must, therefore, recognize that unless we have real honest-to-goodness self-awareness of our own emotions and feelings, that they might influence the data we select to interpret and thereby make our conclusions go far astray.

It would also seem to me that there must be times when the collection of data may reveal nothing of interest or significance. If so, let us be free enough to say so, and not try to squeeze blood out of a stone.

Service to families and individuals is the principal reason for the existence of a family agency. In the collection of statistics it is, therefore, understandable why we always focused on service in the operation of the agency, in the interpretation of our program to the community, and in the procurement of financial support as related to the number of cases served. Our family agency statistics do not reflect the nature or extent of those activities of staff not related to individual cases, and yet many of our case work staff divide their time between case work service to clients and to various non-case work activities. I wish, therefore, we could advance much faster than we are to the point of having uniform statistics that would reflect the extent of staff's full activities, thereby giving a more complete picture of agency service. Of no less importance is my second wish, that of developing the means of having recorded the degree of a case worker's helpfulness to an individual or family. In the final analysis, the number of individuals served is second in importance and in meaningfulness to the degree of helpfulness of the agency. No doubt there are other equally appropriate wishes which you can add. Perhaps the Council of Jewish Federations and Welfare Funds, through its Department of Social Planning, will want to know all our wishes along these lines so that it could give further thought and consideration to them, knowing how deeply concerned we are about making further progress in this field.

JEWISH HEALTH MIGRATION

By MORRIS ZELDITCH
Council of Jewish Federations and Welfare Funds

THE migration of people within the United States is nothing new. Seasonal migration of workers, the movement of families and individuals seeking better economic opportunities, better climate or better social conditions, the continuous movement of the mendicants known as "tramps" and hoboes; these have been and are continuing social phenomena with which we social workers have a concern because social breakdown is perhaps more likely to occur among migrants than among the more settled parts of our population. Even if we exclude from consideration the men who travel constantly and settle nowhere, migration brings about clearly recognized problems involving special types of social responsibility.

The most logical place for this responsibility is the Federal Government, in cooperation with State and local governments; but except for the brief relatively successful experiment of the Federal Government in 1934–35 with the National Transient Bureau and the establishment of special Federal camps for migrant workers in certain agricultural areas, there have been no indications that government is likely to accept responsibility soon for any transient program on a national basis.

The efforts of private agencies in this area, particularly those of the National Travelers Aid Society and the attempts of local social work organizations to deal with the problems of migrating people when these impinge on them, have had some constructive effect in individual cases but can hardly be said to constitute a basic frontal attack upon the problem. Nevertheless, these efforts constitute the major constructive work now being done in this field.

Jewish migration within the United States would, at first glance, hardly seem to constitute any problem for social work. Itinerant Jewish mendicants, considerable in past decades, are now relatively infrequent and there are very few, if any, Jewish migratory workers. The work of Jewish agencies with transients is, in fact, a relatively minor part of their activity. The transients who do come to the attention of Jewish agencies today are for the most part those who are seeking better opportunities for improvement of their economic, social or health conditions.

It is probable that there has always been some migration by chronic sufferers from certain diseases. This is not restricted to Jewish health sufferers, of course, but they are included. We all know of the drawing power of Denver for sufferers from tuberculosis. The establishment of national Jewish hospitals for tuberculosis in Denver and Los Angeles has continued a pattern of migration for health by some sufferers from this disease, many of them Jewish. To a lesser extent, Denver facilities have also been made available for children suffering from chronic asthma. In Hot Springs, Arkansas, the establishment of

a hospital for the treatment of chronic arthritis has tended to make that community a magnet for health migration by arthritics. However, this migration has been relatively small in quantity and has not impinged too heavily upon Jewish communal responsibility as a whole. In fact, there has recently been some diminution of migration by sufferers of tuberculosis, especially since the increase in local facilities and the questions raised by the United States Public Health Service and other expert sources as to the validity of the claim that climate has any direct relationship to the treatment of tuberculosis.

Nevertheless, the claim that certain climates are beneficial to certain disease has not been abandoned; quite the contrary. Frequent advertising appears in magazines and newspapers in all the big metropolitan communities advertising the benefits of the mild, dry climate to be found in the southwestern part of the United States, particularly in Arizona. Some physicians advise their wealthy and sometimes their not so wealthy patients to seek more "beneficial" climates. Although not as widely advertised, the all year round climate of Miami, Southern California, Texas and New Mexico is similarly alleged to have beneficial effects upon chronic arthritis, rheumatic fever, asthma and various other diseases of the upper respiratory tract. The validity of these claims has aroused considerable controversy in medical circles and there is, in fact, no scientific proof or disproof of their truth. It does, however, seem quite clear that many health migrants coming to these parts of the country feel that they are benefited. Whether the effect is psycho-genic or organic, it is real, and these areas continue to attract health migrants from all parts of the country as well as the well-to-do vacationists for whom the regions advertise. In the Southwest communities like El Paso, Texas; Albuquerque, New Mexico; Phoenix and Tucson, Arizona, are the center of much of such migration. Recently, Miami, Florida, has called attention to the amount of health migration it is receiving. Among the many migrants coming to California, especially Southern California, there is no doubt that a sizeable proportion come for health reasons.

If this were the end of the story it would hardly be necessary for social workers to concern themselves with it. But one of the things that has been happening during the past few years is the increasing amount of social breakdown among these health migrants with the result that a proportion of them appeal to the local social agencies for assistance. And in such cases merely returning the migrant to his original residence, a practice which still represents the outer limits of much of the public and some of the private agency activity with stranded transients, is a rather poor solution for the migrant whose return is likely to renew his suffering. Yet, on the other hand, the destination communities to which these migrants present their difficulties are frequently unable to provide any substantial amount of assistance, either because they are too small or because their facilities are already strained for the needs of local residents. That situation is now coming to a head in the communities of Tucson and Phoenix, Arizona.

Early in 1945 the Jewish Federations of these two communities raised the problem for study by the Council of Jewish Federations and Welfare Funds. Because of the mild, dry climate in the Southwest, a large number of health

seekers have migrated from other parts of the country. This is particularly true of people suffering from arthritis, rheumatic fever, asthma and other diseases of the upper respiratory tract. Many migrated because their physicians recommended that they do so, others because of the advertised benefits of the mild, dry climate.

As might be expected, some of these migrants came to the attention of the Jewish family agencies in the communities, requesting financial, social or medical assistance. The Jewish populations are small, number about 2,500 in Tucson and about 3,500 in Phoenix. The facilities, social and medical, for those needing assistance are inadequate for the needs of these migrants.

Accordingly, the Council studied the situation in Phoenix and Tucson. The report clearly indicates that although the total number of Jewish health migrants coming to these communities is unknown, there is a continuing social and possibly a medical problem among the health seekers. The number seeking assistance from the social agencies is relatively very great and is definitely beyond the capacity of these small Jewish communities to assume the total responsibility for any program designed to meet their needs. During the twelve-month period from May, 1944, to May, 1945, 359 cases were handled by the Jewish family agencies in these two cities. Of this number, over 90 percent were not residents of Arizona. In proportion to the Jewish population, the total number of all cases carried by the Phoenix and Tucson Jewish family agencies was twenty-five times as great as the relative proportion of cases known to the Jewish family agency in Los Angeles. And in Phoenix the load is increasing.

The disease most frequently reported by the clients was asthma, which occurred in 48.8 percent of the cases studied. Next in order were diseases of the upper respiratory tract, reported as bronchial involvements (11.1%) and sinusitis (5.4%), for a total of 16.5 percent. Next in frequency was arthritis, reported in 14.3 percent of the cases. After that came rheumatic fever (8.9%) and heart trouble (2.2%), for a total of 11.1 percent. Least frequent of all was tuberculosis, reported in only 9.3 percent of the cases. There is thus a picture of chronic asthma as the most frequent disease reported, with other diseases of the upper respiratory tract, chronic arthritis, rheumatic fever and tuberculosis following in that order.

The results of this survey were reported at a zone conference held in Phoenix, Arizona, in November, 1946. That conference organized the Southwest Health Committee, with representatives from Phoenix and Tucson, Arizona, and El Paso, Texas. Other affected communities may also join.

It was there decided that further study should be undertaken to determine the places of origin of the health migration, financial possibilities, medical prognoses and to obtain other needed data upon which social planning may be intelligently based. That study program has been undertaken for the Southwest Health Committee by the Jewish Consumptives Relief Association of Los Angeles, California. A medical social worker has been employed and is now on the scene collecting data and gathering material on the basis of which a long-range program can ultimately be determined.

There is apparently a large flow of Jewish health migrants from the metro-

politan Jewish communities all over the country. These include not only New York, Philadelphia, Boston and the eastern cities but Chicago, St. Louis and Los Angeles as well. The Phoenix Jewish Social Service reports that it has had correspondence with the Jewish family agencies and with Hospital Social Service Departments in practically all large communities. The nature of that correspondence has generally centered around requests for medical reports, obtaining assistance from relatives and asking help in formulating plans for maintenance.

When these social difficulties become known in a Jewish community as large as Los Angeles, the responsibility for handling them can be absorbed by the local agency with little real difficulty. Its resources are so large relatively that the care of the occasional health migrant whose social breakdown drives him to seek social agency assistance does not become an excessive burden. But most communities to whose climate the health migrants are attracted are much smaller. Miami, Florida, one of the largest, has 30,000 Jews; El Paso, Texas, has about 2,000; Phoenix and Tucson, Arizona, have between 2,500 and 3,500; Albuquerque, New Mexico; San Diego, California, and others which are similiarly destination points for health migration are small communities. Any substantial program for the care of Jewish health migrants is, therefore, clearly beyond the capacity of these communities unaided. Yet the advertisements from private commercial sources, the referrals by private physicians and other individuals and the reputation of the beneficial effects of the climate in these areas continues to attract health migration. The inconsistency of such a combination of circumstances; the efforts of the communities to attract health migrants on the one hand and their inability to provide adequately for the social breakdown cases on the other has caused an increasingly serious dilemma. That dilemma has now reached the point where two of the communities have called upon CJFWF for assistance in assessing the extent of the problem and helping the communities to find ways of meeting it. One national Jewish agency, the Jewish Consumptives Relief Association, has accepted responsibility for and is now providing support for a one-year medical-social work study of the situation in Phoenix and Tucson.

Certain basic questions are posed in any effort to plan with these communities. Some of these questions are:

Is it desirable to reduce the flow of health migration?

Is it possible to do so? How?

Should not government assume the basic responsibility? Federal? State? Local?

Is it likely that this assumption of responsibility by government will be undertaken?

Why have not other sections of the destination communities raised the question?

Is not the total local community the proper source of responsibility rather than the Jewish group alone?

Is it reasonable to demand that migrants who cannot support themselves in their destination communities, return from their communities of origin? Is it socially desirable?

How much responsibility can the Jewish destination communities be expected to assume for Jewish health migrants needing assistance?

How much responsibility should the larger Jewish communities from which the migration originates be expected to assume?

Through what agencies should responsibility be exercised in these larger communities of origin?

Should a national organization assume leadership in getting destination and origin communities together?

Should some national agency assume full responsibility for meeting the problem?

Would the establishment of medical facilities in the destination communities solve the problem?

Is the major problem social rather than medical?

Would a change in the economic situation in the destination communities, through expansion of industrial and business opportunities for employment, eliminate most of the difficulty?