THE PRESENT SYSTEM OF DELIVERING HEALTH CARE TO THE MIGRANT CHILD

March 25, 1980

The Committee on Community Health Services has investigated health care delivery systems in several sections of the United States. Comparisons were made of these diverse systems and the populations they served. In the context of other population-specific health delivery systems, it is apparent that health services to the migrant child and family are, in many instances, non-existent. In areas where health services are available, they are fragmented, episodic, and limited in scope - which results in less than optimal care. This fragmentation exists in the home base states as well as in states along the migratory route.

The reasons for provision of less than optimal health care for migrants are numerous; but, for the most part, they result from a lack of leadership, concern and involvement in the top echelon of government. For example:

1. Departments of the federal government that deal with the migrant population (i.e., Departments of Labor; Agriculture; Health and Human Services; and the Department of Education) have failed to agree on a definition of "migrant." This leads to confusion and duplication of effort and, consequently, to a duplication of expenditures at the federal, state, and local levels in the delivery of health care to this unique segment of society.

2. Migrant parents' choice of health care services are based on the following factors: distance to the service, cost, attitudes, ability to speak the native language, and/or ability to appreciate cultural needs. No one agency meets these criteria in a given area.

3. At least 18 federal and state programs have been identified by the Committee as having input, funding, or program requirements related to the delivery of health care to migrant families. Each program has a different eligibility requirement. There is little or no coordination or definition of responsibility between the programs. At the state and local levels, the migrant is financially disenfranchised. As a result, the migrant is denied access to national programs (such as Title XIX) which were developed for poor children and their families.

The Committee focuses on health care; however, housing, sanitation, social services, nutrition, and health education must also be considered if the health problems are to be solved. Migrant families generate hundreds of millions of tax dollars, yet they frequently have been denied access to health care. The Committee on Community Health Services proposes that the Academy assume a leadership role in seeking a solution to problems of inadequate health care for migrant children.

GOAL

An accessible, comprehensive, and continuous health care system to meet the unique needs of the children and families of migrant workers should be provided.

OBJECTIVES

The following objectives should be met:

1. Define "migrant worker."
2. Identify "home bases" and health care services.
3. Define the population at risk.
4. Identify and provide for sources of medical care.
5. Establish health care systems at "home bases."
6. Develop a tracking system.
7. Identify federal and state health care systems.

Define "migrant worker"

A single definition for "migrant worker" should be established.

Identify "Home Bases" and Health Care Services

All major "home bases" and available health care services should be identified. A "home base" is the geographic area at the start of a migrant stream in which significant numbers of migrant families reside between growing seasons. Three major home bases have already been identified:

1. Southern Florida (East Coast stream),
2. the Rio Grande Valley and Southern Gulf Coast region of Texas (mid-continent stream), and
3. the San Diego area in California (West Coast stream).

A short-term objective is to identify other significant home bases. A long-term objective is to identify the health care systems for the care of migrant families at "home bases," which would include both private and public resources.

Define the Population At Risk

The population at risk should be defined, especially regarding the following data:

1. Geographic locations of the populations at risk, including diffusely scattered groups of migrants.

2. Demographic description.

3. The health status of the demographically defined population at risk. Health status would be determined by the use of health status indicators: infant mortality rates, fetal mortality rates, incidences of reportable diseases, immunization rates, teen-age pregnancy rates, accident rates, and so forth.

Identify and Provide for Sources of Medical Care

Sources of medical care should be identified and provided for at all levels along the migrant stream. (The identification of public and non-public agencies providing care for migrants is also incomplete and inaccurate.)

At the present time, sources of health care along the migrant stream appear to be inadequate and incomplete, and many migrant workers obtain health care along the migrant stream from practitioners in the private sector.

Establish Health Care Systems at "Home Bases"

Proper health care systems should be established at each major home base designed for the population at risk. Many components of the health care system are already established at major "home bases." A short-term goal is to determine the adequacy of these systems and the integration of existing systems with new systems specifically designed for the population at each "home base."

Develop a "Tracking" System

A "tracking" system with two-way communication should be developed along the migrant stream. The present systems are inadequate and, in many instances, disorganized. As a short-term objective, the Educational Tracking System presently in place should be investigated for adaptation to the needs of the migrating population.

Identify Federal and State Health Care Systems

The morass of federal and state systems and programs - with their varying entry requirements - which attempt to meet the health needs of children of migrant workers should be identified. This identification will highlight the areas of health care duplication, overlap, fragmentation, and omission. It also will provide a basis on which a more rationale approach to achieve an accessible, comprehensive, and continuous health care system can be organized.

IMPLEMENTATION

1. The Academy should take the lead and seek the collaboration of provider, consumer, and employer groups in preliminary planning for migrant health care. Provider groups might include Academy Fellows, the American Academy of Family Physicians, and the American Medical Association. Consumer groups might include migrant councils and farmworkers unions. Employer groups might include farmers, canners, and so forth.

2. Health care planning should be initiated under the umbrella of the collaborating group.

3. The health care plan should be presented to the proper legislative entities to facilitate implementation of the plan.

COMMITTEE ON COMMUNITY HEALTH SERVICES

Fernando A. Guerra, M.D., Chairman
Antoinette P. Eaton, M.D.
Louis L. Fine, M.D.
Paul H. LaMarche, M.D.
J. William Oberman, M.D.
Barnard Portnoy, M.D.
Theodore D. Scurletis,M.D.
Earl Siegel, M.D.
Stewart C. Wagoner, M.D.

Willis A. Wingert, M.D., Chairman,
Section on Community Pediatrics

This statement has been revised and approved by the American Academy of Pediatrics' Council on Pediatric Practice.

TPR:ms
5/12/80

American Academy of Pediatrics

P.O. Box 1034 1801 Hinman Avenue Evanston, Illinois 60204

Section on Community Pediatrics
Willis A. Wingert, M.D., Chairman
213/226-3600

Committee on Community Health Services
Fernando A. Guerra, M.D., Chairman
Thomas P. Robb, AAP Staff 312/869-4255

MAY 15, 1980 - UPDATE

DELIVERY OF HEALTH CARE TO MIGRANT CHILDREN

Pediatrician, Pediatric Nurse Associate, Clinic, or *M.D. - Family Practitioner	Services Available
CALIFORNIA	
Hurwitz, Samuel, M.D., FAAP, Guadalupe Health Center, 75 Wellington Avenue, DALY CITY 94014 415/755-7740. (Allergy) (HEW Health Clinic)	CO,SL,S
* Harrington, Donald, M.D., and Friemoth, Jerry, M.D., 1140 Third Street, LIVINGSTON 95334 209/394-7913 (NHSC)	CO,SL-Portuguese (S)
* Barnett, Richard C., M.D., Community Hospital, 3325 Chanate Rd., SANTA ROSA 95402. 707/527-2907 (Health Department) (Family Practice Residency Program - Sonoma County Community Hospital - Public Health Clinic)	CO,S,SL
COLORADO	
* Gilman, Harold E., M.D., 3405 Downing, DENVER 80205 303/623-6171 (Private Practice)	CO,S,SL
GEORGIA	
* Yager, Howard S., M.D., P.C., 3109 East Shadowlawn Avenue, N.E., ATLANTA 30305 404/261-1165 (Private Practice and HMO)	CO (SL)
ILLINOIS	
* Dekker, Anthony, D.O., 5200 S. Ellis Avenue, CHICAGO 60615 312/947-3000. (Adolescent Clinic, especially family planning)	CO,SL,S

*Denotes information received from the American Academy of Family Physicians

Code for Services Available: CO-Comprehensive Care - all services, except those indicated ( )

1.	General Pediatrics	4.	Behavior or Psych.	7.	Hearing	10.	TBC Test
2.	Well child supervision	5.	Laboratory	8.	Vision	S.	Social Services
3.	Screening	6.	X-ray	9.	Immunization	SL.	Spanish spoken in office

Pediatrician, Pediatric Nurse Associate, Clinic, or *M.D.-Family Practitioner	Services Available
INDIANA	
* Crouse, Ben, M.D., 2441 State Street, LAFAYETTE 47905 317/474-4458. (Private practice)	CO, SL (S)
* Shelton, N. Philip, M.D., 621 South Seventh, VINCENNES 47591 812/882-4010. (Private)	Family Practice 5,9,10 (6,7,8,S,SL)
IOWA	
Wallace, Robert, M.D., Director, Muscatine Migrant Committee, 821 Park Avenue, MUSCATINE 52761 319/264-1155 (Free Clinic, University Hospital) (Peak month - August; Season Length-June-Oct.) Peak Migrant Population 2,000	CO, S,SL
MASSACHUSETTS	
McNamara, John, M.D., FAAP, Director, Brockton Children and Youth Project, 165 Quincy St., BROCKTON 02402 617/583-2900. State Department of Public Health)	CO,S,SL
MICHIGAN	
* Genard, Roy J., M.D., Chairman, Dept. of Family Practice, B-100 Clinical Center, Michigan State U., EAST LANSING 48824 517/353-0850. (Free clinic-University Family Health Center) (Environmental toxicology, family oriented medical record)	Family Practice SL (S)
NEW MEXICO	
* Vera, Robert, M.D., 2618 Haines, N.E., ALBUQUERQUE 87106 505/766-3217. (USDHS-Indian Health Service)	CO,SL(S)
NORTH CAROLINA	
* Elkins, Wilson, M.D., Box 585, PLEASANT GARDEN 27313 919/674-6191. (Private Practice	CO,S (SL)

*Denotes Information Received from the American Academy of Family Physicians

Code for Services Available: CO-Comprehensive Care - all services, except those indicated ( )

1.	General Pediatrics	4.	Behavior or Psych.	7.	Hearing	10.	TBC Test
2.	Well child supervision	5.	Laboratory	8.	Vision	S.	Social Services
3.	Screening	6.	X-ray	9.	Immunization	SL.	Spanish spoken in office

Pediatrician, Pediatric Nurse Associate, Clinic, or *M.D. - Family Practitioner	Services Available
NORTH CAROLINA (cont'd.)	
Frothingham, Thomas E., M.D., FAAP, Duke Medical Center, DURHAM 27710. 919/684-5797	CO,S (SL)
TENNESSEE	
* McConnell, David, M.D., 501 E. Main Street, NEWPORT 37821. 615/623-9041 (Private Practice)	CO (S,SL)
TEXAS	
* Milian, Teofilo J., M.D., 303 N. McKinney, SWEENY 77480. 713/548-2188. ((Private practice)	CO,S (S)
UTAH	
* Mangelson, Evan G., M.D., 109 S. 500 W., PAYSON 84651 801/465-2518	Family Practice 6,7,8,9,10,S,SL (3,6)
WASHINGTON	
Berinato, Hazel, R.N., CRN, PNP, Spokane Urban Indian Health Service, SPOKANE 99201. 509/327-8180 (Combined Indian Health Service and NHSC Clinic)	CO (7,6,S,SL)

* Denotes information received from the American Academy of Family Physicians

Code for Services Available: CO-Comprehensive Care - all services, except those indicated ( )

1.	General Pediatrics	4.	Behavior or Psych.	7.	Hearing	10.	TBC Test
2.	Well child supervision	5.	Laboratory	8.	Vision	S.	Social Services
3.	Screening	6.	X-ray	9.	Immunization	SL.	Spanish spoken in office