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Migrant Health Issues

MIGRANT HEALTH ISSUES

by

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The impact of these general and unique characteristics of the migrant may be illustrated through a recent situation faced by a migrant family seeking health care. On December 8, 1978, the Dallas Times Herald reported that a migrant couple's infant son had died because the hospital in Dimmitt, Texas, did not admit the child for treatment.6/ The migrant parents appeared at the hospital with their sick child. Because the parents were Spanish-speaking, their needs had to be communicated through a volunteer interpreter. The hospital staff referred the child to a public clinic. The physician at the clinic diagnosed the condition of the child as bronchitis and severe dehydration. According to the news accounts, the physician administered an antibiotic and told the parents to take the child back to the hospital and he would follow to start intravenous feeding to counter the serious dehydration.

The parents returned to the hospital and, apparently, were asked for a $400 deposit by the hospital before admitting the child. The parents told the hospital that they had no money. They had just come to the area to pick corn, but the fields were so muddy that work was not yet possible. As soon as they had any money, however, they said they would be glad to pay the hospital. The hospital apparently refused to admit the child and the parents left for a neighboring town where they knew of another physician that might help them resolve their problem.

The physician in the next town examined the child, administered another medication and advised the parents that since they were not from the town, it was not likely that the local hospital would admit them.

The parents returned to their labor camp. Apparently, the medication received had some effect because the child appeared better. Later, however, a young daughter noticed that the infant appeared to have gotten worse. The mother of the child bundled up the sick child and headed for the local courthouse hoping to find someone who could get the child the care it needed. The parents met the judge on the steps of the courthouse. While trying to explain the situation to him, the mother noticed that her child had stopped moving. He was dead.

This tragedy reflects virtually all the problems faced by the migrant. The health system in the Dimmitt area had failed to be responsive to the sick migrant child because its parents were non-residents, Mexican-Americans, Spanish-speaking and poor.

MIGRANT HEALTH PROBLEMS AND PROGRAM ACTIVITIES

Problems of the Migrant:1/

It is difficult to imagine any group of people in these United States who are more physically sick, educationally deprived, socially degraded and/or economically poor than migrant farmworkers. Of course, these characteristics are not unique to migrants. Poor people, especially in rural areas, share these same deplorable conditions. What makes the migrant different is the relative degree to which he suffers under these conditions and the additional characteristics of his employment that further limit his ability to rise above these circumstances. Among these additional characteristics are: (a) the temporary nature of his stay in an area, and (b) the linguistic, cultural or racial differences that isolate him from the community in which he is employed.

Temporary Residence:2/

For purposes of employment the migrant farmworkers may reside in an area from a few weeks to several months. As a result, whatever health delivery system or service exists in the area is called upon to be responsive to a peaking workload that the migrant's presence represents. Non-resident status, however, effectively disenfranchises the migrant in the area. Because of the temporary nature of his stay, the tendancy is to reduce or eliminate his claim on the local resources set aside to extend services to the medically indigent. Essentially, these resources are used primarily for the resident poor and not the migrant farmworker.3/

Linguistic, Cultural and Racial Differences:

A large number of migrant farmworkers belong to two disadvantaged minorities, the Hispanic and the Black.4/ As a member of these minorities, the migrant farmworker is socially alienated from many of the communities in which he works. His capacity to avail himself of existing health services is restricted by the difficulty in communicating his needs to the community in which he finds himself, particularly if the community is passively hostile or prejudiced against him.5/

MAGNITUDE OF THE MIGRANT PROGRAM

The magnitude of the problem that the migrant farmworker represents is difficult to quantify. In part, this difficulty is due to the problem of, first, defining migrant farmworkers, and, secondly, counting them.7/ On the surface, it is hard to understand why the U.S. Government can count migratory birds, but somehow cannot count the migrant farmworkers. An illustration may help to explain the problem:

> A farmworker may have migrated last year, but this year is employed in highway construction. Next year he may return to migratory agricultural employment. Is he a migrant farmworker?

The answer depends on why you are counting migrant farmworkers. If you are interested in determining the labor force used this year to harvest crops, you would not count him. On the other hand, if you were concerned with extending health care to migrant farmworkers, you would count him. (Under the Federal law, the Migrant Health Program assumes such a person has left the migrant labor force if he were not employed in agriculture during the last 24 months.8/) In addition, you would be concerned with his entire family since your responsibilities for extending health care extends to his dependents.

The difficulty in defining and counting migrant farmworkers compounds the problem of quantifying the incidences of illness or the health conditions of migrants with any precision. For this reason, data on these aspects of migrant health are not systematically compiled by public sources. However, studies performed for selected groups of migrants and data from clinics indicate alarming levels of the following illnesses and conditions:9/

- Upper respiratory illnesses
- Enteric diseases
- Dermatitis
- Parasites
- Venereal disease
- Anemia
- Malnutrition
- Accidents
- Tuberculosis
- Infant mortality
- Alcoholism
- Depression
- Hypertension

Efforts are currently underway to try and develop better measures of the number of migrants and their health status but, because of the problems cited, the measures are likely to remain imprecise.. In the interim, reasonably accurate estimates will continue to be used.

For example, the Migrant Health Program estimates there are about 700,000 to 750,000 migrant farmworkers and dependents.10/ In addition, the program estimates that there are about 2,000,000 seasonal farmworkers and dependents for which the program is also responsible. These numbers are based on a 1973 study whose accuracy or validity is sufficiently precise for the purposes used in the program, namely, the location of large numbers of migrants and the degree to which the program is reaching the target populations. A similar study is being repeated in 1979.

MIGRANT HEALTH PROBLEMS AND OBSTACLES

An extensive list of problems and obstacles lie between the migrant and the health care he requires. The most obvious one is that his access to health care facilities has to be improved. Where there is no capacity to extend care, it must be developed. Where capacity exists, the attitude of those operating and controlling the capacity must insure that the staff is responsive to migrant's needs and actively seeks to extend him care. Where capacity and the proper attitude toward the migrant are combined so that the migrant has access to the care, the funds necessary to cover the costs for that care have to be made available. Finally, when migrants receive the care they require, an effort must be made to assure that such care is continued as the migrant moves from job to job.

Capacity:

The U.S. Government has long recognized that many rural areas have very serious problems in establishing and maintaining proper health care for their people. To assist in resolving this problem, the Federal Government has pursued the establishment of primary health care clinics through legislation for a variety of programs.11/ The Rural Health Initiative of the Community Health Center Program has resulted in the development of over 350 comprehensive health centers in rural areas in the past 3 to 4 years. The National Health Service Corps has also been working to place primary health care physicians in rural health manpower shortage areas.12/ Over 750 rural areas have benefited from this physician recruitment and placement program. Finally, the Migrant Health Program has established or participated in the support of 112 projects or centers that serve substantial numbers of migrant and seasonal farmworkers in migrant impact areas.13/ These efforts are, of course, supplementary to those of rural primary care practices that voluntarily spring up in needy rural areas based on the efforts and initiatives of private groups and physicians.

The 1978 amendments to legislation establishing the Migrant Health Program changed the definition of migrant high impact areas (HIAs) from 6,000 to 4,000 migrant and seasonal farmworkers and dependents. The 1973 data indicates that there are 141 counties that meet this definition of an HIA. BCHS has a health delivery capacity in all but about 17 of these counties. In recognition of this coverage, the efforts of the Migrant Health Program and BCHS has moved in the direction of expanding the coverage and scope of services to migrants within existing health clinics. In this regard, the level of available funding is the primary constraint.

Attitudes Affecting Access:

Where a capacity to extend care exists, it is important that additional efforts be made to reduce the social and cultural barriers that limit migrant access to available care. The migrant must feel welcome at existing health facilities rather than alienated, rejected or ostracized. In part, this means that, where a cultural or linguistic barrier exists, steps should be taken to ameliorate the condition through the use of staff that can act as cultural or linguistic bridges or interpreters.

Optimally, such staff should be at all professional levels, especially at the points of public contact, e.g., the outreach workers, receptionists, nurses, and providers of health care.

The Bureau has pursued a policy of requiring all projects in areas of substantial migrant impact to facilitate migrant access to care where practicable through:

- Outreach workers.
- Bilingual staff.
- Transportation services.
- Night clinics.
- Governing board representation.

As health clinics expand in size their capacity to meet most, if not all, of these factors affecting migrant access to care will be realized.

Funds:

Needless to say, substantial resources will have to be brought to bear on the migrant health problem if it is to be resolved. Comprehensive care, including hospitalization, costs between $350 to $450 per person per year including out-of-pocket expenses. Assuming there are 750,000 migrants and dependents, between $262.5 and $337.0 million would be needed to cover the needs of the migrant and his dependents. Part of these costs are being funded by State and local governments as well as by the migrant himself. it is unlikely that much over $50.0 million is being provided to fund migrant health needs from all Federal sources. The required resources for 2 million seasonal farmworkers and dependents would be approximately $700.0 to $900.0 million. Taking all these amounts into account, clearly a substantial gap exists between available resources and estimated requirements. Until this funding issue is systematically addressed and resolved, the resulting unattended health problems of the migrant and seasonal farmworker will continue.

Continuity of Care:

The quality of medical care to a substantial degree is dependent not only on skills and capacities of health professionals and the facilities at their disposal but also on the access and availability of current and prior health information on a patient and the capacity to assure continued treatment and followup where warranted. The continuity of care for a migrant presents a more difficult problem given the changes in residence associated with migratory work.

To address this issue, the Migrant Health Program (MHP) has developed and fostered the use of:

1. A summary personal health record carried by the migrant, and:

2. A migrant referral system to alert clinics of continuing medical problems of individual migrants moving into their service areas.

The effectiveness and utility of these systems are being improved as BCHS implements its quality indicators of care such as immunizations for children, hypertensive screening, prenatal care for expectant mothers, or followup on pap smear tests. These systems should allow clinics to followup on their important elements of health care as the migrant moves into their service areas.

OTHER MIGRANT NEEDS AFFECTING HEALTH STATUS

Even if migrant health needs were met through effective access to ambulatory and hospital care, it is likely that many of the health problems found by the migrants would continue. This is apparent if we return to the observed illnesses of the migrant. For example, a higher incidence of upper respiratory illnesses, tuberculosis and pesticide poisoning relate directly to the working conditions that migrant farmworkers face and the crowded housing in which they live. Health care will reduce the duration and possible complications of these illnesses. It is not likely, however, that the incidence of such illnesses will fall dramatically, unless housing and working conditions substantially change. Enteric diseases, parasites, and dermatitis relate to poor working conditions as well as to contaminated sources of drinking water and inadequate or no sewage systems. Again, while being able to alleviate these conditions, medical care will not likely reduce their occurrence dramatically. More potable water and sanitary systems need to be introduced where the migrant lives and works to address these health issues. Alcoholism and depression are problems that are difficult to treat, especially in a migrant who is in an area only temporarily for purposes of employment. Nutrition lessons are difficult to learn or practice in an environment of poverty. Higher incomes and a change in lifestyle for the migrant probably will have more to do in resolving these health issues than traditional health care.

Funding

Fiscal years 1980 and 1981 Zero Base Budgets (ZBB) for the Migrant Health Program are to expand the coverage and scope of services to migrants with appropriated resources (see attached). These expansions will largely take place through existing clinics serving more migrants and will include fuller coverage of services such as pharmacy, prenatal, maternity and well-baby care. In addition, hospital care will be expanded proportionately to 10 percent or more of appropriated amounts. Of special interest is the expansion of services through the establishment of birthing clinics in conjunction with the Bureau's efforts to respond to the adolescent health initiative and its continuing concern for maternal and child health. Funding for increasing the number of migrants under a prepaid system of care (Decision Package No. 5) just missed the cut-off level of the PHS review.

OFFICE OF MIGRANT EDUCATION

The Migrant Health Program (MHP) and the Migrant Education Program (MEP) have been exploring the possibilities of a collaborative effort to extend care to migrant school-aged children enrolled in the Migrant Education Program. The direction currently under consideration is to capitate or pay for services to migrant children in areas served by migrant health clinics to cover the special services required by MEP as well as the extension of comprehensive health care afforded by the MHP. These services would include:

1. Required school physicals.
2. Vision tests and glasses as necessary.
3. Hearing tests and hearing aids as necessary.
4. Ambulatory episodic and preventive care.
5. Other health services at MH clinics.

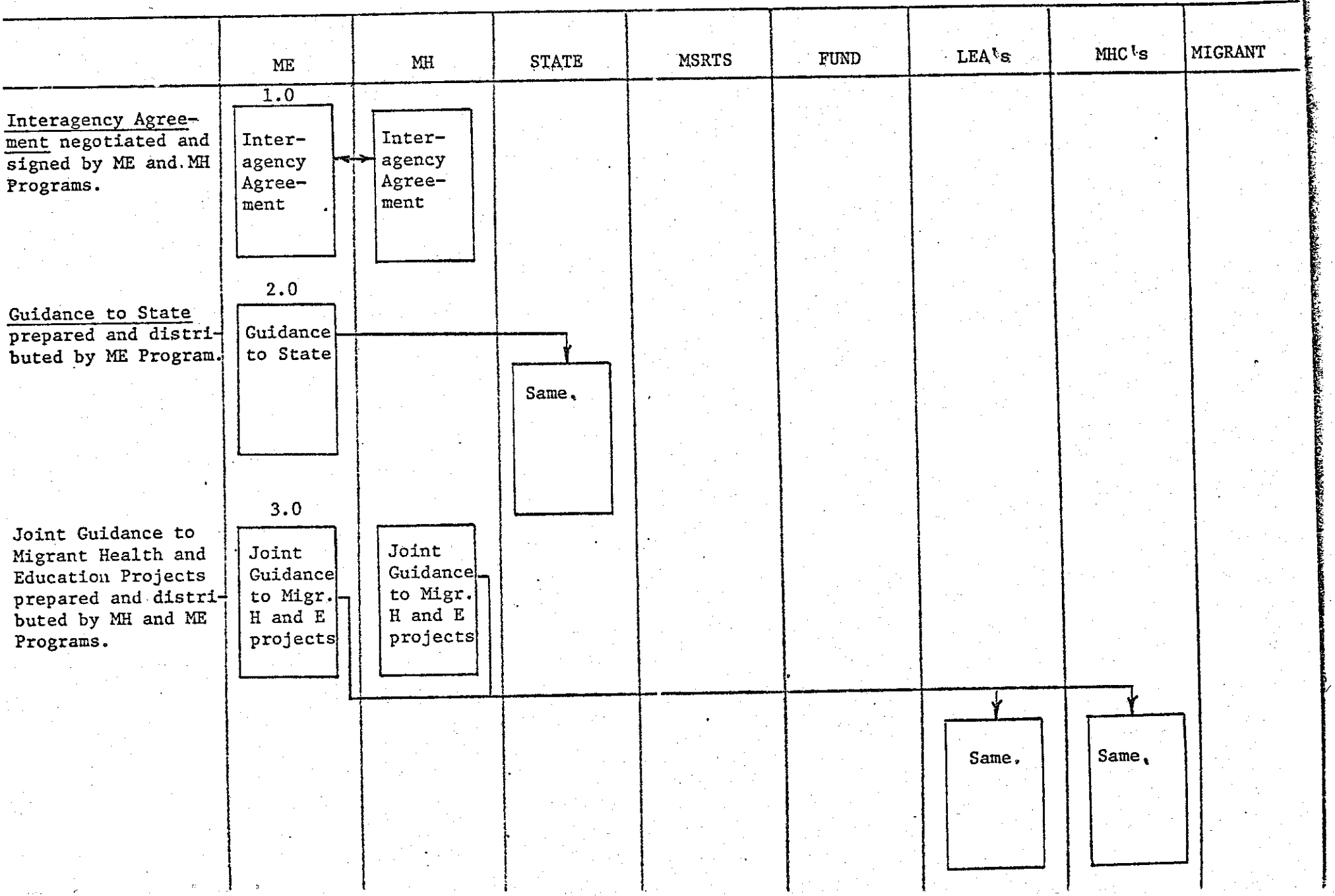
The general procedure for implementing such an approach is outlined in the attached systems flow charts. While accurate cost estimates are not available at this time, rough estimates for such a collaborative effort are as follows:

Service	Annual Cost
Physical examinations	$ 25.00
Vision tests and glasses	10.00
Hearing tests and aids	5.00
Ambulatory health care	50.00
total per student	$ 90.00

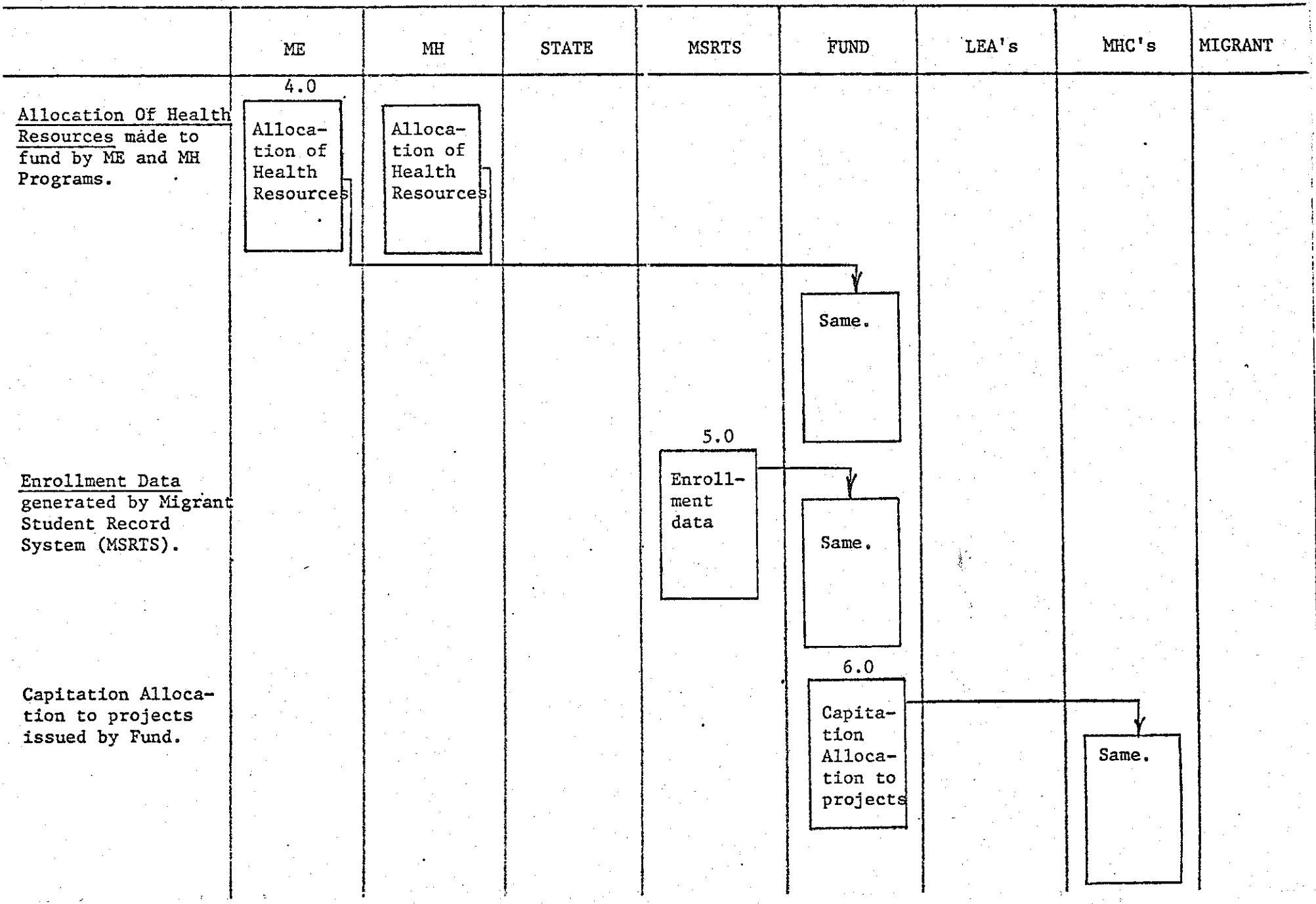
The MEP has approximately 250,000 active migrant children in their program. All of these children are are not within areas served by MHP clinics. Nevertheless, assuming that all were able to obtain their special service needs from MHP, the cost would be $10 million. The MHP would be covering all other medical services at a cost of $12 million. Currently, the MEP is expending $14 million for health care for less than full coverage of their enrolled migrants.

A desirable additional benefit for migrant children would be preventive and restorative dentistry. The costs for such services would be in the neighborhood of $60 per child at $15 million. Such services currently appear to be outside the budgetary expectations of both programs. However, recognizing that coverage for all migrant children is not a reasonable expectation at this time, the possibility of extending dental services to a portion of this target group should not be completely eliminated at this time, particularly in those areas where dental services are available in MHP clinics.

MIGRANT CHILDREN ASSURANCE SYSTEM



MIGRANT CHILDREN ASSURANCE SYSTEM



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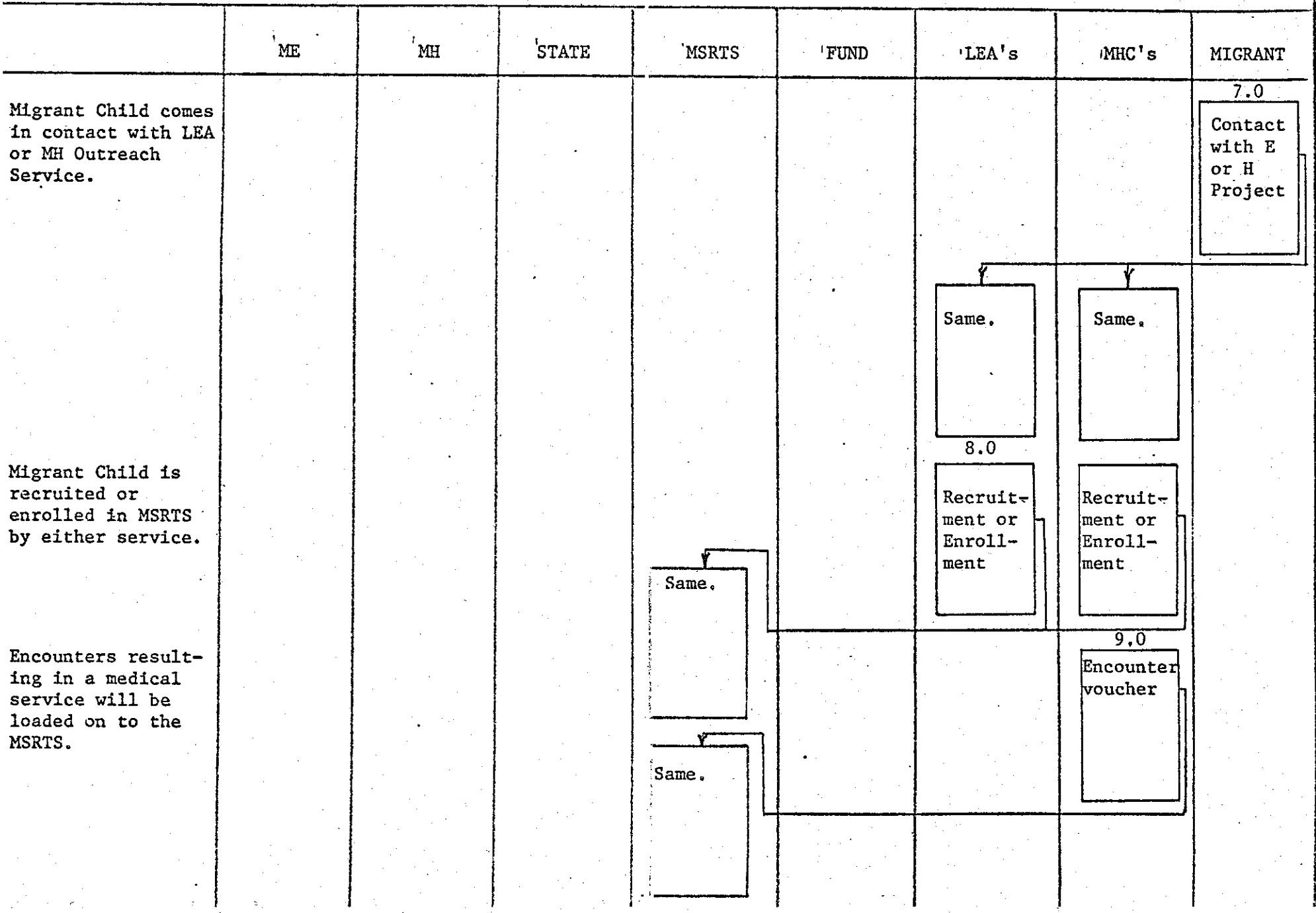

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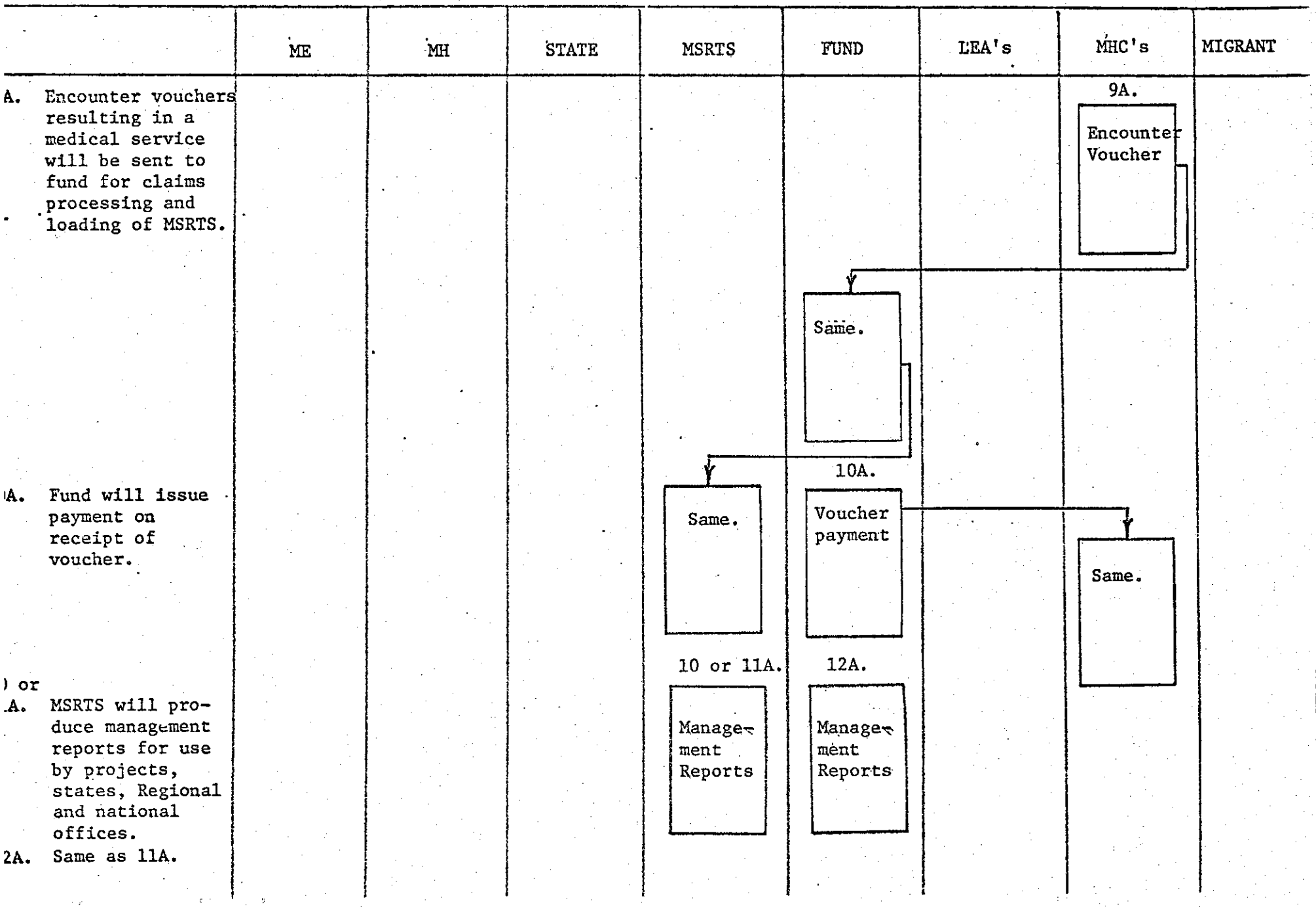


Continuity of Care and the Migrant Student Record Transfer System (MSRTS)

The Migrant Education Program (MEP) has been operating a computer-based Migrant Student Record Transfer System (MSRTS) for some years. This system has had a number problems in the process of its development. However, at this point in time, it has achieved a level of technical and operational capability which is promising to the MHP and its concern for continuity of care for the migrant.

The MSRTS has the capacity to store educational and/or medical profiles. It was developed initially to serve the needs of the MEP, but with some adjustments it could serve as a source of a medical profile for all migrants who have access to care from MHP clinics.

Arrangements are being made between MEP and MHP to test the feasibility and practicability of such an approach to the problem of continuity of care for migrants. The flow processes of such an approach is contained in the attached document. Essentially, the system will allow direct or indirect loading and retrieval of medical profiles of migrant patients. The costs for such a capacity are initially estimated to be about $250,000 per year based on the following considerations:

1. Loading of Data - MSRTS experience indicates a cost factor of $0.15 per record. On the assumption that 250,000 migrant records would need full loading, this cost would amount to $37,500.

2. Capture of Data - MH clinics would have to undertake a special effort to provide the MSRTS with a hard copy for loading. Assuming a cost of $0.50 per hard copy prepared, the cost would be $125,000.

3. Computer Terminals - If it is likely that sufficient demand would exist to warrant the placement of a terminal to access the MSRTS computer directly in those clinics serving substantial numbers of migrants year round. In addition, it would be advisable to establish a central terminal capacity to serve those clinics which do not serve large numbers of migrants year round. A hard copy generating terminal rents for $209 per month or can be purchased for about $10,000. Assuming that 15 terminals will be required, the rental costs would be $37,620. A cathode tube terminal would cost $250 per month or can be purchased for about $20,000. An 800 number for national communication with a central computer access point would cost about $6,000 to $10,000. Two (2) telephone/computer operators would cost about $15,000. Total costs for equipment, 800 telephone linkages and staff would be $65,6200.

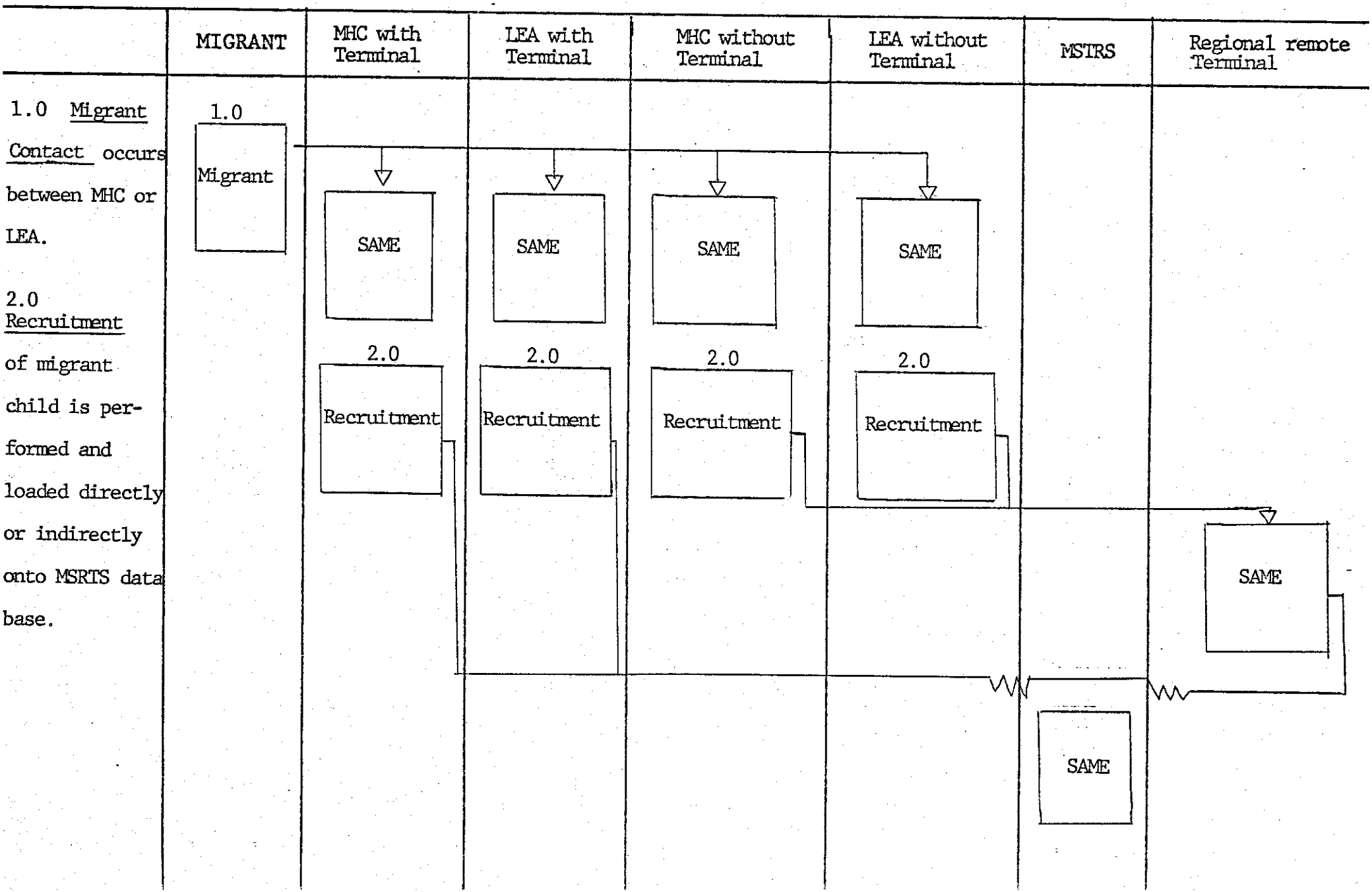
4. Training - Operators at each terminal location would have to be trained on using the MSRTS. Such training could be done centrally at an estimated cost of $370 per operator for a total cost of $7,400.

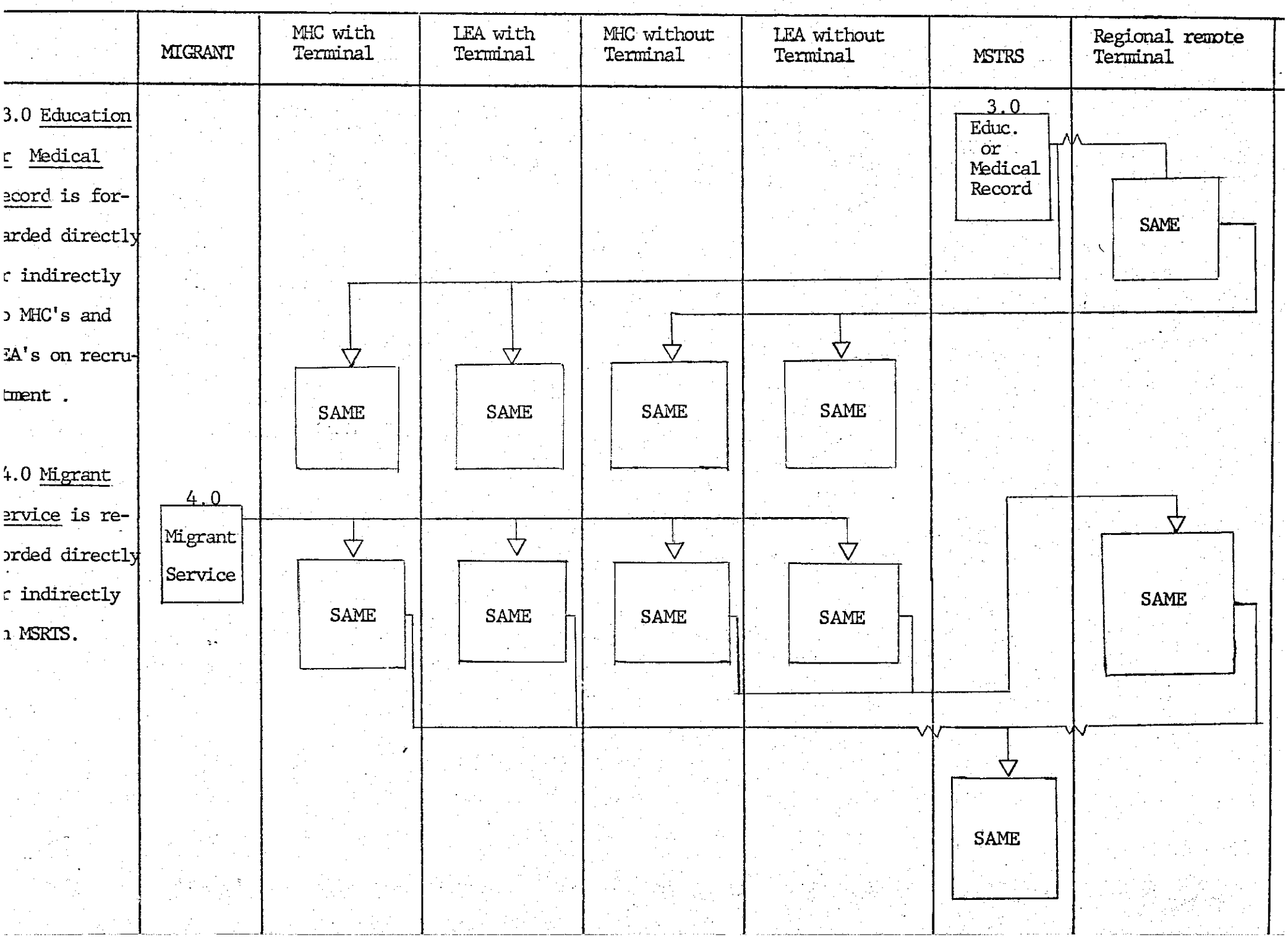
5. Additional Programming - There will clearly be a need to purchase additional programming to format output reports to MH clinic needs. In addition, special management reports are likely based upon MSRTS data. About $10,000 of programming would appear sufficient to meet this need.

Summary of Costs

First Year:	Loading of Data		$ 37,000
	Capture of Data		125,000
	Computer Terminals		65,620
	Training		7,400
	Additional Programming		10,000
		TOTAL	$245,520

MIGRANT HEALTH PARTICIPATION IN MIGRANT EDUCATION
MIGRANT STUDENT RECORD TRANSFER SYSTEM




MIGRANT
MHC with Terminal
LEA with Terminal
MHC without Terminal
LEA without Terminal
MSTRS
Regional remote Terminal
3.0 Education or Medical record is forarded directly r indirectly o MHC's and EA's on recruitment .
4.0 Migrant ervice is reorded directly r indirectly n MSRTS.
3.0 Educ. or Medical Record
SAME
4.0 Migrant Service
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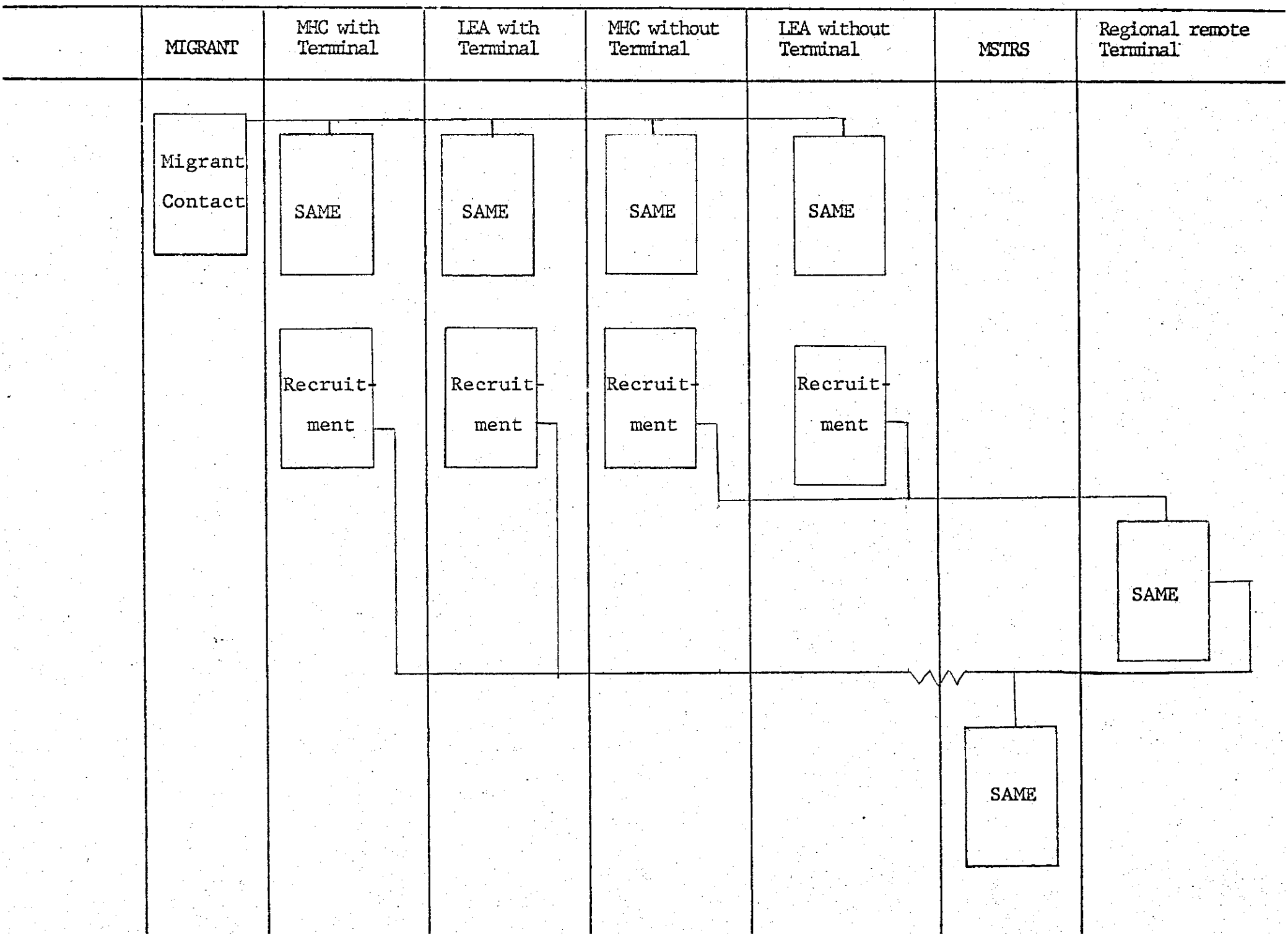
MIGRANT
MHC with Terminal
LEA with Terminal
MHC without Terminal
LEA without Terminal
MSTRS
Regional remote Terminal
Migrant Contact
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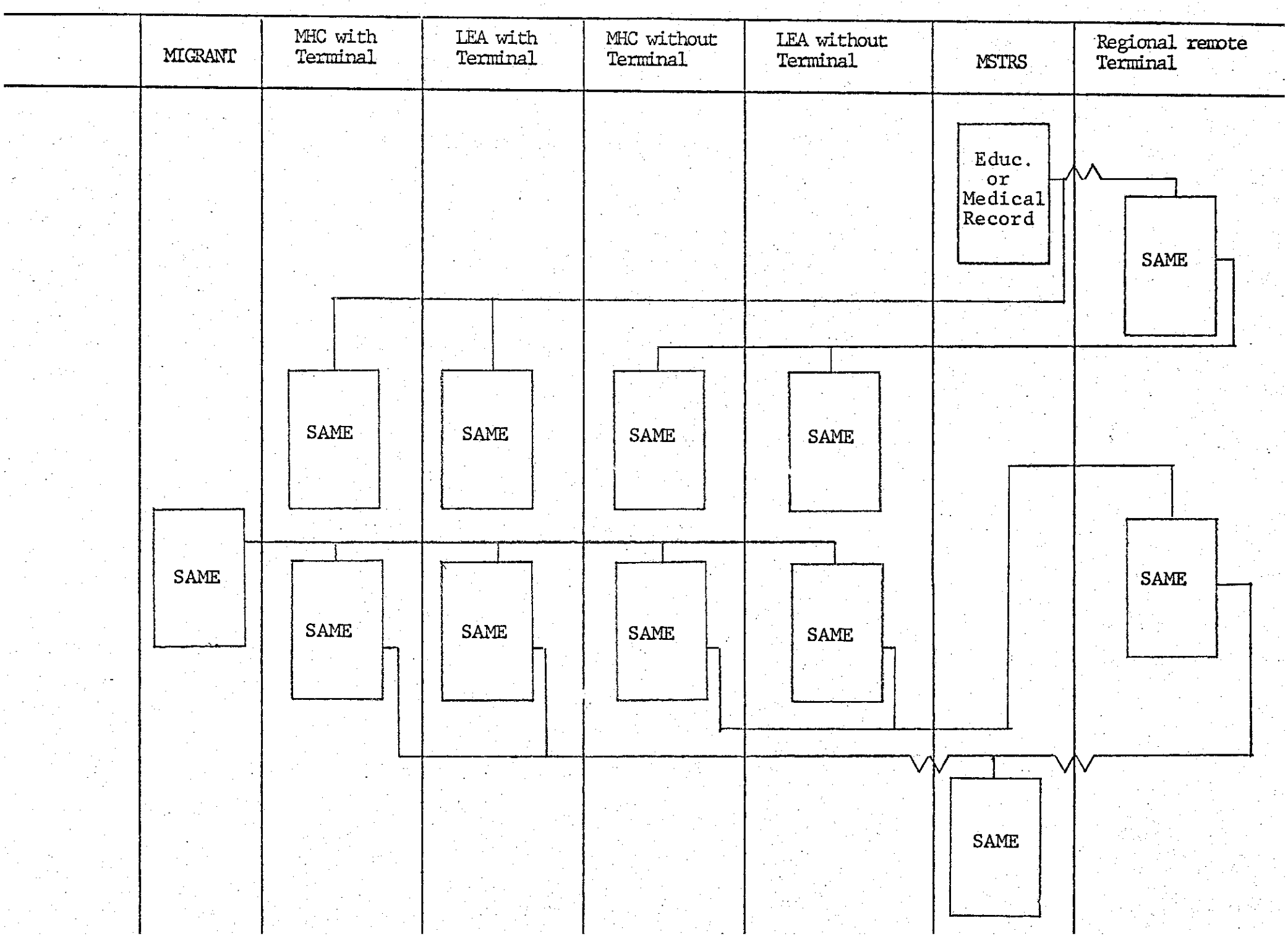
MIGRANT
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Expansion of Health Services to Seasonal Farmworkers by the CHC/RHI Program

The CHC/RHI proposes to assume greater responsibility for supporting the extension of comprehensive health care to seasonal farmworkers. The decision to openly assume responsibility for health services to seasonal farmworkers (and their dependents) is in recognition of the CHC/RHI's general responsibility to extend care to underserved areas and populations. In a direct sense the CHC/RHI program does not make a distinction in people served. Theoretically, this responsibility extends to migrants as well. But for the fact that specific language directs the Migrant Health program to serve migrants (primarily) and seasonals (secondarily), the CHC/RHI could have been called on to respond to migrant needs under its current legislation. This decision to formally begin to assume responsibility for seasonal farmworkers by the Section 330 should result in freeing up Migrant Health Section 329 resources to expand the number of migrants served as well as permitting broader ambulatory and inpatient services to be extended to this priority target population.

The mechanism that the CHC/RHI program proposes to use is to foster the use of Section 330 funds in a) new starts in migrant high impact areas and b) the funding of seasonal farmworkers in existing projects. The extent to which the CHC/RHI will assume responsibility for funding seasonal farmworkers health care depends on funds made available through the appropriation process. Currently, it would appear feasible to target between $3 to $5 million of section 330 to cover the actions identified in a) and b) above. These funds will be incorporated in the development of the allocation formula being developed for 1980.

MIGRANT INITIATIVE - ACTION SCHEDULE

		Action Responsibility	Completion
1.	Literature Search and Bibliographic Review of Migrant Documents.	Purchase Order	90 days
2.	Comparative Analysis of Migrant Definitions and Migrant Counts.	Contract	60 days
3.	Analysis and Quantificaiton of Health Services to Migrants.	HSA/BCHS	30 days
4.	Analysis and Quantification of Educational Services to Migrants.	OE/MEP	120 days
5.	Analysis and Quantification of Environmental Services to Migrants.	Purchase Order	90 days
6.	Analysis and Quantification of Nutritional Services to Migrants.	HSA/BCHS/USDA	60 days
7.	Analysis and Quantification of Employment Services to Migrants.	HSA/BCHS/DOL	60 days
8.	Analysis and Quantification of Migrant Housing Requirements	HSA/BCHS	30 days
9.	Identification and Analysis of Institutions Reporting Migrant Interests.	Purchase Order	90 days
10.	Analysis and Costing of Assurance Mechanism for Migrant Health.	HSA/OPAL/BCHS	30 days

1. Literature Search and Bibliographic Review of Migrant Documents

The following tasks will be undertaken and completed within 90 days:

1. Identification of studies and documents that authoritatively identify and analyze health and health related issues affecting migrant farmworkers.

2. Collection of key studies and documents identified in (1) above.

3. Review and summarization of key issues and data that substantiate conditions affecting migrant health and health related issues.

4. Preparation of an "Executive Summary" that critically describes major health and health related problems affecting migrant farm labor.

Areas of specific concern in relation to the migrant and his health condition are:

1. Income/Employment

2. Demographic Characteristics

3. Housing/Environment

4. Nutrition

5. Education

6. Occupational Safety

   - transportation
   - pesticide

7. Health Status

2. Comparative Analysis of Migrant Definitions and Migrant Counts

1. Identification of migrant farmworker definitions and by Federal agencies.

2. Description of utility of definitions by Federal agencies.

3. Analysis of the characteristics of migrants counts in terms of factors such as:

   a) consistency
   b) reliability
   c) durability
   d) collection methodology
   e) timeliness
   f) basis for projection
   g) inter program conversion
   h) cost

4. Advantages, disadvantages, feasibility, and advisability of a census approach to migrant counts.

3. Analysis and Quantification of Health Services to Migrants

1. Identification of direct health services for migrants:
   a. Federal level
      - Migrant Health Program

2. Identification of indirect health services for migrants:
   a. Federal level
      - CETA
      - Migrant Headstart
   b. Federal/State level
      - Migrant Education

3. Migrant eligibility under general health service programs:
   a. Medicaid
   b. Title XX
   c. Maternal and Child Health
   d. Crippled Children's Program
   e. Family Planning Program
   f. Other Categorical Programs
   g. Hill-Burton Program

4. Independent State health services for migrants.

4. Analysis and Quantification of Educational Services to Migrants

The Office of Education has funded a major study to evaluate the Title I State Bloc grant program. Part of this study will be the evaluation of the Migrant Education Program. The evaluation is scheduled to be completed on or about the 30th of September. One of the aspects of the program will be the dropout problem of migrants within the Migrant Education Program. The measure of this problem is contained in the following data registered on the Migrant Student Record Transfer System (MSRTS):

	STUDENTS		
Age	Number	Percent Annual Dropout	Cumulative % of Dropouts
13	33,000	-	
14	31,000	6.1	6.1
15	29,000	6.5	12.1
16	24,000	17.2	27.3
17	20,000	20.0	39.4
18	14,000	42.8	57.6

A second measure of the problem is the grade levels achieved by 18-year olds. The data are as follows:

Grade Level	Number of Students	Percent of Total
7	66	0.5
8	167	1.2
9	789	5.6
10	1,800	12.8
11	3,200	22.8
12	8,000	57.1
TOTAL	14,022	100.0

These data indicate that only 1 out of 4 migrant children complete high school on time. The data further indicate that close to 60% of the migrant children have dropped out of school before reaching 18 years of age.

5. Analysis and Quantification of Environmental Services to Migrants (Water and Sewage)

The following tasks will be undertaken and completed within 90 days:

1. Identification and description of programs with capacity to address migrant water and sewage issues.

2. Estimate of the water and sewerage requirements of areas with substantial migrant impact.

3. Technical and practical approaches toward the resolution of migrant water and sewerage problems.

4. Estimate of technical assistance and financial requirements of a migrant water and sewerage program.

6. Analysis and Quantification of Nutritional Services to Migrants

The following tasks will be undertaken and completed within 60 days:

1. Identification and description of programs within capacity to address migrant nutrition issues.

2. Estimate of nutritional deficiencies of migrants and their significance insofar as physical and mental development.

3. Estimate of requirements to correct nutritional deficiencies.

4. Estimate of impact of lowered physical and mental development on factors such as education, health and income.

7. Analysis and Quantification of Employment of Migrants

The following tasks will be undertaken and completed within 60 days:

1. Identification and description of employment services extended to migrants.

2. The quantification of the degree of participation of migrants in the services extended.

3. Estimate of the impact of the employment services on employment and income of migrant farmworkers.

8. Analysis and Quantification of Migrant Housing Requirements

1. Identification of Programs capable of addressing migrant housing requirements.

2. Determination of the volume of housing required compared to available structures.

3. Estimated costs required to correct short-falls in migrant housing requirements.

9. Identification and Analysis of Institutions Reporting Migrant Interests

Prepare a study identifying and analyzing:

a. The institutions at the local state regional and national levels intent on improving the conditions faced by migrants.

b. The systems or approaches used by institutions to assure proper attention to the problems of upstream and homebased migrants.

c. The barriers limiting institutional responses to migrant problems.

d. Recommendations to assure proper advocacy and institutional responses to migrant needs.

10. Analysis and Costing of Assurance Mechanism for Migrant Health

1. Compile data of assurance programs covering migrant farmworkers.

2. Develop estimates of costs for covering migrant health through an assurance system for the following groupings:

   a. Total population
   b. Children below 20 years old
   c. Women in child bearing age 20 years and above

These estimates will be made where practicable making a distinction between upstream and home-base costs by inpatient and ambulatory services.

ALTERNATIVE APPROACHES TO MIGRANT HEALTH CARE

Medicaid

Discussions with the Health Care Financing Administration (HCFA) on migrant farmworker Medicaid eligibility has not resulted in any optimistic prospects for migrant eligibility. The residency issue, for example, continues to be a limiting factor even with the introduction of language allowing eligibility within states to be based on an impermanent stay within a state, i.e., residency based on a "for purpose of employment" status. This more flexible definition of residency is effectively neutralized by additional provisions of proposed regulation that require residency in only one state, even if based on a "for purpose of employment" definition. Most recently, HCFA has drawn attention to a problem of consistency between different programs and regulations they administer as the basis for discontinuing or discouraging further efforts to resolve the migrant farmworker eligibility issue at this time.

These administrative obstacles to making migrant farmworkers eligible under Medicaid are difficult to overcome in the near term and, while efforts will continue to try and overcome these obstacles, the Medicaid mechanism clearly cannot be considered a promising participant in the Migrant Health Initiative. This judgment is reinforced by a number of additional considerations that relate to Medicaid eligibility and the migrant.

- The duration of employment of a migrant during his/her stay away from homebase in any one location generally lasts about 6 to 8 weeks. The process for declaring a person eligible for Medicaid is such that many migrants will have left the area of employment by the time his/her eligibility is established or verified.

- Criteria in some states based on single family parents would reduce migrant eligibility particularly amongst Hispanics who travel as a family (husband and wife) unit.

- The application of income criteria based on the annualization of most recent earnings would eliminate eligibility of many migrant families.

- A positive effort to make migrants eligible under state administered Medicaid is unlikely under current budgeting constraints and normal biases to serve local residents before extending services to out-of-state migrants. As a result, alternatives to the normal Medicaid approach should be given serious consideration.

Alternatives to Medicaid

The Migrant Health Program has been experimenting for about 5 years with a number of different entitlement programs to test various administrative mechanisms and to capture data on costs applicable to migrant medical utilization patterns. The following are one set of such cost factors:

COST CENTERS	PER CAPITA In Area	Out of Area	Total
Inpatient Hospital	67.20	35.18	102.38
Outpatient Hospital	6.85	1.60	8.45
Inpatient Physician	28.47	10.04	38.51
Outpatient Physician	3.47	.67	4.14
Office Physician	25.06	3.56	28.62
Administration	26.70	10.40	37.10
TOTAL	157.75	61.45	219.20

NOTE: These cost factors are for calendar year 1978 and do not include co-payments by enrolled migrants of $3.00 per physician encounter or $35.00 per hospital admission.

It should also be noted that in-area utilization (and therefore expenditures) for hospital and specialty physician care were controlled by referrals from the Migrant Health Project in the area.

These data are not sufficiently valid to be used as true national migrant cost factors. Nevertheless, they allow for one to do some gross estimating of what an entitlement program might cost under differing degrees of coverage. For example, if this entitlement program were extended to the 700,000 migrants under similar administrative arrangements and resulted in similar utilization patterns, the costs would have been as follows:

COST CENTERS	IN $ THOUSANDS		
	In Area	Out of Area	Total
Inpatient Hospital	47,040	24,626	71,666
Outpatient Hospital	4,795	1,120	5,915
Inpatient Physician	19,929	7,028	26,957
Outpatient Physician	2,429	469	2,898
Office Physician	17,542	2,492	20,034
Administration	18,690	7,280	25,970
TOTAL	110,425	43,015	153,440

These data suggest that one could cover all migrant out-of-area (interstate) medical care for about $43 million, assuming no inflation. Such an approach would leave out other services such as pharmacy, outreach, nutrition, etc., largely required for migrant health centers.

Another approach to an entitlement program could be to target coverage to selected groups within the migrant stream, e.g., women of child-bearing ages and/or children 20 years old or younger. While this age and sex group represents between 50 and 55 percent of the population, it represents about 75 percent of medical service utilization, principally because of pediatric care and visits associated with pregnancies. A rough estimate of costs for an out-of-area (interstate) entitlement program for this group would be about $32 million representing a capitation cost of about $80 to $90.

A more economical alternative would be to limit coverage of migrant health needs to ambulatory care out-of-area. Recognizing the weaknesses of data, one can nevertheless project a rough cost of about $6.80 to $7.00 per capita or $4.9 million. The MHP estimates that $3.3 million of this amount is currently being covered by its present allocations to upstream Regions for medical care (physician, laboratory and x-ray services) to migrants. An additional $1.6 million would allow for coverage of all migrants out-of-area for services limited to episodic ambulatory care assuming a $3.00 per visit co-payment. Other required services such as preventive care, pharmacy, outreach, counseling, community services, transportation, etc. currently

required by law would continue to require separate grant support. In-area or services in home-base states as well as services to seasonal farmworkers would also require separate programming and funding.

At this low level of requirements, it may be possible for HCFA to lend some financial support from its more flexible legislative authorities.

PROPOSED MIGRANT WATER AND SEWERAGE INITIATIVE

General

This presentation is a preliminary analysis of an important health issue affecting migrant farmworkers. Additional information and facts will have to be developed in order to bring the issue into better focus and frame more actionable recommendations.

Facts and Circumstances

There are about 41.5 million people in rural areas. Migrant farmworker families represent about 700,000 of this number or roughly 1.7 percent. Seasonal farmworker families represent about 2,000,000 or about 4.8 percent.

About one-third of the people in rural areas do not have potable water supplies, indoor plumbing and/or sewage disposal facilities. It is likely that migrant and seasonal farmworkers form a substantial part of this sub-group of the rural population.

The lack of potable water and sewerage systems has a high social and economic cost[1/] in terms of (a) malnutrition and anemia induced in part through frequent bouts with diarrhea, (b) the expenditure of energy in hauling water to residents, (c) expenditures for health care as a result of illnesses directly related to the lack of potable water and sewerage systems, and (d) the loss of income due to such illnesses.

The transmission of waterborne diseases by migrants represents a direct hazard to the health of rural populations, as well as to the public in general. The outbreak of typhoid fever in a Florida labor camp involving 200 migrants is illustrative of this hazard. The increased number of giardia cases in selected upstream communities where migrant farmworkers routinely work is further evidence of this hazard. Waterborne or water-related health problems that are abnormally high among migrants are:

- Gastroenteritis
- Dermatitis
- Anemia
- Parasites
- Hepatitis
- Malnutrition

1/ The social and economic costs are estimated to be about $130 per capita per year. See Attached.

Sources of Funds

The major Federal agencies with resources that could be brought to bear on water and sewage issues are:

1. Environmental Protection Agency (EPA).

2. Farmers Home Administration (FmHA).

3. Housing and Urban Development (HUD).

4. Economic Development Administration (EDA).

The Environmental Protection Agency (EPA) will have $3.8 billion in 1980 for waste water treatment facilities. These funds are available on a grant basis to cover 75 percent of the design and construction of waste water treatment facilities. Allocations are made to the states using the following formula:

- Fifty percent based on need as measured by the value of projects seeking funds.

- Fifty percent based on State populations.

From the perspective of migrant health, access to these resources are limited by the following circumstances:

- Health factors are not factored into allocations or priorities.

- The operation, in implementation, have an urban bias.

- The authorizations speak primarily to waste water treatment and not to integrated systems. Only $80,000,000 are allocated for potable water quality control and standards enforcement.

- The interest of migrant farmworkers are submerged by more numerically and financially influential groups.

- The documentation, review and approval processes are complicated, costly and time-consuming.

The Farmers Home Administration (FmHA) has the authority to make loans and grants for the study, design and construction of rural water and sewerage systems in communities of less than 10,000 population. For 1980, $700 million for loans and $265 million for grants are requested for these purposes. In addition, about $10 million is available for rural development grants that could cover water and sewerage components of such projects.

From the perspective of migrant health, a number of the same limitations affecting access to EPA funds also apply to the FmHA. In addition, a problem that comes into play where migrants are concerned is the limited ability of the migrant (and other rural poor) to meet the costs of operating and maintaining a water system (much less, the servicing of loans) without some form of operating subsidy.

The Department of Housing and Urban Development (HUD) has a number of programs that could be brought to bear on the water and sewage issue in relation to their general housing efforts. One of these programs, for example, is the Rural Housing for Domestic Farm Labor. About $25 million is requested for 1980.

The Economic Development Administration (EDA) is authorized to fund water and sewerage projects in relation to their economic development projects. Access to these resources to meet migrant needs would appear to be limited to those instances where residential and developmental needs for water and sewerage systems coincide.

Estimate of Capital Requirements

A rough estimate of the costs for potable water and sewerage systems per capita is about $1,500. Assuming that half the migrant farmworkers do not have such facilities,[2/] the cost for bringing them into being would be in the neighborhood of $525 million.

Since it would be difficult to address the needs of migrants independent of resident farmworkers, it would be legitimate to consider their needs as part of needs of migrants. Using the same formula, the water and sewerage needs of seasonal farmworkers would amount to $1,500 million.

Assuming that these needs were to be resolved in 5 to 10 years, the annual requirements would be between $202.5 and $405 million. This represents substantially less than 4 to 8 percent of current Federal efforts to address water and sewerage requirements. Assuming further that State and local agencies were to assume 25 percent of the costs to bring these systems into being, the annual percentage from Federal sources would drop to between 3 to 6 percent.

Estimate of Operating and Maintenance Costs

A rough estimate of the costs for operating and maintaining water and sewerage systems is between 7 and 10 percent of costs. Accordingly, the

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2/ Census data on Texas border migrant home base counties without complete plumbing facilities is attached.

operating and maintenance costs for migrant and seasonal farmworker water and sewerage systems would be as follows:

- Migrant farmworkers $ 37 - 53 million

- Seasonal farmworkers $105 - 150 million

Total $142 - 203 million

The costs per capita would be about $105 to $150 which compares favorably with the estimated social and economic costs of $133 per capita resulting from the absence of water and sewerage systems.

Special Considerations

The U.S.-Mexico Boarder Health Association recently adopted a resolution identifying the need for potable water and sewerage treatment as a priority issue along the border. This issue has been incorporated into the outline for the recently signed U.S.-Mexico Border Health Agreement. Approximately 21 percent of the migrants in the U.S. are home-based in this Border area. The U.S. Representatives in the Pan American Health Organization and the World Health Organization have voted to pursue the objective of making potable water accessible to all people in the world as a theme for the 1980 decade.

Finally, the White House has initiated a special effort last fall to address the water and sewerage needs of rural areas.

Recommendations

A. HEW should recommend to the Administration or to Federal agencies funding water and sewage projects that:

1. Criteria be established to take into account health factors in prioritizing the allocation of funds with particular concern for the health factors of migrant farmworkers.

2. Mechanisms should be established through which the poverty of populations being served can be ameliorated or eliminated as a barrier to the establishment or extension of water and sewerage systems.

3. A priority effort should be mounted to foster grant applications from migrant home-base and high impact areas through direct technical assistance or development grants.

4. Consideration be given to earmarking funds, e.g., $200 million for priority use in migrant home-base and high impact areas.

B. HEW should request the Administration to advise both domestic and international agencies capable of addressing water and sewage issues to give top priority to projects along the Mexican-American border.

BORDER AREA SELECTED DATA

	A Migrant	B Seasonal	C Total	D Population	E Percent C + D	F Percent Poverty	G Percent Plumb. Def.	H BCHS Clinics
TEXAS	399,485	109,100	508,585	12,244,678	4.2	14.7	6.0	
1 - El Paso	6,900	700	7,600	424,479	1.8	17.4	7.9	2
2 - Hudspeth	620	420	1,040	2,968	35.0	28.2	14.9	-
3 - J. Davis	40	50	90	1,456	6.2	26.5	13.0	-
4 - Presidio	180	60	240	4,810	5.0	40.9	25.3	-
5 - Brewster	180	90	270	7,867	3.4	27.1	7.9	-
6 - Webb	18,000	3,000	21,000	81,009	25.9	38.4	16.7	1
7 - Zapata	2,000	880	2,880	4,828	59.7	50.7	37.0	2(1)
8 - Starr	6,700	1,800	8.500	20,885	40.7	51.9	46.4	3
9 - Hildago	63,000	14,000	77,000	227,853	33.8	42.0	25.1	7
10 - Cameron	53,000	6,300	59,300	176,931	33.5	38.5	21.3	6
11 - Valverde	5,700	1,100	6,800	31,943	21.3	24.5	--	1
12 - Kinney	300	370	670	2,253	29.7	44.2	25.6	(1)
13 - Maverick	10,000	560	10,560	22,164	47.6	44.2	25.5	1
14 Terrell	--	--	--	1,834	--	23.6	3.6	-
BORDER TOTAL	166,620	29,330	195,950	1,011,280	19.4	--	--	23(2)
Culbertson	--	--	--	3,485	--	18.6	7.8	-
Reeves	--	--	--	16,272	--	20.6	8.4	-
Pecos	20	100	120	13,448	0.9	15.1	5.5	-
Crockett	40	360	400	4,304	9.3	13.4	2.0	-
Sutton	30	350	380	4,382	8.7	25.4	10.9	-
Edwards	360	400	760	2,025	37.5	35.9	13.4	-
Real	110	400	510	2,339	21.8	27.6	12.7	-
Uvalde	1,500	3,900	5,400	20,549	26.3	28.9	16.6	-
Zavala	6,100	1,800	7,900	11,073	71.3	43.1	28.6	2
Dimmitt	4,900	1,900	6,800	10,881	62.5	51.0	42.6	-(2)
Medina	1,600	420	2,020	21,970	9.2	24.7	14.0	-
Frio	1,600	460	2,060	12,398	16.6	35.5	27.3	-(2)
LaSalle	2,200	480	2,680	5,456	49.1	47.9	42.2	2
Atascosa	1,700	420	2,120	20,266	10.5	28.6	21.6	1
McMullan	130	90	220	853	25.8	24.1	24.0	-
Duval	600	310	910	12.161	7.5	43.6	29.9	-
J. Hogg	200	170	370	4,804	7.7	46.3	26.0	2(1)
Live Oak	1,100	200	1,300	6,453	20.1	26.4	13.4	-
J. Wells	2,200	300	2,500	33,919	7.4	26.6	16.3	1
Kleberg	1,900	200	2,100	32,823	6.4	22.1	5.7	-
Brooks	1,500	220	1,720	7,749	22.2	42.0	27.0	-
Kennedy	150	180	330	1,248	26.4	30.0	14.9	-
Willacy	4,500	3,100	7,600	16,849	45.1	46.1	30.1	2(2)
2nd BAND TOTAL	32,440	15,760	48,200	260,707	18.5			10(7)
TOTAL	199,060	45,090	244,150	1,271,987	19.2			33(9)

BORDER AREA SELECTED DATA

	A Migrant	B Seasonal	C Total	D Population	E Percent C + D	F Percent Poverty	G Percent Plumb. Def.	H BCHS Clinics
ARIZONA	10,700	29,600	40,300	2,225,077	1.8	11.5	4.3	-
Cochise	600	900	1,500	73,950	2.0	13.4	3.1	1(1)
Pima	--	--	--	443,958	--	10.8	2.5	4
Sta. Cruz	--	--	--	17,543	--	20.0	9.0	(1)
Yuma	7,500	19,000	26,000	66,020	40.1	13.6	5.4	1
BORDER TOTAL	8,100	19,900	28,000	601,471				6(2)
Maricopa	2,100	6,000	8,100	1,221,414	0.7	8.9	2.1	1
Pinal	500	3,700	4,200	85,764	4.9	17.6	9.6	2(1)
Graham	--	--	--	19,166	--	19.3	7.3	-
Greenlee	--	--	--	12,047	--	8.1	2.0	-
2nd BAND TOTAL	2,600	9,700	12,300	1,338,391	0.9	--	--	3(1)
TOTAL	10,700	29,600	40,300	1,939,862	2.1	2.1	--	9(3)
California	178,700	340,060	518,760	21,202,559	2.4	8.4	1.5	
Inperial	1,700	16,000	17,700	84,276	21.0	16.2	5.5	10(1)
S. Diego	950	6,600	7,550	1,584,583	0.5	8.6	1.5	3
BORDER TOTAL	2,650	22,600	25,250	1,668,859	0.9	--	--	13(1)
Riverside	12,000	13,000	25,000	529,074	4.7	10.9	1.5	1(1)
Orange	1,800	8,800	10,600	1,699,666	0.6	5.2	0.5	-
Los Angeles	1,500	3,100	4,600	6,986,898	0.1	8.2	1.2	2(3)
Venthra	8,000	13,000	21,000	437,853	4.8	7.4	0.6	(2)
Sta. Barb.	3,600	4,600	8,200	279,693	2.9	7.7	1.0	(1)
San. L. Obispo	300	2,100	2,400	129,154	1.9	10.9	1.1	1
Kern	7,000	30,000	37,000	349,874	10.6	12.6	1.4	5(2)
S. Bernadino	700	2,200	2,900	696,871	0.4	9.9	1.0	5 -
2nd BAND TOTAL	34,900	76,800	111,700	11,109,083	1.0	--	--	14(9)
TOTAL	37,550	99,400	136,950	12,777,942	1.1	--	--	27(10)
New Mexico	3,080	19,890	22,970	1,143,827	2.0	18.6	8.3	
Dona Ana	2,100	8,500	10,600	79,593	13.3	20.7	6.2	4
Hidalgo	--	--	--	5,820	--	22.1	4.1	-
Luna	--	--	--	14,421	--	20.5	6.5	-
BORDER TOTAL	2,100	8,500	10,600	99,834	10.6	--	--	4
Grant	--	--	--	24,377	--	11.8	7.9	-
Sierra	--	--	--	8,302	--	23.9	7.8	-
Otero	--	--	--	42,727	--	12.3	1.9	-
2nd BAND TOTAL	--	--	--	75,406	--	--	--	-
TOTAL	2,100	8,500	10,600	175,240	6.0	--	--	4

BORDER AREA SELECTED DATA

	A Migrant	B Seasonal	C Total	D Population	E Percent C + D	F Percent Poverty	G Percent Plumb, Def.	H BCHS Clinic
U.S.	846,700	1,894,000	2,740,700	213,030,000	1.3	10.7	5.5	73(22
BORDER	179,470	80,330	259,800	3,381,444	7.7	-	-	46(5)
2nd BAND	69,940	102,260	172,200	12,783,587	1.3	-	-	27(17
GRANT TOTAL	249,410	182,590	432,000	16,165,031	2.7	-	-	73(22

SOURCES: 1978 Migrant Health Program Target Population Estimates (Draft)
County and City Data Book - 1977, Bureau of the Census
Directory of BCHS Projects (Draft)

Cost of No Water and Sewerage

40 Days Diarrhea and Parasitic Infection
50% Lost Nutrition
20 days of lost food
$ 1.50 per day for food
$30.00 Lost food costs per capita

300 calories per day for hauling water
x364
109,200 ÷ 3,000 = 36.4 days of food
36.4 x $1.50 = $54.60 ÷ 4 = $13.65 per capita

2 Encounters for water related illness
x$20.00 per Encounter
$40.00 per capita

1 week lost earnings
40 hours x $2.50 = $100 ÷ 2 = $50 per capita

Uncalculated costs

- Lost Development
  - Mental
  - Physical
  - Dental
- Reduced Life Expectancy

$133.65 per capita per year

- Increased mortality

DRAFT

RURAL ENVIRONMENTAL PROBLEMS

Problem and Current Effort:

About one-third of U.S. rural residents do not have potable water, indoor plumbing, and/or sewerage facilities. These environmental deficiencies have a direct link to poor health status, including parasitic diseases and gastroenteritis.

HEW does not have the authority to provide funding for housing or for developing water and sewerage systems; these are the functions of HUD, EPA, and USDA. However, legislative authority for both community and migrant health centers requires that the centers provide environmental services, unless they can show that such services are not needed in their target areas.

Through the National Demonstration Water Project, a CSA-funded public interest group, several rural primary care centers have successfully served as focuses of community organization and grantsmanship to bring water and sewerage facilities to their communities, thereby leveraging capital funds available from non-HEW sources.

Proposal:

This initiative can build on the successful experiences at Beaufort-Jasper, South Carolina and Marianna, Arkansas to use the rural primary care center as the community infrastructure for rural water and sewer projects. The centers would detail a person to:

- help the community articulate its needs,
- identify sources of assistance,
- maintain momentum,
- provide administrative support,
- tap other resources.

Justification:

Improving environmental conditions is a cost-effective means of preventing illness and premature mortality. Primary care centers are the logical focus of such improvements since:

- the link between health status and environment is clear,
- the centers already have expertise in effective management and grantsmanship.

- the centers are recognized community-based organizations, for they are non-profit corporations controlled by their users.

Questions for Discussion:

1. Should this be an HEW effort?
2. How should HEW target such projects?
3. How can HEW assist such projects?