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SPECIAL ARTICLE

POLITICS IN THE DEVELOPMENT OF A MIGRANT HEALTH CENTER

A Pilgrim's Progress From Idealism to Pragmatism

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Abstract New methods of health-care delivery have been recommended to correct the inequities in the distribution of health services to rural and urban poor. A migrant health center developed in 1970 to accomplish this aim illustrated the many attendant problems. The award of the grant to an outside consumer group rather than to the county health department resulted in political pressures during the center's development. Other factors isolated the center. These included categorical funding specifically directed to a community's ethnic minority and the lack of a regional network of health care. Confusion was created when legitimate spokesmen of the target group, other segments of the local community or interested private and governmental agencies were not defined. Although a program for curative and preventive medicine was established for a minority, the center was less successful in becoming self-supporting and in affecting the social and economic determinants of health. (N Engl J Med 292: 890-895, 1975)

HEALTH care in America has been the subject of many thoughtful reviews.[1-4] There is general agreement that some reorganization of the medical-care system is essential to reach underserved populations. However, this goal is much easier to conceive than to execute. This paper relates the problems encountered in developing a rural health center in a small community. Many problems were unanticipated because the developers of the project believed that the health needs of the migrant farm workers, coupled with the developers' obvious good will and well conceived plan, would galvanize the resources of interested groups to develop a model facility. This naïve assumption underestimated not only the inherent difficulties but also the external and internal pressures that a large federal grant would create. With the passage of time the "sound and fury" has died down, and the health center has become an accepted part of the community.* It seems appropriate now to review the center's early history and to discern its lessons.

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*"A Clinic with Character," *Denver Post*, March 3, 1974.

BACKGROUND

In October, 1969, two unusually severe blizzards in northern Colorado stranded migrant workers in a camp with poor housing, water and sanitation facilities. Militant Chicanos (Mexican-Americans) occupied the camp to dramatize the plight of the workers. Mexican-American students of the University of Colorado in Boulder, who were supporting the workers, asked officials at the University of Colorado Medical Center (UMC) what they were doing to meet the health needs of these and other migrant workers in Colorado. Sensitive to the students' concerns, the dean of the School of Medicine called together interested parties from the medical school, the state and federal governments, and representatives of the health providers in the affected county. It was decided that further study was needed to determine the UMC's responsibility for the provision of health service to migrant workers and to set institutional goals.

The study revealed that health care for migrants is supported mainly by extensions of the Migrant Health Act of 1962 (PL 87-692) that provide limited outpatient coverage. In 1963 the Colorado Department of Health (SHD) received a contract to provide migrant health care. The

program was heavily dependent upon the co-operation of local physicians in a fee-for-service arrangement. Hospitalization was specifically denied under the law because of limited funds. In Colorado the Medicaid program (Title XIX, Social Security Amendment, 1965, PL 89-97) covers only those on welfare or in categorical aid programs including Aid to Dependent Children and Aid to the Needy Disabled. The migrant workers, because of nonresident status, are ineligible for welfare and Medicaid benefits.

Local hospitals are generally reluctant to incur unreimbursable expenses for a migrant's hospitalization, and they frequently refer the patient to the UMC hospital. Although that hospital was designed to serve the indigents of the state, it has made no specific provision for supporting the care of indigent transients from other states. Furthermore, as a result of the hospital's location the majority of service is provided to residents of metropolitan Denver. The care provided to rural residents is sporadic and usually at a secondary or tertiary level. At the time no attempt had been made to set up a regional network of care, nor was there a system of transportation for patients from outlying areas.

Abbreviations Used

Camp:	Camp of stranded migrant workers
CHD:	County Health Department
CHPC:	Comprehensive Health Planning Council
FUND:	Foundation for Urban and Neighborhood Development
HEW:	Department of Health, Education, and Welfare
MHS:	Migrant Health Section
SHD:	State Health Department
UMC:	University Medical Center

It was concluded that such a network would help all rural residents, including migrant workers, and its formation was recommended as a long-term goal by the study group. Short-term goals included the establishment of Sunday clinics during the migrant season in high-impact areas and facilitation of referrals for admissions and outpatient care at the University Hospital. The UMC administration agreed to solicit funds to underwrite bills incurred by the migrants. During the three months of the study, the occupation of the migrant camp ended, and pressure on the university for action abated.

Development of the Health Center

In March, 1970, appropriations for the Department of Health, Education, and Welfare (HEW) were finally authorized by the passage of PL 91-209. Funding for migrant health was increased by $6 million. Assurance was given that the entire increase would be allocated even though there were only three months of the fiscal year left for disbursement. Rather than spread the money thinly over existing projects such as the one in Colorado, the Migrant Health Section (MHS) of HEW decided to encourage the formation of comprehensive health centers at 10 or 12 locations along the "migrant stream."

The MHS solicited a proposal from the UMC, which was believed to be a unique position to develop such a program rapidly. After discussing the implications of the proposed migrant program, the UMC officials decided not to submit a grant request but to support another grantee if one came forward. Their response was based on the fear of the following developments: commitment to a potentially open-ended service activity for one ethnic group that could set a precedent for demands by other groups; involvement in a project fraught with potential consumer and professional conflicts, compounded by the UMC's inexperience with the problems of migrancy and Chicanos; and competition of such activities with traditional research and teaching goals.

The MHS representative then approached other potential grantees. He met with the county-health-department (CHD) director and representatives of the county medical society from the area of greatest migrant concentration. It was hoped that they might develop a successful program that would provide a model for other medical societies and physicians in rural localities. A number of local physicians were not completely sold on the concept of a migrant clinic. However, when it became clear that a well conceived health program had a good chance of receiving funding, the CHD director submitted a proposal to develop a clinic in the county seat that would be open to all low-income people of the county. Although a laudable objective, this plan was contrary to the requirement of the migrant health program that, as much as possible, the clinic resources be used for migrants. Furthermore, the MHS wanted the project to be located near the camp instead of in the county seat 42 km away. Because it was becoming increasingly sensitive to the need for consumer input, MHS did not favor funding a local health department. It also feared that the award of a large federal grant might result in efforts to decrease tax support of the CHD, which was already considered to be underbudgeted.

Other organizations approached included two large, established group practices and consumer groups. Among the latter was the Foundation for Urban and Neighborhood Development (FUND), a nonprofit foundation established in 1967 composed of a professional advisory board and a permanent staff of sociologists, lawyers, migrant workers and settled-out migrants. FUND's major projects at the time were community development with American Indians and Chicanos (primarily in Head Start), a program for settlement of migrants from the "migrant stream" and the development of low-cost housing.

FUND's only experience in the health field was an association with public-health and UMC-based physicians in the initiation of a highly successful urban neighborhood-health program in Denver.[5] These physicians served as FUND's medical consultants. FUND's grant proposal placed emphasis on the composition of the health-care team, which included "inside" personnel (physicians, nurses and family caretakers) and "outside" personnel (drivers and "consejeros" — the acknowledged leaders and advisers in the Mexican-American community). As a result of its migrant settlement project, FUND had identified a number of such respected members of the migrant group and the settled agricultural workers, and planned to rely on them as its natural allies in the delivery of health care. Steinman has described a similar team member called a "home front worker" in a health project in rural Kentucky.[6]

FUND knew that even though a health center was accessible, its use would not be guaranteed.[1] It was conscious of the ethnic and language barriers to health care, and emphasized the importance of the center's being bilingual and culturally relevant, including respect for folk medicine.[7-10] It planned to hire community members and train them on the job as technicians, nurse aides and family caretakers (similar to case aides). FUND subscribed to the World Health Organization definition of health as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[1] In short, it believed in all the "right" things. It is not difficult to see why the FUND request ranked third nationally, well ahead of the competing proposal from the CHD.

In May, 1970, a meeting was held in the MHS office in Denver to announce the provisional award of a grant to the FUND group. The federal representatives, hoping to forestall any bitter infighting, noted that Colorado was fortunate to get funds and urged that the competing groups come together to work out their differences. Everyone agreed that it would be difficult, at best, to establish a health center and that destructive competition should be avoided.

This apparent consensus did not prevent several of the parties from feeling aggrieved. The CHD honestly thought it should have been awarded the grant because of its integral place in the community and its ability to provide immediate medical service. The SHD representatives believed that the extra migrant health money should have been given to them to improve their established but underfunded migrant health program. Despite meetings that were held to attempt reconciliation, efforts were begun to transfer the grant award from FUND to the CHD. Letters were sent by the CHD and SHD directors to congressmen, senators and the Secretary of HEW protesting the procedures in awarding the grant. Local physicians and the CHD director traveled to Washington to visit with members of the Colorado Congressional delegation and the Department of HEW in early July. Their principal complaint focused on FUND's failure to clear its proposal with the county Comprehensive Health Planning Council (CHPC), whose membership included some of the developers of the competing grant proposal. However, there was no requirement at the time for CHPC review of health-center proposals.

Pressure was brought to bear within the UMC because some of its faculty members were supporting FUND. The University's vice-president for medical affairs met with the faculty members, determined that their participation was consonant with previous university commitments of support and did not attempt to curtail their activities. The Colorado Medical Society was petitioned by the county medical society to hold a hearing with SHD and CHD directors, MHS representatives, county-medical-society and UMC physicians to review the procedures in the awarding of the grant. This hearing, held in July, ended amicably with a pledge of co-operation from all sides. A major reason for this show of harmony was a letter of support addressed to FUND by the president of the county medical society. However, in September both the MHS and FUND were censured at the annual meeting of the Colorado Medical Society by its House of Delegates on the unopposed recommendation of its Public Health Committee. This recommendation stemmed largely from efforts of a local physician who had been active in the group that had submitted the competing grant proposal.

In November a letter from the Secretary of HEW, Elliot L. Richardson, to the SHD director dashed any hopes that the grant might be withdrawn from FUND. The letter read in part:

> The reviewers determined that both were good proposals but that the FUND application documented closer ties with the migrant worker group, presented a more innovative approach to team medicine, and met our criteria for more comprehensive coverage by focusing its limited funds on a smaller population. Failure to arrange for all appropriate reviews of the FUND application by state and local agencies was caused in part by the delay in receiving additional funds and in part by changes in administrative procedures. The legislation extending the Migrant Health Act, signed by the President in March, requires involvement of consumers of services in development and implementation of migrant health projects. Thus the new funds which became available late in the fiscal year had to be committed to projects with significant consumer involvement. This change in program focus, coupled with the problems of implementing decentralization of this grant program placed unusual demands upon our staff and resulted in a disruption of the regular review procedures.

Mr. Richardson then went on to outline his plans to prevent a recurrence of such problems in the future.

A Brief Look at the Aftermath

Since the migrant season had begun six weeks before the grant was awarded and the health care available to the migrants was extremely limited, there was considerable pressure by the consumers and the MHS to provide comprehensive health services quickly. Although the recipient of a large health grant, FUND had no medical expertise. In the beginning medical participation came solely from UMC physicians who acted as consultants. The operational staff, including physicians and nurses, had to be hired. This step was beneficial to the program because the migrant workers helped in the selection of all staff members. However, the recruitment process was not optimal since it could not begin until funds were allocated, and by that time (late May) most physicians had made commitments elsewhere for at least a year. Since a new building was not included in the grant award, remodeling of a warehouse was undertaken. A rented apartment nearby served as a base for minimal clinical services until the remodeling could be completed.

It is gratifying to note that the center has survived and has met a number of its original goals. Although it does not provide all the comprehensive health services that were once planned, it has made a substantial impact on delivery of medical and dental care to an otherwise excluded minority. One short-term goal was to provide preventive and acute health-care services to 2000 seasonal agricultural workers and their families. In 1973 the clinic recorded 12,365 medical, 3642 dental and 3841 consejero services. Other goals that have been met are the provision of health-care employment opportunities for members of the seasonal agricultural group, principally as nurses, nurse aides, consejeros, medical technicians, and dental

assistants. Furthermore, the emphasis on language and cultural understanding has greatly influenced the accessibility and atmosphere of the center.

Consumers were involved from the outset in the establishment, governance and operation of the health-care facility. FUND's original plan was to phase itself out in two or three years or as soon as the health program could be transferred to a representative consumer group. It was officially dissociated in 1972, and the grant award turned over to the consumer group. The health center's goal of self-sufficiency has not been met because of the near-indigent condition of its clientele and the lack of a national health-insurance plan. However, it has obtained funds for a demonstration program to provide migrant hospitalization. Furthermore, a substantial increase in funding from Public Law 89-749 Sec. 314E has allowed for expansion of its service to other rural poor. Services have also been expanded to include those with an ability to pay, which has augmented the accounts receivable.

As noted, much of FUND's energies for the first 5½ months of the grant year were devoted to survival. The provision of traditional medical care was also hampered by the expenditure of much energy in other areas. Since FUND believed that health was just one dynamic in social change it hoped to tie in development of housing, sanitation and a migrant co-operative for transportation and food. The members of the staff entered into local negotiations involving zoning for housing as well as into controversies surrounding alleged prejudicial handling of Chicanos by the schools and police. Although diffusing somewhat the development of medical care, these activities did reinforce FUND's ties with the target population.

Much bridge building has occurred since those early turbulent days. The town police department has become a staunch supporter and has presented a good-citizenship award to the center. Two settled-out migrants serve on both the center's grantee board and the school board. The relation with the CHD has greatly improved. The major factors responsible for this were the award by the MHS of a smaller grant to the CHD to establish a migrant program at the county seat and the change in the health center's management, with an almost complete turnover of personnel, as well as the appointment of a new CHD director, allowing issues to be faced on their own merits instead of being affected by past differences. This better atmosphere has been translated into integrated planning to prevent duplication of services. Furthermore, the health-center grant-renewal application is now reviewed annually by the CHPC.

Discussion

In examining the health center's early history, one can recognize a number of general problems that either slowed its development or caused strained relations among the groups involved.

In the first place the standards for submission and review of grants in health-care delivery programs are not well defined. Unlike those for research in basic science or clinical fields of medicine, which require acknowledged expertise, proposals may originate from consumer and professional groups with divergent philosophies and varying strengths. In this case, the CHD had the medical expertise as well as a management structure. FUND, although weak in these areas, had a more innovative health-care approach and better consumer ties. Neither potential grantee was ideal, and compromises had to be made. Although this diversity of choice may occasionally be disadvantageous, it is useful in that it allows for nonestablished groups to attempt innovations.

The review of proposals for such programs is also difficult. In traditional biomedical research it is much easier to define appropriate reviewers who are acknowledged leaders in their fields. The repositories of theoretical and practical expertise in health-care delivery, however, cannot be so easily identified. In addition, in contrast to the laboratory, where variables can be defined and controlled, what works in delivery of care for a specific population in a certain area may not necessarily work in other areas. Even if appropriate reviewers can be defined, there are many agencies that believe they must have a say in the award and the development of such contracts. The granting agency and the grantee are expected to consult medical societies (county, state, and national), county and state health departments, comprehensive health-planning agencies, third-party carriers, neighborhood and other consumer groups and local, state, and federal elected officials. Even when all concerned groups seem to be involved, important people or agencies may be unwittingly excluded.

Secondly, the time constraints in the funding process compromised success. The approval by Congress and the release of funds near the end of the fiscal year telescoped the time available for development and review of proposals. There was hardly enough time to write a coherent and honest proposal, let alone co-ordinate involvement of interested but philosophically divergent groups. Once the contract was awarded, results were expected quickly not only by the consumers but also by the MHS, which wanted to vindicate its choice of grantees. Unfortunately, many government grants are still made in the same manner. Funds for some programs are delayed almost interminably while other "windfall" appropriations occur that make expenditure necessary in a very short time. It is obvious that the funding of future experiments in health care should be more carefully worked out. Furthermore, funding should be graduated to allow for planning and development.

Thirdly, the development of health-care models by outside organizations infringes on any community's established framework. Even in the best of situations such infringements can generate political pressures to which state universities and governmental bodies are particularly vulnerable. A university's reluctance to enter the fray may be reinforced by internal disagreements about the compatibility of social programs, often labeled "service," with traditional goals of teaching and research.[4,11] In view of recent efforts to commit health professionals on graduation to work in underserved areas, it will be incumbent on universities to assume a leadership role in reorganization and redistribution of medical care despite the attendant external and internal risks.

Fourthly, valuable time needed for the planning and

execution of this project had instead to be devoted to seemingly interminable meetings with concerned groups —both professional and lay — to promote "co-ordination and communication." Such words implied a willingness on the part of all parties to work together and develop a trust relation. In this case divergent attitudes and preconceived notions about "establishment," "longhairs," "power" and the like made trust a scarce commodity, and adversary relations developed. The co-ordination of groups with such discordant philosophies would have been difficult at best but was further complicated by the unhealthy competition for the grant award alluded to earlier.

As in most projects conceived to do "good" and to redress injustice, certain people both in FUND and in those opposed to FUND were convinced of the clarity and completeness of their vision and the purity of their motives. Challenging these convictions resulted in ego bruising, which then led to attempts to vindicate their own position and to neutralize the power of the conflicting group. Some members of one competing faction attempted to marshal allies to sway the funding agency and consumers concerning the legitimacy of their aspirations vis-à-vis the other faction. Such tactics only resulted in bitterness and were confusing to the consumers. This development was not only bad politics but bad policy since it was counterproductive to the achievement of the goal, which required co-operation of all concerned.

Such behavior is not unique when groups of divergent interests are involved. There is urgent need for a mediator who not only understands human nature but has a historical perspective on the groups involved and the methods that they employ. The mediator must have the power to appeal to the self-interest of all the groups, so that mutual problem definition and resolution is advantageous. He must be able to identify those who would rather "go it alone" or see a project go down to "glorious defeat" rather than compromise. Unless such attitudes are dealt with, they vitiate any attempts at co-operation. In this case the MHS representative, a two-year physician assignee who supervised the award of the grant, might have filled that role. However, his term of duty ended at the initiation of the project, and he was not replaced.

Fifthly, identification of the consumers was difficult. Since the award was from the MHS, migrants were the principal consumers. Yet by definition they are a transient group. Some could be identified as traveling the same route year after year, but others could not. An easier group to identify was the "settled-out" migrants. An attempt was made to develop a consumer board that was truly representative of migrants and their settled counterparts, but it was difficult to determine if the board members really spoke for the migrant community. Even if they did so initially, there was some question whether they would continue to do so after they became a part of the board. The possibility that they would be co-opted by the clinic's leadership was a major concern of the consumers and of FUND itself. Also, the consumers had no expertise in health or decision making involving large amounts of money or in dealing with the kinds of problems with which they were presented. As others have noted, the development and training of such consumers is difficult.[12-16] The history of the development of the group that evolved into the grantee board is beyond the scope of this account. Suffice it to say it was a painstakingly slow process for all concerned.

Finally, the categorical nature of the funding tended to isolate the target group. Such categorical funding stems from the admittedly unique needs of the population. In this case transiency, formidable cultural and language barriers and economic deprivation (especially inadequate wage and bargaining rights) make the migrants more vulnerable and also under-represented at the state and federal levels. On the other hand, many of their problems are not unique. Professional services, including health care, have been declining in rural areas for a number of decades. Many other rural and urban residents are also victimized by the lack of a comprehensive national policy for health-care distribution and financing. In this case the admitted need for better rural health care for all could not be met by a small program funded specifically for migrants. Although such programs are important, health-care problems cannot be solved separately for specific groups. Not only do some people construe such programs to be unfair but these programs are less efficient than if they were integrated into a regional network of care. However, as in the case described, it is advantageous if emphasis on the needs of the most excluded segment of a community precedes broadening of services.

Health problems cannot be solved without addressing other important aspects of the community's health such as housing, jobs, and transportation. Programs that focus on curative medicine without major attention to these traditionally nonmedical areas will achieve at best a marginal success that falls short of everyone's expectations. Such a massive endeavor, however, cannot be carried out successfully by small individual groups but requires considerable co-ordination of public and private sectors. No matter what form the future reorganization of the health-care delivery system takes, since physicians will continue to play an important part, increased attention must be given in the medical curriculum to preventive medicine, economics, political science, ecology and behavioral science.

We acknowledge the memory of Andy Hernandez, whose untimely death saddened us all, and the help of Gabriel Llanas, who drew on his many years as a migrant to help us understand better. We are also indebted to Jim Kent, Art Warner and all the others, whose enthusiasm, energy and ideas made the project possible, to Dr. Peter Dawson, Ms. Connie Coldiron and the present clinic staff of Plan de Salud del Valle, who contributed suggestions for revision of the manuscript, as well as data on the current activities of the program.

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MEDICAL PROGRESS

BONE-MARROW TRANSPLANTATION (Second of Two Parts)

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Current Problems

uccess or Failure of Marrow Engraftment and Marrow-Graft Rejection

A review of the literature of human marrow transplantation before 1967 showed a high incidence of complete ailure of engraftment.[113] Failure of initial allogeneic engraftment is no longer a major problem. Excluding five patients who died too soon to be evaluated, 33 of 34 grafts in patients with aplastic anemia were successfully established, and 63 of 68 in acute leukemia were successful. The quantity of marrow infused ranged from 1.1 to 10.9 × 10^8 per kilogram of recipient body weight (Table 4). Despite this range of one order of magnitude, there was no correlation between marrow dose and success or failure of engraftment nor of nadir of white-cell count or time to recovery above 1000 per cubic millimeter. Although there has been concern about the dose of marrow cells required for engraftment[114] precise determination of this number seems to be neither practical nor necessary.

Experiments in canine littermates matched at the major histocompatibility complex have shown that prior exposure to transfusion of whole blood from the marrow donor may jeopardize the success of a subsequent marrow graft even in this "compatible" donor-recipient combination.[50,51] Data similar to those in dogs have been reported in irradiated mice[115] and also in mice treated with cyclophosphamide.[19] Presumably, rejection was due to immunization of the recipient to histocompatibility antigens on platelets and leukocytes. With blood transfusions from random donors or from family members other than the marrow donor, immunization of the recipient and rejection of the graft might be expected only when the marrow donor and the transfusion donors share "minor" histocompatibility antigens not present in the recipient. The results of allogeneic marrow grafting for the treatment of aplastic anemia have shown that patients given transfusions from family members have a high rate of failure of marrow engraftment or of marrow-graft rejection.[100] The two patients who had not been transfused before grafting had prompt engraftment and are among the long-term survivors. One patient who rejected his graft had had transfusions from both parents, which should have exposed him to the risk of sensitization to all family "minor" transplantation antigens that he did not inherit. Although Mathé et al.[10] had earlier reported an apparent harmful effect of transfusions before grafting in patients with leukemia, we have not observed graft rejection in our patients with acute leukemia, and most of the failures of engraftment occurred in the earlier patients. More aggressive modern chemotherapy is one explanation for this differ-

Table 4. Marrow Cells Infused and Days Required for White-Cell Count (WBC) to Go above 1000 per Cubic Millimeter.

Disease	No. Analyzed	Marrow Cells Infused		Day WBC>1000/Cubic Millimeter	
		median	range	median	range
		$x\ 10^8/kg$			
Aplastic anemia	34	2.6	1.1-9.4	17	5-37
Acute lymphoblastic leukemia	31	3.3	1.4-10.9	21	11-35
Acute myelogenous leukemia	32	3.0	1.1-6.4	22	12-37

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acknowledged a problem that we are particularly interested in: conflicts between primary-care physicians and subspecialty consultants. At the Beth Israel Hospital the primary-care physicians were actual members of the hospital staff. We suspect that these conflicts are even greater when the patients are from primary doctors outside the hospital. To our regret, the authors did not discuss how they dealt with these conflicts, or how they provided good continuity of care for outside referring physicians.

Numerous students of the American health-care scene have underscored the need for solid lines of communication between primary-care providers and other tiers of the health-care system.[2-4] When patients are referred by a primary physician to a center for secondary or tertiary care, the quality of "follow-up" information the doctor receives is a good measure of these lines of communication. A study that we are conducting on this provider-to-provider communication has corroborated our suspicions that university centers, in their attempts to reorganize their outpatient facilities, should certainly address themselves to the role of outlying physicians.

Our particular practice is located within 80 km of two university medical centers and their nearby nests of subspecialists. We are currently examining what factors influence the quality of follow-up information that we receive on patients referred to these various secondary and tertiary centers. We use rigid standards for referral: no patient is referred without a personal telephone call to the consultant, an introductory letter, pertinent x-rays and laboratory reports, and a written request for follow-up information.

To date, after some 200 referrals, we have received follow-up data in only 75 per cent of cases after a waiting period of 60 days. Private subspecialists have provided follow-up information in over 90 per cent of cases, but that from university-based subspecialists is only 65 per cent. We assume that referring physicians using less rigorous referral standards receive even less follow-up communication.

Whereas we applaud the Beth Israel Ambulatory Care experiment, we wonder if their new system has broadened its sense of responsibility to encompass the follow-up needs of outlying physicians. Are other referring practitioners in Boston, and across the country, experiencing the same poor communication that we are?

Richard O. Cummins, M.D.
Robert W. Smith, M.D.
Louisa, VA National Health Service Corps

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MIGRANT HEALTH CENTER

To the Editor: The paper by Dans and Johnson on "Politics in the Development of a Migrant Health Center" (April 24 issue of the *Journal*) is an important analysis of community-medicine history and issues.

The authors have been scrupulous in avoiding value judgments and perhaps for that reason did not mention the rather unimaginative performances of some state and county health departments that received migrant health funds in the six or eight years before the major funding change in 1970. The authors refer only to the problem that in the early years of the Migrant Health Act the funds were spent by county health departments in (expensive) fee-for-service arrangements with local physicians. An even greater problem arose from the fact that most of the migrant health funds in those years did not go into direct service for the target group but rather were used to supplement county health-department payrolls — for example, by paying 10 per cent of the health officer's salary, 50 per cent of a public health nurse's salary and perhaps 100 per cent of a sanitarian's salary. Presumably, additional services were to be provided to migrants and migrant camps as a result of the increase in personnel that the funds permitted. Such additional services were often hard to identify qualitatively and impossible to quantitate.

The implications of the migrant health experience are important for the health-care changes that lie ahead. The "rationalizing" of the health-care system is not rational at all to an agency whose very life blood flows from fragmented funding procedures. A period of chaotic transition, controversy and resistance should be scheduled as a part of the planning and early operational processes in changing delivery patterns. Participation in the resolution of the chaos and conflict provides a tremendous learning experience in health-care issues for medical students, for residents, and sometimes for old hands.

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To the Editor: In 1970 an insurgent group at HEW changed the policy of the Migrant Health Program (MHP) to concentrate its resources in large comprehensive health projects.[1] The recent *Journal* article[2] describing the political evolution of one resultant project in Colorado illuminates the local results of this policy change.

The MHP unquestionably needed change. Before 1970, projects were small (average of $61,000) and widely dispersed, sponsored by health departments with conflicting priorities and misleading precedents, overbudgeted for nurses and sanitarians, underbudgeted for physicians, and incapable of responsive care of good quality.[1] Stymied by the entrenched nature of these grants, the would-be innovators seized the "new-money" windfall in the fiscal-year 1970 HEW appropriation to effect change with uncommitted funds.

Dans and Johnson comment that "the time constraints in the funding process compromised success." Desirable as lead time usually seems, the short action time (three months) caused by the lateness of the appropriation was an absolute prerequisite for reform, and, thus, for the Colorado project to be funded. Health departments, private physicians, and others would lose (or thought they would) from the new policy of concentrating resources. Given time, all would have made ample use of the leverage of their sympathetic Congressman. Likewise, within HEW, the forces of the past and "conserverism"[3] would have regrouped and ultimately triumphed. As it happened, however, by the time the forces of opposition had mobilized, the innovative forces within the Public Health Service had acted, the grants had been made, and HEW was bound to rationalize its position and support the projects.

The insurgents expected that, in Colorado as well as several of the other projects funded,[4,5] there would be periods of local upset and transition as described by the authors, and trusted that the final equilibrium would be advantageous to the migrants. The Colorado experience is probably typical in requiring wearying effort but producing marked success. According to the report of Dans and Johnson, the center is delivering good-quality, comprehensive, accessible, and acceptable services to a substantial number of migrants who were ill served previously. It is supplying jobs for members of the service population, serving as a focus from which health issues unrelated to medical care can be addressed, and it is a nidus around which other health programs can accrete. Its introduction seems to have brought the migrants into local political life for the first time.

The Health Revenue Sharing and Health Services Bill of 1974 (HR 14214) sought to double the MHP authorization and require the MHP to promote more Colorado-type centers in high-impact migrant areas. President Ford vetoed the legislation in December, citing cost as a problem,[6] but Congress will submit a similar

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New England Journal of Medicine

bill to the President soon. It is to be hoped that logic and experience will prevail, and that the new bill will be signed into law.

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5. Aron M: The culture of bureaucracy: dumping $216 million on Bakersfield. Washington Monthly, October, 1972, pp 23-32
6. Ford GR: Memorandum of disapproval. Vail, Colorado, December 23, 1974

The above letters were referred to the authors of the article in question, who offer the following reply:

To the Editor: The letters of Drs. Gilson and Shenkin are complementary and are important additions to our article. Dr. Gilson is correct in that we tried to avoid value judgments and therefore did not go into much detail in the area to which she refers. One of the reasons the migrant health program did not favor funding the county health department was the very reason she cited — namely, the past practices of many health departments of supporting positions that only marginally or intermittently served the target group. We agree with her comments on the implications of the migrant health experience on change in other areas.

We appreciate Dr. Shenkin's comments on what might be called the "hidden agenda" of the migrant health program. From our vantage point, however, we can only speculate that the scenario was as he proposes. As he perceptively notes, the same time constraints that compromised successful planning were essential for the project's birth. As he suggests, forces for change do not have time "to get everything together" since too much time can be used by opponents of change to subvert it. It is an important dilemma to recognize because change agents can be faulted by established organizations (as noted in the article) for not "touching every base" and for not proceeding in a more systematic and studied fashion. We agree that without such a change in migrant-health-program funding, a number of the benefits that he cited probably would not have occurred.

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SAM JOHNSON, M.D., M.P.H.
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To the Editor: The account by Dans and Johnson of the origins of the migrant health center in Fort Lupton, Colorado (N Engl J Med 292:890, 1975) afforded a good discussion of the politics leading to the awarding of the money to a consumer-oriented group, the Foundation for Urban and Neighborhood Development (FUND). Perhaps some lessons from subsequent experience there, as learned by one who was medical director in 1971-1972, will be of interest.

When the center began, FUND was a team of just half a dozen people. They worked with small groups of people — for example, Head Start parents — helping them to articulate their concerns and to learn to work together, to remedy the powerlessness of the poor. Emphasis was on listening to people, on learning from experience, and on fostering active participation by everyone. Decisions were made informally by group discussion.

Favorable results of this approach were the sensitivity and community involvement of the clinic staff. Half the staff members were from low-income, Mexican-American backgrounds. English-speaking staff members learned Spanish and during the winter visited migrants at their homes in Texas. The atmosphere of the center was warm and informal, and sometimes people came just to sit in the waiting room because they liked being there. The center was an exciting place to work in.

At the same time, the informal style of making decisions led to problems. The first of these was partially due to the fact that FUND was in Denver and the health center was in Fort Lupton, 40 km away. Half the FUND staff stayed in Denver; half worked in Fort Lupton. FUND in Denver was the recipient of the grant and provided occasional suggestions and directives that irritated the staff in Fort Lupton, who came to reject the authority of the group in Denver. The Denver group fired the project director in Fort Lupton, demoralizing and angering the staff there. The conflict might have been avoided if the authority and responsibility on both sides had been clearly defined and consistently adhered to, but under the circumstances that was impossible. The conflict was at last resolved when FUND turned the grant over to the local elected consumer board.

We also learned the necessity of defining the job of project director. After the first director was fired, a second one took over, selected by the Fort Lupton staff. He was not expected to make most decisions, but to raise issues for discussion and resolution. But that changed when the consumer board took over. He was expected to carry out the board's policies: not to listen to the staff but to direct it. That was not clear at first.

The role of the consumer board also had to be defined. Soon after the board assumed control, it began to review the director's decisions about every person he hired. The staff resented this practice. The board fired the director, the staff closed the clinic down, a compromise was reached, and the clinic reopened. The director left several months later. A new director has since come on the job, and things are going more smoothly.

In this area, as in others, the emphasis on everyone's participation in making decisions led to confusion and conflict, and it took time for lines of authority and responsibility to become clear.

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Letters to the Editor should be typed double-spaced (including references) with conventional margins. The length of the text is limited to 1½ manuscript pages.

PEEP, SHAW AND CHURCHILL

To the Editor: The correspondence section of the *Journal* has recently reached a peak of exciting reading. Surely, the most delicious exchange of letters over the past years must be associated with Best PEEP (N Engl J Med 292:1130-1132, 1975).

It was strongly reminiscent of that classic exchange of telegrams between the late George Bernard Shaw and Winston Churchill occasioned by the opening of a new play by Shaw.

To Winston Churchill:

Sending 2 tickets to my opening night stop
Please come stop Bring a friend stop
If you have one.

George Bernard Shaw

To George Bernard Shaw:

Sorry unable to make opening night stop
Will come second night stop If you
have one.

Winston Churchill

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