Care Division Hospital of the Department of Safety, under the direction of Dr. E. B. Brandes. The serological examinations were made at the U. S. Public Health Service Venereal Disease Research Laboratory, Stapleton, N. Y.

TABLE 62.—*Distribution of 256 homeless Negro men of different settlement status according to age, and percentage of each group serologically positive for syphilis* [1]

Age group	All men examined				Percent serologically positive		
	Total	Local homeless	Intrastate transients	Interstate transients	Local homeless	Intrastate transients	Interstate transients
Total	256	106	24	126	38.7	37.5	29.4
15–24	57	5	6	46	20.0	----------	21.7
25–34	80	30	8	42	26.7	50.0	33.3
35–44	56	26	8	22	50.0	50.0	18.2
45–54	42	25	2	15	44.0	50.0	60.0
55–64	15	15	0	0	46.7	----------	----------
65 and over	6	5	0	1	20.0	----------	----------

[1] The blood specimens were collected in the spring of 1938 at the Cincinnati, Ohio, Shelter Care Division Hospital of the Department of Safety, under the direction of Dr. E. B. Brandes. The serological examinations were made at the U. S. Public Health Service Venerea lDisease Research Laboratory, Stapleton, N.Y.

The expected percentages in each group, if all groups had been similar in age distribution, are summarized in table 63, arranged by color and legal settlement status. It will be noted that, in all categories, white men have a considerably lower incidence of positive serology than do Negroes. In both races interstate transient males showed a lower percentage of positive sera than did the local homeless. This is believed to be an important consideration.

In conclusion it may be said that, from the consideration of incidence on the basis of serology only, unattached males in Cincinnati constitute, to their contacts, a considerable danger from syphilis and that, of the three groups by legal settlement, the local homeless has the highest incidence rate and consequently is most dangerous.

TABLE 63.—*Expected percentage*[1] *of persons of different legal status, serologically positive, among homeless men in a population adjusted for age within a race, according to race*

Race	Legal settlement status		
	Local homeless	Intrastate transient	Interstate transient
White	10.4	7.4	8.3
Negro	33.6	34.8	28.9

[1] Based on data from a study of the serological reactions for syphilis of homeless men. The blood specimens were collected in the spring of 1938 at the Cincinnati, Ohio, Shelter Care Division Hospital of the Department of Safety, under the direction of Dr. E. B. Brandes. The serological examinations were made at the U. S. Public Health Service Venereal Disease Research Laboratory, Stapleton, N. Y.

The type of syphilis among transients is probably identical in every way with that found in resident groups. Contracted in the same manner, it has the same incubation period, symptoms, and objective signs, and, without treatment, will remain infectious for the same length of time. However, an infectious case of syphilis will become noninfectious much more quickly if treated adequately; hence the question becomes, "Do transients receive treatment for syphilis as early as comparable residents and are they equally likely to continue treatment?" Early and continuous treatment for syphilis in the needy depends on a number of factors and, in the light of existing knowledge about these factors, a reasonably correct judgment can be made.

Treatment of an individual case of infectious syphilis depends initially on the patient's realization that his symptoms or lesions are a manifestation of disease for which he should have medical advice. There is no reason to assume any difference between transients and comparable residents in this respect.

The individual must also know of available medical care and be willing to avail himself of it. In this respect the transient is at a distinct disadvantage. In many cities treatment is not available to the transient. Even where clinics will accept him, he is less likely than the resident to know of treatment centers or physicians that will treat him free or at reduced rates. Also, he is probably more averse to admitting his condition to public officials than a local man would be. The transient usually thinks of himself as definitely a stranger in the community. He knows that residents think he does not belong. He

has learned early in his transiency that a request for assistance is often granted only as he promises to leave the jurisdiction of the agency to which he applies. It would be very surprising if he were not more reluctant than the resident to request public medical care for syphilis.

Fortunately, it seems very probable that the ill effects of the transient's ineligibility for treatment, or at least the discrimination against him when he seeks it, will soon be mitigated. Paragraph 5, Section XV, of the "Regulations governing allotments and payments to States for venereal disease control activities for the fiscal year 1940" states: "To receive funds under this Act, diagnostic and treatment services shall be as freely available to infected residents of other States and counties as to people who reside in the governmental unit providing the services." [54] As the funds provided for this purpose increase and as the numbers of clinics receiving financial aid under the Act become more numerous, there should be less discrimination against the transient with syphilis, and he should be more likely to avail himself of known facilities; as a consequence, his danger to residents will be lessened.

Typhoid fever and dysentery.—In these two diseases one would expect the greatest difference in incidence between transients and residents. The deplorable sanitary conditions under which many transients live have been widely discussed. Transients who live in crowded camps without a safe water and food supply and without proper sewage disposal would be expected to have a higher incidence of these diseases than would residents of towns and cities with adequate sanitary facilities or rural people living in well-ordered individual homes.

Morbidity reports on these diseases are, unfortunately, not available by residence status. However, health workers and most social workers who have had any experience with transients testify to the high prevalence of this type of disease among them. Dr. Lee A. Stone, Director of the Madera County (Calif.) Health Department, tells of one migratory agricultural family: "The Dozier clan * * * began presenting the county with cases of typhoid fever. A total of 11 cases of typhoid fever occurred out of the 42 (individuals) in the clan." [55] Only 3 cases of typhoid fever occurred in Madera County in 1938, all of them among migratory agricultural workers from Oklahoma.[56]

Dr. Ellis D. Sox, Health Officer of Tulare County (Calif.), says: "Of the 12 cases of typhoid fever occurring in Tulare County during the

[54] See (*121*).
[55] See (*109*), p. 3.
[56] From (*53*).

last 6 months of 1938, all but 2 were in camps and directly in our migratory population. Forty-three cases occurred during the last 6 months of 1937." His comments on the work being done to combat the situation are: "The control of typhoid fever has been largely through immunization and education until the present health department was estabished [July 1938] and since then the control of typhoid fever has been primarily through cleaning up of insanitary conditions." [57]

The Agricultural Experiment Station of the University of Washington reports that in the hop camps of that State, "Sickness, particularly dysentery, was found in nearly all camps. In one large camp the nurse on duty said that in 2 weeks she had dispensed 3 gallons of dysentery medicine. In no other camp was this service provided * * *." [58]

Dr. J. D. Dunshee, of the Arizona State Board of Health, says: "Typhoid fever has been found existent with 4 cases in one camp and 3 additional suspicious ones in the same camp. Dysentery is common * * *." [59] In a report by the Children's Bureau several instances of small localized epidemics of both typhoid fever and dysentery are cited.[60]

During the Transient Case Study all persons interviewed were questioned on immunity to typhoid fever. Presumptive immunity was based on (1) having had typhoid fever at any time; or (2) having had *three* inoculations against typhoid fever at weekly intervals within the last 3 years. In table 64 the data from these questions are shown.

It is believed that the transient groups studied contain a relatively high proportion of presumptive immunes as compared with either a predominantly rural or an urban population, and that this is true largely as a result of the intensive campaign of immunization carried out by the departments of health of some of the western States, particularly Arizona, California, and Washington. Dr. Walter M. Dickie of California reports on September 4, 1937, that "Up to August 27, almost 24,000 injections of typhoid vaccine have been administered to migrants." [61] The Maricopa County (Ariz.) Health Department had placed emphasis on this campaign during the year prior to the Transient Case Study, and the California State Department of Health had done likewise throughout the counties with any considerable transient agricultural problem.

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[57] From (*53*).
[58] See (*122*), p. 20.
[59] See (*39*).
[60] See (*74*).
[61] See (*32*), p. 127.

TABLE 64.—*Distribution of transients with presumptive immunity to typhoid fever interviewed in 20 study cities, according to family attachment* [1]

Family attachment	All persons in cases interviewed	Persons with presumptive immunity to typhoid fever	
		Number	Percent of total persons in cases interviewed
Total	16,145	5,305	64.0
Family transients	7,105	1,849	26.0
Unattached transients	9,040	3,456	38.0

[1] Persons included in the selected sample of transients applying for public assistance in 20 cities covered by the Transient Case Study. The Study extended over a 6-week period between March 8, 1938, and May 7, 1938. The interval for which disabling illnesses were reported by transients includes the 3 months preceding the date of interview.

Six cases of typhoid fever were reported as having occurred during the 3-month survey period among the 6,560 transients in interviewed cases in Arizona and California. Expressed as an annual incidence rate, this is 367 cases per year per 100,000 transients, although the annual rate of typhoid and paratyphoid fever reported for the entire United States was 11 per 100,000 in 1938.[62]

It is doubtful whether or not the rate determined for transients is as high as the one actually occurring among these people. For example, although roughly one-fourth of the 6,560 transients interviewed in Arizona and California were unattached transients, no case of typhoid was reported as having occurred among this group within 3 months. The factor of health selection probably operated to eliminate from the unattached transient group studied those who had had typhoid fever during the 3 months just prior to the Transient Case Study. It is a debilitating disease and one with a comparatively long period of convalescence. Few unattached transients who had had typhoid fever in the preceding 3 months would be found by the method of study used since the majority of those who had suffered from the disease had probably either merged into the resident population by returning to their States of legal settlement or had remained in the hospital as convalescents.

Another reason for suspecting that the number of cases reported was fewer than actually occurred is that so few of the cases were diagnosed by physicians. An illustration is the "R" family, interviewed in California. The family consisted of a grandmother, two of her daughters, her son and daughter-in-law and their five children. The family migrated from Oklahoma to California in January 1938 for the health of one of the daughters who suffered from "asthma." None of them had presumptive immunity to typhoid fever. On

[62] See (*120*).

February 14, one of the grandchildren became ill with symptoms of "fever and diarrhea." Of two physicians who saw the child independently, one thought it had measles, the other diagnosed the condition as scarlet fever. Forty-three days later, at the time of the interview, the child was still ill. On the tenth or eleventh day of March, six other members of the family became ill. Of the six, two were considered typhoid fever cases by physicians and hospitalized; another had "diarrhea and stomach pain" but was not seen by a physician and was still ill at the time of interview; two others, aged 10 and 3 years, had "fever and headache" and were seen by a physician but no diagnosis was made; and the last, a baby of 10 months, had been seen by a physician and the case diagnosed as "measles." The grandmother was of the opinion that some of those not hospitalized had typhoid fever also, since "they acted like Robert and Lucille did." She could very well be correct.

Smallpox.—The incidence of smallpox among transients has been, and still is, very high. Dr. Lee A. Stone, of Madera County, Calif., reported 44 cases of smallpox in one camp in a period of about 4 months in 1938.[63] Dr. A. N. Crain, Director of the Maricopa County (Ariz.) Health Unit, reports: "We have had and are still having [March 1939] an epidemic of smallpox, brought into the State by transients. There have been 150 cases from such contacts and new cases are yet being found."[64] Dr. Warren F. Fox, health officer of Imperial County, Calif., reports: "During the past few months [spring 1939] we have had 10 cases of smallpox imported * * * from Arizona. One case crossed the State line in the eruptive stage via a freight car!"[65] Dr. Ellis D. Sox, Health Officer of Tulare County, Calif., reports in March 1939: "We are in the midst of a small epidemic [of smallpox] at the present time which has been brought into this county by migratory workers from the northern part of the State and * * * from Buckeye, Ariz. The county has had 360 cases of smallpox during the last 12 months."[66] Dr. John J. Sippy, District Health Officer, San Joaquin County, Calif., reports 62 cases of smallpox in the county during 1938, 15 of which were in migratory agricultural workers. Up to March 1939, 3 cases of smallpox had occurred in San Joaquin County, 2 of which were exposed in Maricopa County, Ariz., and rode by auto to California.[67] On one day in the field the author of this study saw 5 cases diagnosed as smallpox and traceable to cotton workers in Arizona.

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[63] See (*109*).
[64] See (*53*).
[65] See (*53*).
[66] See (*53*).
[67] See (*53*).

The percentage of transients having presumptive immunity against smallpox either because they have been vaccinated or have had the disease is somewhat higher than for immunity against typhoid fever. Table 65 shows the number and percentage of transient persons who "had had smallpox or had a vaccination scar and had been vaccinated within the past 7 years." The higher percentage of presumptive immunity against smallpox does not, however, mean that transients necessarily have better protection against smallpox than against typhoid fever. Individual protection against the latter, in present-day practice, is predicated on avoidance of exposure, chiefly through food and water, and on artificial active immunization if exposure is believed unavoidable. This is not the case with smallpox. No person is considered reasonably protected against this disease unless he has had a successful vaccination against the disease within the last few years.

TABLE 65.—*Distribution of transients with presumptive immunity to smallpox interviewed in 20 study cities, according to family attachment* [1]

Family attachment	All persons in cases interviewed	Persons with presumptive immunity to smallpox	
		Number	Percent of total persons in cases interviewed
Total	16,145	7,554	92.3 46.8
Family transients	7,105	2,915	41.0
Unattached transients	9,040	4,639	51.3

[1] Persons included in the selected sample of transients applying for public assistance in 20 cities covered by the Transient Case Study. The Study extended over a 6-week period between March 8, 1938, and May 7, 1938. The interval for which disabling illnesses were reported by transients includes the 3 months preceding the date of interview.

Along with the program of inoculation against typhoid which has been cited, many local and State health departments are giving a great deal of attention to seeing that all migratory agricultural workers are protected against smallpox. In Tulare County alone, 18,000 individuals were vaccinated against smallpox during 1938 by the County Health Department.[68] Equally heroic efforts are being made by other health departments in California and Arizona. However, it is not likely that any such departments, under their present budgets, will be able to approximate 100 percent vaccination of the transients under their jurisdiction without serious neglect of other duties. Even in the Farm Security Administration camps where

[68] See (*53*).

health workers are assigned full time, only 864, or 80 percent, of the 1,083 family individuals in interviewed transient cases had presumptive immunity to smallpox.

Meningococcic meningitis.—In the case of meningococcic meningitis, transients are perhaps more likely than any other class to give rise to an epidemic. It is a matter of general epidemiological knowledge that when a number of adults, not previously accustomed to such conditions, are quartered in congregate shelters, the probability of epidemic meningitis occurring among them is greater than among groups not so constituted. Cook,[69] studying enlisted men in the United States Navy, has shown that the attack rates of this condition are in inverse ratio to length of exposure to congregate living; and further, that men entering "barracks" life during the fall and winter months had a much higher attack rate than those whose service life began during the spring and summer.

Congregate shelters for homeless men have many of the characteristics necessary for an outbreak of meningitis, and epidemics of the condition have occurred in them. One such epidemic was reported as arising in a municipal lodging for homeless men in Cincinnati when 20 cases occurred during the spring of 1935.[70]

INTRODUCTION OF NEW COMMUNICABLE DISEASES

The spread of most communicable diseases from one country to another or from one community to another depends primarily on the movement of human carriers. There are a few exceptions such as plague, yellow fever, and tularaemia, in which animal hosts may transport the condition to new territories, but the majority of communicable diseases are dependent on man for introduction into new populations. Whether syphilis was introduced into Europe from the Western Hemisphere or from the Orient, it was nevertheless seen in Europe only after there had been a movement of people from those areas to Europe. The history of epidemic diseases among the South Sea Islanders and recent studies of epidemics in the Faroe Islands all support the contention that most communicable diseases are spread by human carriers.

Since transients are persons who have migrated, more or less recently, into communities other than those in which they were born, they have one characteristic, that of migration, necessary for the spread of communicable disease. That they are needy persons has no significance. But several other conditions are necessary to make a migrating group responsible for the introduction of a commun-

[69] See (*29*).
[70] See (*10*).

icable disease into an uninfected area. These factors are: (1) There must be at least one individual in the migrating group who has the disease in a form that is communicable; (2) there must be, in the area to which migration is directed, a means of transmission from infected to noninfected persons; (3) there must be, in that area, individuals susceptible to the disease.

This discussion will be limited to the class of communicable diseases endemic in parts of this country and practically nonexistent in others. The distinction between these diseases and those that recur periodically is not entirely clear. Measles has been classified in this study as an endemic disease, that is, one existing at practically all times throughout the United States. Yet there are months in which no cases are reported from some States. This is also true of malaria, anterior poliomyelitis, and other diseases discussed in this section as not endemic in parts of the United States. This last group of diseases does, however, have this distinguishing characteristic: They are not expected to occur at fairly regular intervals in all States, while in the case of tuberculosis, measles, diphtheria, and the other conditions discussed previously, not only can it be predicted that cases will occur, but the expected number can be estimated with some degree of accuracy. It is on the basis of unpredictability, then, that the diseases discussed in this section are classified. The classification will serve and is used only to illustrate the influences of the introduction of pathogenic organisms into areas relatively free of the conditions caused by them.

Malaria.—Probably malaria is the best example of this class of "unpredictable" diseases, both from the standpoint of economic importance and limited endemicity. The discussion of this disease will be used to illustrate the principles involved in introducing a disease into areas not ordinarily suffering from it.

In the years 1936 and 1937 combined, 241,510 cases of malaria were reported to the various State departments of health and to the United States Public Health Service from 38 States. Of this number, 206,694 cases, or 86 percent, were reported from 4 States, Georgia, Mississippi, South Carolina, and Texas. Twenty-three other States in 1936 and 20 States in 1937 reported fewer than 100 cases each. While it is recognized that reporting of malaria is very incomplete, it is believed that data on the true incidence, if available, would not materially affect this picture of endemicity within the United States.

There are certainly several States where, for a number of reasons, no cases of malaria occur during the average year. Some localities may lack a type of mosquito capable of transmitting the disease from one human to another. In most States, however, even in the

majority of those relatively free of the condition, mosquitoes capable of transmitting the disease may be found in the vicinity of human habitations; and, furthermore, the resident population is susceptible to malaria. In such communities, in order for malaria to invade the resident population, there is needed only the presence of persons with malaria in a stage easily transmitted, and opportunities for mosquitoes to feed on them and subsequently on the noninfected.

No recent localized epidemics of malaria have been proved to be due to transients as such. However, since the only real difference between transients and other types of migrants is a matter of financial status, which is not a factor with which the malarial parasite is concerned, epidemics apparently due to migrants and designated as "imported epidemics" will illustrate the situation satisfactorily.

In the late summer and early fall of 1934, 37 cases of malaria were diagnosed in Aurora, Ohio, although prior to this epidemic no cases had been reported in the community since 1920. In the report of this outbreak the authors conclude: "It is probable * * * that the epidemic here reported was due to the introduction of an infected individual." [71]

In reporting an epidemic which occurred in Paw Paw, Mich., in August 1934, the health officer of the county says: "Several residents (of Paw Paw) have chronic malaria and some of their original infections were contracted while visiting Central American countries." [72] An epidemic of 30 cases of malaria occurring within a mile radius of Mills Fall Pond in Tazewell County, Va., in August and September 1935 was believed by the investigator to have arisen from members of camping parties from eastern Virginia who spent 2 or 3 weeks on the lake during the summer.[73]

With reference to the small epidemic of malaria reported at Covington, Va., in 1923, there is quoted below a portion of the Quarterly Report on Malaria Control, 1923, submitted by Clinton A. Kane, Director of Malaria Control, State Department of Health of Virginia:

> One small epidemic of malaria occurred in Covington and was investigated * * *. Twenty cases of malaria were reported in July from Covington, Alleghany County, Va. As this county has never before reported malaria, an investigation was made by Dr. Roy K. Flannagan, Assistant Health Commissioner, and later in August a survey in detail was made by the Malaria Department. Many breeding places of *Culex* were found in Covington but only in one section of the area was *Anopheles* breeding found. This was a large seepage area located in the section from which the malaria cases occurred * * *. In tracing the history of malaria in this town it was found that (a railroad company) was doing excavation work and had imported laborers from the tidewater section of Virginia, which, of course, is in the malaria belt. Upon further investigations it was

[71] See (*60*), p. 1.
[72] See (*85*).
[73] See (*52*).

found that one of these men was boarding in the part of the town in which malaria later occurred. While living there he had a relapse, having had malaria previously to this attack. The infection was undoubtedly carried to Covington in this way.

It would seem then that epidemics of malaria not only may but do occur in areas practically free of the condition as a result of the immigration of individuals who harbor the parasite. In this manner, a transient or any other type of migrant might introduce the infection and in so doing introduce a great danger to the resident population.

Similarly, other diseases may be introduced into areas and populations relatively free of them by the entrance of individuals harboring, in an infectious form, the respective pathogenic organisms. For example, trachoma (a disease relatively unknown there formerly) has been reported as appearing in California in migratory workers. Although knowledge of the method of spread of infantile paralysis is not complete, studies of epidemics suggest that it is transported from one locality to another by carriers of the virus, who might well be transients.

CREATION OF UNUSUAL AND INCONSTANT DEMANDS ON PUBLIC MEDICAL FACILITIES

In Part I the causes responsible for the enactment of legal settlement status and poor laws have been discussed. In Part II it was shown that the practice of agencies that dispense public assistance, whether under statutory provision or not, is, among other considerations, often directed toward the exclusion of nonresidents from public benefits. It has been further shown that when the number of transients increases in relation to the general population, especially in times of general economic distress, the tendency is for States and communities to increase all requirements prerequisite to public assistance as residents.

These are but natural human reactions. They are rooted in the impulse, almost an instinct, to protect one's property. While the average man may have no objection to the assistance of individual nonresidents whom he sees and recognizes as needy, he has an aversion to increased appropriations and increased taxes to support or assist persons whom he considers outsiders. There is also the very widespread belief that public organized assistance to nonresidents may tend to attract still greater numbers of such persons. It is believed that this effect will come about in any area in direct proportion to the excellence of the quality and quantity of relief given to transients in that area, as compared with relief dispensed to needy residents in other areas. If badly needed assistance is available anywhere, people will move to the community in which it is available. The

force of this attraction depends both on the compelling nature of the individual's consciousness of need and the relative amount of assistance available in another community. It is doubtful whether very many unattached individuals would migrate any considerable distance solely to secure lodging in a better municipal lodging house than the one in which they find themselves. The benefits received might not compensate them for the uncertainties of a change of locale and the difficulties of travel.

But for the sake of a relatively much more expensive type of public assistance, the situation may be quite different. Hospitalization for tuberculosis will serve as an example. There are in the United States thousands of tuberculous persons who realize their need of hospitalization but are unable to finance their stay in such an institution from private resources or to gain admission to available free beds for the tuberculous. Let any State or community provide free sanatorium care for all tuberculous persons regardless of residence status and it is likely that many persons will promptly migrate there when it becomes known that such care is available. If, in addition, that State or community were in the area reputed to have a salubrious climate for respiratory diseases, the number of tuberculous migrants attracted and their rate of migration would be increased.

The same principles operate in the search for public medical care for ordinary conditions. The number of persons who migrate great distances for medical care is, however, small. Only 1.8 percent of the unattached interstate transients and 1.2 percent of the interstate transient families interviewed in 20 cities had started migration in order to seek medical care. If those interviewed in Hot Springs, Ark., are eliminated, the percentage is negligible. Migration for free medical care is principally rural-urban and intrastate.

Restrictions against transients are set up in the statutes and administrative practices of practically all public hospitals and clinics. But, on the other hand, transients do receive some free public medical care. It has been shown that in the 20 cities studied there were 206 agencies that gave medical care to transients. Of these, roughly one-third restrict care to transients with emergency conditions, another third limit the ordinary care given to transients to selected cases only, and about one-fourth make no restrictions. In the statutes and administrative rulings governing the admission policies of these institutions, one can usually find some such clause as "nonresidents shall not be admitted to (hospital or institution) except for emergency conditions." Even if some such provision is not made in the law or by formal ruling, emergency transient cases are usually admitted in practice.

Considerable differences exist between communities in what is considered an emergency condition. The staff of almost any hos-

pital considers an acute case of appendicitis or a broken leg as an emergency condition and will admit all persons with such conditions to the hospital. In the one condition the danger to life or, in the other, the danger of permanent deformity is universally recognized and everyone agrees that the circumstances constitute an emergency. The distinction is not so clear cut in less dramatic or less drastic conditions.

Then, too, there are conditions for which transients are admitted to the hospitals in order to protect the public health. Most States require that the criminally insane and those afflicted with smallpox, diphtheria, scarlet fever, and other dangerous communicable diseases be isolated. In such conditions no consideration is taken of the residence status of the individual.

What then are the effects on community health of this demand on the public hospitals and clinics by transients? It is believed that there is very little direct effect on resident health. It is doubtful that any significant number of residents are deprived of beds in hospitals, visits to out-patient departments, or attention in clinics because those services have already been rendered or must be rendered to transients. Certainly in city or county general hospitals, venereal disease clinics, or out-patient departments, one would not expect the staff to admit transients to the point that service to residents would be lacking in quantity.

This might, however, occur occasionally in medical facilities under private and nonprofit association control. Many such hospitals set aside a certain number of beds for charity patients. It has been shown that some hospitals and clinics do not restrict the type of service given to transients, nor do some of them make any distinction between transients and residents. If such hospitals are the only ones offering free hospitalization and clinic care in a community and if an unusually large number of transients migrate to the community, indigent residents needing this type of care might well be refused the service because of prior application by transients. It was stated in one study that "The overcrowded hospitals which must take emergency nonresident cases sometimes do not have room for those who have legal residence." [74]

A more certain effect of the presence of transients on the health of the community is the drain on health funds and appropriations through the hospitalization and medical care that communities furnish to them. The study will not, at this point, consider the right of transients to medical care, regardless of residence status. Transients are consuming tax funds and private contributions set aside by the residents of communities for the medical relief of indigent

[74] See (*115*), p. 31.

residents and only the effect of this financial load will be discussed. Little data are available about the amount of funds consumed by transients in this manner. No comprehensive data on the subject for the entire United States exist, but it may be stated with certainty that the amounts are generally proportionate to the number of transients in the various communities. The Transient Case Study has shown that, out of 14,076 transients not eligible for Federal hospitalization as United States veterans or merchant seamen, 430 were admitted to hospitals as bed patients during a 3-month survey period.

In order to estimate, for one area, the number of interstate transients actually admitted to hospitals, the 66 county or nonprofit association general hospitals in California were requested in March 1939 to furnish these data from their admission records or from estimates. California was chosen because it is known to have both relatively large numbers of transients and a rather complete system of county hospitals.

Table 66 shows the results obtained from this questionnaire. Roughly two-thirds of the hospitals replied. Of the county hospitals that replied all had admitted interstate transients to bed service. The mean annual number admitted was 571 per county hospital. If the replies are accepted as accurate, using $4.54 as the daily per capita cost in general hospitals [75] and 12.5 days as the average hospitalization per patient,[76] the average annual cost to the people in each of these 15 California counties for free hospitalization in county hospitals of interstate transients in 1938 was $31,000.

TABLE 66.—*Distribution of transients admitted as in-patients to 42 registered*[1] *general hospitals in California, 1938, according to control of hospital*

Control of hospital	All registered hospitals[1]	Hospitals replying to questionnaire			Transients admitted[2] to in-patient service, 1938			Mean annual number admitted by hospitals accepting any transients
		Total	Giving care to transients	Not giving care to transients	Total	Free	Part-pay	
Total	66	42	28	14	8,918	8,294	624	318
County	27	15	15	0	8,560	8,227	333	571
Nonprofit association	39	27	13	14	358	67	291	27

[1] Registered with American Medical Association, Hospital Number, J. Am. Med. Assoc., 112:935-938 (March 11, 1939). Only hospitals under the control of county governments and nonprofit associations are included.
[2] 1 hospital reported number discharged.

Only 13 of the 27 nonprofit association general hospitals replying to the questionnaire had admitted interstate transients to in-patient

[75] See (*117*) for derivation of this figure.
[76] Refer to (*67*), p. 909 for derivation of this average.

service and the mean number admitted annually was 27. From the replies it would seem that the load borne by county hospitals in California was much greater than that of nonprofit association hospitals.

A study of transients applying for free and part-pay medical care in Los Angeles in 1937 showed that, of 1,011 applicants to 7 public and 9 private agencies during the period January 25 to February 24, 167, or 16.5 percent, were hospitalized, and 849, or 84 percent, were accepted for medical care "in spite of the established policy of the majority of the medical care agencies not to care for transients." [77] From these data it would appear that roughly 2,000 transient patients a year are admitted to free or part-pay hospital beds in these 16 medical agencies of Los Angeles, and that an additional 9,000 are given medical care other than hospitalization. It has been estimated that hospitalization of transients at Los Angeles County General Hospital alone costs about $170,000 annually and that 92 percent of it is free care.

The most thorough available analysis of the cost of hospitalization of transients or "nonresidents" is that of the Department of Admissions of Louisville City Hospital. This department estimated in 1937 that "it means that the nonresidents cost the city $14,740.50 last year for care only. The taxpayer foots the bills." [78] The annual report of this same department for 1938 [79] shows that 427 nonresidents applied during the year for admission to the wards as bed patients. One hundred forty-eight of these were rejected because of lack of residence and 279 were admitted to the hospital and referred later to other hospitals, physicians, and fiscal authorities. The average length of hospitalization of all cases referred after hospitalization was 12.3 days and the average daily cost per patient $2.60. On these bases hospitalization of nonresidents in this hospital cost Louisville taxpayers approximately $9,000 in 1938. It should be noted that of all nonresident applicants 260, or 60 percent, were from Kentucky outside Louisville. Kentucky has a small transient problem as compared with some of the southwestern States, which accounts for the high proportion of intrastate transients among these applicants.

If plans are made for providing more adequate medical care to transients, consideration should be given to the financial burden now being carried by a relatively few States and communities in supplying public medical care to individuals who are largely the legal responsibility of other States.

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[77] See (25).
[78] See (80).
[79] See (79).

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