EVALUATORY STUDY ON OPERATIONS OF THE MIGRANT HEALTH PROGRAM UNDER THE MIGRANT HEALTH ACT

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FOREWORD

This report concludes an evaluatory study of the operations of the Migrant Health Program authorized under the Migrant Health Act (PL 87-692) passed in September, 1962 and conducted by staff of the American Public Health Association under contract with the United States Public Health Service. The report is based on a study to determine if the program, authorized by the Act has achieved, or shows promise of achieving the intent of Congress to improve health services in rural areas, emphasizing the needs of domestic agricultural migratory workers.

Throughout the Study there was an awareness that the Migrant Health Act represented pioneering action by Congress to remedy years of neglect of a significant number of American citizens. All persons closely associated with the Study were imbued with the same desire as the Congress which passed the bill and those who administered its provisions; namely, to determine the most effective ways of providing health services to migrant seasonal farm workers.

This report does not imply universal endorsement of its conclusions or recommendations. It does represent a concensus of opinion and a considered judgement of the many persons who were involved. Those suggestions which may be controversial will most certainly provoke more thought on Migrant Health Problems, and this in itself is a valuable contribution.

RECOMMENDATIONS

1. IT IS RECOMMENDED THAT the Migrant Health Act (PL 87-692) be extended five years beyond its current expiration date with a review to be conducted at the end of three years and with consideration given to suggested modifications designed to enhance its effectiveness.

   RATIONALE: As a beginning effort, the achievements made possible under the Migrant Health Act must be viewed as considerable. The creation of family health service clinics, providing preventive medical care in some areas for the first time, gave tangible proof of direct-service benefits to migrant farm workers and increasing local interest in their specific health problems. Recognizing the limitations of the Act itself, its internal administration and program implementation, we feel that it must be viewed not as a solution, but as a step, in the creation of comprehensive health care for farm workers and their families.

2. IT IS RECOMMENDED THAT Congressional appropriation of an amount not less than $10,000,000 be authorized annually to finance continued operations of the Migrant Health Act, and that such appropriation include sufficient funds to provide necessary medical and hospitalization coverage for domestic seasonal farm workers and their families.

   RATIONALE: Most of those involved in the operations of the Migrant Health Act report that its most serious deficiency relates to medical care. Exclusion of payment for hospitalization and inadequacy of funds for private medical care are serious handicaps. They severely restrict and sometimes negate the potential benefits from clinic service by preventing follow-up

of patients referred both for emergency and rehabilitative services. Total medical care costs (including hospital and dental care) for 1962 in the United States were roughly $21 billion or $110 per person. Proportionately the total care for 1,000,000 migrants would be $110,000,000. However, this proposal does not aim at total care for all migrants as some are presently covered. To some extent, it is estimated that ten percent of the maximum would provide necessary services for those seasonal farm workers who require primarily emergency, maternal and rehabilitative care under Migrant Health Programs. Efforts under the initial appropriation have demonstrated the great inadequacy of allocated funds in solving the complex problems of domestic agricultural farm workers on a national scale. In order to build upon the advances made under the Migrant Health Program substantial increases in financial support are needed.

3. IT IS RECOMMENDED THAT state and local governments should eliminate their residency requirements as a basis for receipt of hospitalization services public assistance. To encourage such assistance to needy migrant families, such as programs for aid to dependent children, larger federal public assistance grants should be given to counties with substantial numbers of migrant families when such residency requirements are eliminated.

RATIONALE: The counties must now contribute to the cost of public assistance, so their imposition of residency requirements is understandable. If, however, through Federal legislation more money is granted to them to serve the needs of non-residents, they may be expected to relax their restrictions. The lowering of residency requirements in various political subdivisions

would undoubtedly benefit many migrant agricultural workers. Especially is this true in areas where the availability of hospital services is dependent upon compliance with residency requirements. It is doubtful, however, that residency requirements could be reduced sufficiently to qualify a majority of those migrants who reside in any one jurisdiction for only a brief period and therefore the contributory approach seems most realistic.

4. IT IS RECOMMENDED THAT consideration be given to financing special seasonal farm workers health studies to be conducted by responsible national, state and local organizations.

RATIONALE: At present, funds under the Migrant Health Act are restricted solely to service projects. Yet, there is a continuing need to study (a) ways and means of providing and evaluating health services, and (b) methods of extending health coverage to seasonal agricultural workers, including medical and hospitalization insurance.

The study results indicate that while health services in project and non-project areas may be available to the agricultural worker, the extent of utilization and barriers to their usage often are based upon opinion and not facts. Studies of situations by demonstrating the existence of needs may in themselves stimulate improved programming, or in non-project areas, initiate requests for federally-supported funds for health care.

Several types of health insurance programs have been sponsored by farm organizations and growers with no final evaluation as yet as to their feasibility. Further exploration of insurance methods is recommended,

particularly for areas where clinics cannot be readily organized, but where care is available through private physicians' offices or hospitals.

Other special studies which seem indicated are (a) the extent of hospitalization and (b) evaluation of health education methods among seasonal farm workers.

5. IT IS RECOMMENDED THAT the term "Domestic Agricultural Migratory Worker" be changed to "Domestic Seasonal Farm Worker" and that this latter term be used in all subsequent legislation respecting eligibility for coverage under the Migrant Health Act.

RATIONALE: Extensive contact with and research into the medical problems confronting this nation's domestic agricultural labor force demonstrate with dramatic clarity that serious unmet health needs characterize migrant and non-migrant alike; they are, indeed, virtually indistinguishable from health problems affecting all of the rural poor. Further, as most farm workers migrate in search of work at some time during their unemployed months, and as such migration usually causes loss of legal residence, classification of the farm labor force on the basis of migrancy is both unrealistic and injurious. To single out the migrant minority as deserving of special consideration is to ignore the equally difficult circumstances of the great majority of American seasonal farm workers.

6. IT IS RECOMMENDED THAT efforts be continued to pass legislation aimed at improving the situation of migrant seasonal farm workers in regard to a minimum WAGE law, unemployment insurance, workmen's compensation, child labor

and the right to collective bargaining.

RATIONALE: These benefits are now enjoyed by practically all workers in America except migrant seasonal agricultural workers. In our study of health needs and services for migrants it became increasingly clear that their many social and economic needs overshadowed health problems. In fact, proper maintenance of health cannot be attained without improvements in their economic status and some legal protection of their human rights.

7. IT IS RECOMMENDED THAT consideration be given to ways and means of establishing Community Health Service Clinics, particularly in rural areas, throughout the United States utilizing already established medical channels in all communities where such services are available, which is in keeping with the policy statement of the APHA adopted at their 91st Annual Meeting, November 10, 1963.

RATIONALE: Community Health Service Clinics would not serve to fulfill the day to day needs of agricultural workers in their acute and sub-acute medical problems. However, present fragmentary and uncoordinated health services would be eliminated by proper organization of public and private agencies giving preventive, treatment and rehabilitative services within one community health service center.

It is recognized that no single pattern for community services can be applied throughout the country and that patterns should be based upon service areas and not necessarily limited by political boundaries. Regionalization of certain health services may be necessary in order to

provide a full range of services in the most economical manner.

The APHA supports the principle that comprehensive medical care of good quality should be available to all persons in our society. The Association proposes that this can be facilitated through improving the organization of services within the framework of community health service centers under dynamic public health leadership.

8. IT IS RECOMMENDED THAT principal emphasis be given to financing projects which give evidence of developing truly comprehensive health service including medical care.

RATIONALE: The present study revealed numerous gaps in the health services currently available to migratory agricultural workers. While considerable progress has been made through the grants program to date, relatively few areas have developed the basic core of health services needed. In many project areas only health education and sanitation services are provided; in others, primary emphasis is placed upon nursing services and communicable disease control. The absence of adequate diagnostic and treatment services for migrants was especially noticeable in most of the areas visited. Since migrants are in need of total health care, as they move throughout the stream, comprehensiveness of services provided should be a major criterion used in reviewing applications for new project grants and requests for continuation of existing projects. For the purpose of grant review, "comprehensive health service" may be defined as those services required to prevent illness, to maintain good health, and to cure or alleviate any sickness. This should include necessary rehabilitation efforts to return

workers to their jobs and others to full family participation.

9. IT IS RECOMMENDED THAT application procedure and reporting forms be greatly simplified for use in the Migrant Health Grants Program.

RATIONALE: The study revealed that the application and reporting forms and procedures currently used in the Migrant Health Grants Program are extremely complex and time consuming. Many project directors questioned both the amount and nature of the information requested. It was found that the preparation of the annual reports of even the smaller projects ($7,500 or less) required two to three weeks. The Migrant Health Grants Reporting Kit that is currently used was designed to obtain detailed information regarding the migrants in the project area and data regarding the services provided them. The study team's review of the kit suggests that it is probably unrealistic to expect health service projects to collect the amount of data currently requested especially on demographic details. In addition, the validity of some of the information obtained through this method is very questionable. For this reason, it is recommended that the data collection forms and procedures be carefully reviewed and simplified wherever possible.

10. IT IS RECOMMENDED THAT close cooperation be maintained between the Public Health Service Migrant Health Branch and the Office of Economic Opportunity to obtain maximum benefits to rural areas through coordination of health services and facilities provisions of these two Congressional Acts.

RATIONALE: The passage of the Economic Opportunity Act of 1964 (PL 88-452) has contributed possible means to combat the impoverished status of rural areas and specifically through assistance for migrants and other seasonally employed agricultural employees and their families. The community action section of the Act provides for programs in the fields of health employment, housing, and welfare among the types of activities permitted in both urban and rural communities. Section 311 of the Act provides assistance specifically for migrants, and other seasonally employed agricultural workers and their families through authorizing programs for housing, sanitation, education and day-care for children. These programs are essential to any lasting improvement in the health of seasonal farm workers. It seems vital therefore that a close working relationship be maintained by the Migrant Health Branch and the administrators of the Economic Opportunity Act.

11. IT IS RECOMMENDED THAT (a) intensive effort be directed toward developing a uniform basic core of health services in all areas where projects are located; (b) attention be given to developing and implementing an effective patient record and referral system; and (c) methods of improving inter-area communication and coordinated use of health resources be explored, in order that continuity of health care may be provided.

RATIONALE: The wide variation of services offered among the different projects suggests that their scope has been determined less on the basis of the health needs of migrants than on a basis of avoiding controversial reactions. (a) Health needs of migrants are the same as those of the rest of the population. The services required to meet these needs vary in almost

every locality. Health needs require efforts and facilities designed to achieve the physical, mental and social well-being of all the people. Local assessment will determine what services are required to provide their goals. (b) Inasmuch as several projects may deal with one population group during the course of a year, the need for continuity is obvious. Continuity of health care for a migrant appears, in part, now dependent upon the sheer mechanics of seeking service in different localities. Lack of continuity may cause the complete loss of efforts applied earlier in the workers' migration.

12. IT IS RECOMMENDED THAT family planning be included as an integral part of health service clinics which also should make available medical advice and services acceptable to the individuals concerned.

RATIONALE: Problems associated with family life were reiterated time and again in field interviews. The study team concurs with the policy statement by the APHA adopted on October 21, 1959 which states that "Serious public health problems are posed when family size impairs ability to sustain a healthful way of life, when childbearing may affect adversely the health of the mother and her offspring, when the cultural and spiritual aspirations of the family are frustrated by sterility.

"...The healthful effect of family planning and spacing of births has been recognized by leaders of all major religious groups, as well as by leaders in medicine, welfare, and public affairs. Several methods are now available for the regulation of conception, one or another of which may be selected as medically appropriate, as economically feasible, or as consistent with the creed and mores of the family concerned."
(American Journal of Public Health, Volume 49, No. 12, pp. 1703-1704.)

13. IT IS RECOMMENDED THAT (a) the current PHS Regional structure be modified to encourage freedom of movement of the consultative staff in accordance with the inter-state movement of migrants and (b) the present consultative staff in Washington be appropriately supplemented with staff to give increased attention to program development and evaluation along the major migrant streams.

RATIONALE: The traditional regionalization pattern of the Public Health Service draws artificial geographic boundaries, incongruent with the movement of the migrant farm force. In some parts of the country the same migrant group may pass through as many as four separate PHS Regions, thereby "belonging to" each region only for short periods of time. The present pattern of regionalization, therefore, ought to be modified in accordance with the geography of the various migrant streams throughout the nation.

It is apparent that further program development will call for additional consultative staff to provide service to local projects. Service at present is of high quality, but there is need to extend and broaden its functions. The Washington, D. C. staff cannot adequately service the entire country. The prospective increase in projects scattered throughout the nation would indicate the probable need for qualified consultants in each of the three main migrant streams.

14. IT IS RECOMMENDED THAT the effective employment of sub-professional health personnel be encouraged and when possible, recruited from the indigenous group. This should be promoted wherever appropriate under proper supervision. The training, placement and use of community health aides in Migrant Health

Projects, should be examined and evaluated to this end.

RATIONALE: Sub-professional health workers are needed to cope with the great shortage of trained personnel in many rural areas. Use of members of indigenous work group as part of health teams has facilitated meaningful communication between client and professional personnel, and has helped to dispel fears and antagonisms of many persons in need of personal health services.

However, the backgrounds, training, roles and functions of these personnel have varied among the projects, as did the extent of their contribution. An evaluation of selection criteria, their roles and function, should be conducted with the view towards developing health education techniques adapted to this segment of the rural population.

15. IT IS RECOMMENDED THAT training centers in intercultural understanding be established in important areas of migrant concentration and that participation in such programs be encouraged for both professional and sub-professional members of the Migrant Health Staff.

RATIONALE: Difficulties encountered with cross-cultural understanding and language differences have impeded the effectiveness of available health services. Acceptance of health care by ill-educated, semi-illiterate persons is often influenced by deeply ingrained beliefs, the attitudes and motivations of these people must be appreciated. Too often impoverished farm workers are talked <u>to</u> instead of <u>with</u>, so that they become alienated even by well-meaning professional personnel.

Training centers can possibly be established through contractual arrangements with universities where resource persons may be available for interpreting migrant culture to health personnel.

INTRODUCTION

Prior to the enactment of the Migrant Health Act of 1962 (Public Law 87-692), few concerted efforts were made at the national level to cope with the health problems presented by the nation's migratory farm labor force. Numbering more than a million persons, migrant farm workers and their families are in the lowest economic stratum of the United States population.

The Migrant Health Act was passed on September 25, 1962, authorizing an appropriation of funds not to exceed three million dollars annually for three years, and empowering the Public Health Service to make grants to public and non-profit agencies, institutions and organizations. Grants awarded were designed to help finance family health service clinics and other special health projects for the benefit of domestic agricultural migratory workers and their families. Grant recipients were encouraged to seek support of all other programs promoting a similar purpose. A three-year limitation incorporated into the Act imposed the provision for review of the program's effectiveness prior to Congressional consideration of its future in 1965.

As its primary objective, this Study attempted to determine the extent to which the Migrant Health Program has achieved---or shows promise of achieving --- the intent of Congress to improve health conditions of domestic agricultural migratory workers. The study's secondary purpose involved an examination of health conditions in areas of general rural poverty and as assessment of factors relevant to non-project situations in an effort to determine possible consequences of program expansion.

The American Public Health Association was requested to make recommendations relative to continuation of the Act and to offer, where indicated, appropriate suggestions to increase its effectiveness. The American Public

Health Association was chosen to make this study because it was felt that "an objective, impartial evaluation by a nationally known and recognized organization of professional competence such as the American Public Health Association would be highly desirable in making recommendations to Congress regarding the need for continuation of the program when present legislation is reconsidered."

Funds to implement the Migrant Health Program were not appropriated until May, 1963. This Study was begun in April, 1964 -- prior to a full year of program operation. The short period of the program's existence did not permit a meaningful statistical analysis, nor did the time allotted for this Study allow significant investigative research. As a consequence, this report evolves from a review of previous reports, field visits to a majority of projects as well as rural areas without projects and a free use of knowledgeable consultants. The Study itself was arranged to obtain as much information as possible within the time allowed by contract, retaining a sufficient margin for objective consideration of findings and thoughtful concern with recommendations.

Personnel recruited for this Study were individuals with years of previous experience with the problems of both migratory workers and others similarly affected. Two field workers were associated for more than a decade with studies of migrant agricultural workers along the East Coast. One member of the Study Group, now a university professor, partially financed his education as a migrant farm worker in California; he later spent years investigating various social problems of Southwestern Indians. Another field worker had spent two seasons devoted to interviewing seasonal farm workers, exploring their backgrounds, migratory patterns, personal needs, and individual situations; data from over

seven-hundred documented interviews were contributed to this Study. The physician-director of the Study represented experience as a private practitioner in rural areas, surveyor of war-time health resources, health director of war refugee camps, and medical care administrator in poverty-stricken Appalachia.

A highly qualified Advisory Committee of twelve members gave supplemental advice and direction to the active study group. These committee members represented the fields of medicine, public health, nursing, engineering, welfare, education, church, and agriculture. All were presently, or had been previously, associated directly with the health problems of the medically indigent, migrant and non-migrant alike. In addition, numerous consultants have been used to strengthen those areas in which their past experience qualified their contribution to the preparation of this report.

To create an informed and historically objective approach to domestic migrant workers and their difficulties, a review was made of all available literature of the past half century which dealt directly with their activities. The most impressive fact to emerge from this review was that, in spite of the full documentation given to the unfortunate situation of seasonal farm workers over a period of some fifty years, no permanent program or sustained effort to benefit their condition had been forthcoming until the passage of PL 87-692.

To explore the availability of health services in rural areas of the United States, a consultant, now with the Institute of Governmental Studies of a large state university, surveyed available literature and sampled by questionnaire various agencies in the twenty-seven states that employ a minimum of 5,000 migrant workers at peak season. Agencies sampled included the health and welfare departments, agricultural extension services, state medical societies, and, where such agency existed, the state committee on migratory labor. Replies were

received from at least one agency addressed in all states, and from all agencies in several states. The results of this survey indicated a general abdication of responsibility for migrant health care, and a corresponding state-wide framentation of available services.

The field work of the Study extended into twenty-eight (28) states and included thirty (30) projects operating under the Migrant Health Program as well as some impoverished rural areas having no projects. Twenty-two State Health Officers or members of their staff and others knowledgeable about agricultural labor were consulted relative to general health problems as well as those of domestic agricultural migrant workers.

The time specified for completion of the study did not permit a visit to every project or of those visited to see them at the peak of their operations. Most statistical data on each project and available to the field staff were copies of those already submitted to the Migrant Health Branch and recently published. While these figures represented for the most part less than a full year of project operations, they still were considered in the final evaluation of services.

The importance of increased concern over the situation of the migrant seasonal farm worker has been intensified by Congressional action to discontinue the "Mexican National" or "Bracero" program on December 31, 1964. An estimated 400,000 single Mexican Nationals have come into the United States each year to perform seasonal farm work throughout the country. Through Inter-national agreement these workers were protected under insurance for health care, a minimum wage provision, transportation guarantees, and adequate housing stipulations. Though these provisions were not always of the most desirable quality, it must be viewed as significant that the United States

Government recognized such guarantees as minimal protection for foreign contract labor. And yet more significant still is the fact that domestic workers, our own citizens, have not been extended the same rights and benefits available to imported labor. With a need to attract and retain replacements for some 400,000 Braceros from our own domestic unemployed, it appears obvious that coverage at least co-extensive to that enjoyed by foreign workers will have to be provided.

The results of the Study point inescapably to the conclusion that the present Migrant Health Act must be seen as but a first step in any attempt to effect permanent improvement of the health of the seasonal farm work force. Additional efforts to improve housing, environmental sanitation, wage base, education and community acceptance are all equally important and interdependent.

BACKGROUND OF MIGRANT HEALTH NEEDS

The domestic agricultural migrant workers have been considered the most depressed segment of our population for many years. Their situation has been studied in much detail by individuals, organizations, governmental agencies and commissions. Each year, new evidence of their plight has been accumulated; however, very little has been done to improve their situation other than infrequent, fragmentary, and uncoordinated local actions. Public Law 87-692 is the first specific act passed by Congress to initiate a program toward alleviating the unusually depressed conditions faced by these American citizens who, because of their transiency, forfeit most of the local legal entitlements available to other residents. Their mobility, low economic status, language difficulties and cultural differences, multiply many times over the problems shared with other rural poor.

The Domestic Agricultural Migrant Worker may earn sizeable sums for brief periods on a piece rate basis but the only meaningful index is their annual wage. The unpredictability of weather and crop production places him in a very low annual income category. In 1961 the average seasonal farm worker found 134 days of work and earned $912. Since he is not covered under Unemployment Insurance, he must earn enough when employed to provide for his family during many months of idleness. The migrant worker has practically none of the benefits enjoyed by those in other industries. He has no organization to speak for him in seeking minimum wages and hours; health and safe working conditions; or any of themany other fringe benefits taken for granted by most American workers. Although legally entitled to Social Security coverage, his migrancy generally results in too short a work period with any one employer, or insufficient wages to require reporting to a Social Security Office. The

migrant worker frequently makes no offer to pay his Social Security contribution because of personal financial stress and his inability to even purchase necessities for living. He usually must pay for transportation to localities where temporary hired hands are needed, and returns to the place where he can live most economically during the winter or when work is scarce.

The vast majority of migrant agricultural workers reside during the non-working season in the Southern part of the country where the minimal need for well-insulated housing, heating and heavy clothing helps to relieve some economic pressure. Generally in his home-base area he is totally indistinguishable from his non-migratory neighbor who is usually of the same ethnic or racial group. The married worker generally accepts migratory status because of economic necessity, and only the occasional single worker entering the migrant stream appears to prefer it to other alternative means of livelihood available to him.

The domestic agricultural migrant worker moves to find work -- not from desire, but from necessity. He normally has a family above the average in number and prefers to take them with him since additional workers add to the family income and make independence a bit more likely.

Migration penalizes a farm worker in many ways. It prevents his establishing permanent residence and normal home life. Frequent and enforced disruptions in the continuity of education of migrant children result in retardation and encourage school drop-outs. Migrants are employed for short periods in many temporary work areas and discover that persons of similar ethnic or racial extraction are either absent or in the minority. As a rule migrant farm workers' families are not accepted socially by communities and are discouraged in remaining longer than is absolutely necessary to the production of local crops. Particularly for the Spanish-speaking do language barriers present

obstacles to the transmission of positive community attitudes toward the migrant, and they hinder communication of migrant needs and desires to local residents. Additionally, language difficulties often interfere with or prevent continued education of migrant children.

The domestic agricultural migrant worker is among the most destitute of the poor. He is normally unable to clothe, feed or house his family adequately. Medical care is sought and obtained only in situations requiring emergency attention or when a chronic condition becomes extreme. The migrant workers' cultural background and economic status results in the use of home remedies and folk-curing practices before consideration is given to the possibility of using available medical services. This appears to be true even where such services are available at no cost to the worker. Only after medical services adapted to their situation have been made available for an extended period, and after language and cultural barriers have been surmounted do migrant agricultural workers tend to accept them.

If the migratory agricultural worker in transit is asked what he considers his greatest need to be, he will more frequently mention higher wages, a better place to live, or solutions to his travel problems before he mentions health services inasmuch as these appear to him to characterize his life. In health matters, migrant families focus their concern on their children. The worker and his wife normally seek medical services only when disabled. Throughout the years the domestic migratory agricultural worker has rarely had access to medical services, and when available, has usually been excluded by legal technicalities.

The domestic agricultural migrant workers have the same health needs as any other citizen of the United States, but they are seldom met. The methods

devised and implemented by communities to meet these needs vary significantly, but in almost every case the results have been limited.

THE MIGRANT HEALTH PROGRAM

Direct Operations - Migrant Health Branch

The Migrant Health Act (PL 87-692) was passed by Congress on September 25, 1962, and authorized an appropriation not to exceed $3,000,000 a year for three years to enable the Surgeon General to make grants to public and other non-profit agencies, institutions and organizations, to help finance family health service clinics and other special health projects for domestic agricultural farm workers and their families as well as to encourage and cooperate in all programs having the same purpose. The three-year limitation was incorporated in the Act to provide for a review of the adequacy of the program prior to consideration of its continuation in 1965.

Although the Act authorized the appropriation of a maximum of $3,000,000 a year for three years, no funds were made available until May, 1963. At that time $700,000 was appropriated specifically for grants to projects already having approval of the Migrant Health Branch of the Public Health Service. For the fiscal year 1963-64 the sum of $2,000,000 was appropriated with $500,000 designated for direct operations of the Migrant Health Branch and the remainder for project grants. For the current fiscal year (1964-65) the maximum of $3,000,000 was made available with $500,000 for direct operations and $2,500,000 for grants to new as well as continuing projects.

To carry out the provisions of PL 87-692 the Public Health Service established the Migrant Health Branch within the Division of Community Health Services. The major responsibilities of the Branch are:

1. To administer the Migrant Health Program;

2. To supplement and assist health efforts whether or not they involve a need for grant assistance;
3. To encourage and promote inter-agency, inter-governmental and inter-area planning and program development for the improvement of migrant health services and conditions;
4. To maintain a general intelligence unit on the overall problems of rural health of which those of migrants are an important part;
5. To carry on continuing evaluation of the migrant health situation and the program's effectiveness in meeting migrants' health needs.

To implement these responsibilities the Migrant Health Branch established a central office staff of members drawn from the fields of medicine, nursing, sanitation, health education, rural health and public administration. To expedite work in the field a Migrant Health Representative was placed in each of eight regional offices of the Public Health Service where he serves as liaison with state, public and voluntary organizations in promoting improvements in health services to migrant workers.

The Migrant Health Branch is assisted in the consideration of grant applications by a Review Committee composed of members from the fields of public health, medicine, agricultural, social science, employment and community organization. Members are further qualified by specific knowledge of migrants and their health problems throughout the United States. The Committee meets three times a year.

The Migrant Health Branch established guidelines by which grant applications are evaluated, in order to assure that projects carry out the intent of Congress in passing the Act; namely, to improve health services to migrants and upgrade

their health conditions.

Applicants for grants are informed of the purposes of the Act and requirements to be met for project approval. Assistance in developing plans and in making out the application is given, if the applicant desires, by regional or central office or both.

Requests for grants are then reviewed by the following before actual submission to the Review Committee:

1. State Health Officer where the project is to be located;
2. The Regional Office of the USPHS serving that State;
3. Migrant Health Branch, USPHS;
4. Other DHEW agencies having pertinent technical aspects;
5. Office of Grants Management, USPHS, for conformance with governmental rules and regulation;
6. Other public and voluntary agencies, as appropriate.

After thorough discussion in the Project Review Committee, an application is approved, not approved, or deferred for modification or for other reasons. Approved applications are given a priority rating based upon program content, soundness of plan, possible contribution to migrant health, and the availability of appropriation funds.

While no specific state or local cash-matching funds are required, the project applications indicate that forty percent of the total budgeted costs of grant-assisted migrant health projects have been met from other than Public Health Service grant sources. In addition to state and local financial contributions, such matching takes the form of making available services, facilities and equipment, physicians services, donations of drugs and other supplies,

costs of hospital care, laboratory services, transportation of patients and other volunteer services. Many of the project communities also provide day care centers, emergency welfare assistance, recreational services and clothing centers for migratory agricultural workers and their families.

Evaluation of Direct Operations

Evaluation of Migrant Health Program requires an examination of the organization and operations of the Migrant Health Branch in implementing its responsibilities under PL 87-692. The American Public Health Association Study Group has received full cooperation from the Public Health Service in providing information on all phases of the program. Project applications and reports have been made available for review and all central staff as well as regional representatives have supplied information and assistance whenever requested. While trying to be impartial, the staff has been fully aware of problems confronting the Public Health Service in carrying out the wishes of Congress.

The findings of the Study indicate that the Migrant Health Program has clearly operated within Congressional intent. Given consideration of the short period of operation and the numerous problems encountered in local areas throughout the nation, the Study results reveal that the Program has been exceptionally effective. The potential benefits to be derived from continued operation and possible expansion of coverage to other areas of rural poverty have been amply demonstrated in the visible accomplishments achieved under the Migrant Health Program.

Staffing and organization of the Migrant Health Branch was accomplished by the Public Health Service prior to the time when funds became available for grants. Advance preparation of projects made it possible to allocate all

funds as they were received by the Branch and to create a fairly widespread variety of projects serving a small (17%) but notable segment of migrant farm workers' group. While a total of $9,000,000 was authorized under the Act, only $5,750,000 will have been made available for projects during the three years of its existence. Applications for grants have persistently exceeded the funds in hand, leading to some frustrations and criticism from communities which have not received assistance.

Early in the conduct of this Study comments were received expressing concern about the apparent disproportion of the total authorized annual appropriation ($3,000,000) allocated for direct operational services of the program ($500,00). However, Congressional awareness of the appropriation apportionment was established in the budgetary presentation in hearings prior to passage of the Act, and where the proposed activities of the Public Health Service were fairly well outlined. It is the Study Group's opinion that this seeming disproportionment may be due to relating direct services to ordinary administrative costs. In fact, only a fraction of direct operational service funds are used for administrative purposes. The major portion of such funds supports the promotional, educational and consultation services necessary to the development of the most effective methods of improving the health of domestic agricultural migratory workers.

Some early criticism of the program was also aimed at supposed failure of the program in establishing more family health service clinics since this was apparently the primary intent of the Migrant Health Act. A study of grant applications together with actions of the Review Committee indicate that all reasonable requests for grants to establish clinics were approved. A relatively high proportion of grants to provide nurses, sanitarians and health education activities apparently were due to the immediate need in localities already

providing some health services to migrants. There was also an effort to utilize delayed funds to the fullest extent possible in the limited time left under the Act. It is doubtful that a greater number of family health service clinics of an acceptable nature could have been approved.

STUDY OF PROJECTS

PROJECTS IN OPERATION

Between the appropriation of the initial fund by Congress in mid-May, 1963, to June 30, 1964, over eighty-five applications were submitted and forty-five grants awarded. Forty projects were in operation at the beginning of the current fiscal year, and approximately eleven more projects have since been approved. The projects range from those providing comprehensive health coverage services to those providing a single service; no single project included all services. In some areas having projects of limited scope it was learned that more comprehensive services were actually available to migrants from other sources. Project requests were based on the perceived greatest needs tempered by acceptability to local government or other voluntary groups.

During the course of the study team's visits to projects and in their discussions with Public Health Officials and other persons interested in and dealing with domestic agricultural migrant workers, no new facts relative to the conditions and problems of this group were found. However, while the total needs of migrants remain the same over the nation, local resources, attitudes and environments determine particular problems and the manner in which they are solved. The study team's attention was therefore focused upon problems within project areas to determine whether or not Federal funds were being used effectively in improving the health conditions and services given to migrant families, and upon these same needs as they relate to the rural agricultural poor.

The projects operating under the Migrant Health Act were designed to improve health services to a specific segment of agricultural workers. A study of their operation offers an opportunity to evaluate the needs of both migrant and non-

migrant farm workers in certain localities as well as permitting comparison with needs of other rural poor in the same areas.

This table indicates the wide-spread operations of the Migrant Health Program and the variety of services being supported by project grants.

PROJECTS OPERATING ON 7/1/64

GRANT NUMBER	SPONSOR (Health Dept. /or Migrant Committee	STARTING DATE	FAMILY HEALTH SERVICE CLINICS	SANITATION	NURSING	NUTRITION	HEALTH EDUCATION	DENTAL SERVICE	SOCIAL WORK	IMMUNIZATION	CONSULTATION	OTHERS
MG-29, Ariz.	H.D.	6/63	x		x		x					
MG-49, Ariz.	H.D.	6/63	x	x		x	x		x			
MG-50, Ark.	M.C.	6/63	x	x	x		x					
MG-06, Cal.	H.D.	7/63	x	x	x		x		x		x	
MG-09, Colo.	H.D.	6/63		x	x	x	x	x				TB
MG-11, Fla.	H.D.	7/63		x	x		x				x	
MG-18, Fla.	H.D.	9/63									x	
MG-34, Fla.	H.D.	1/64	x	x	x		x					
MG-20, Ind.	H.D.	6/63		x	x		x	x				
MG-23, Iowa	M.C.	6/63		x	x		x					
MG-64, Kan.	H.D.	1/64		x	x		x	x				
MG-74, Kan.	H.D.	4/64	x	x	x		x	x				
MG-54, La.	M.C.	3/64	x		x		x	x				
MG-30, Mich.	H.D.	1/64									x	
MG-31, Mich.	H.D.	6/63	x	x	x		x					
MG-10, Minn.	H.D.	6/63		x								
MG-67, Minn.	H.D.	4/64			x							
MG-08, N.J.	H.D.	6/63		x	x		x	x	x	x		
MG-15, N.M.	M.C.	6/63		x	x		x					
MG-38, N.Y.	H.D.	6/63	x	x	x		x					
MG-47, N.Y.	H.D.	6/63	x	x	x		x					
MG-48, N.Y.	H.D.	6/64										
MG-60, N.Y.	H.D.	6/64	x	x	x				x			
MG-27, N.C.	M.C.	6/63	x				x			x		
MG-28, N.C.	H.D.	6/63	x	x			x					
MG-56, N.C.	H.D.	6/63	x								x	
MG-57, N.C.	H.D.	5/64										
MG-01, Ohio	H.D.	6/63			x		x	x		x		
MG-21, Ohio	H.D.	6/63	x	x	x		x					
MG-24, Ohio	H.D.	6/63		x								
MG-61, Ohio	H.D.	4/64	x				x	x				
MG-36, Ohio	H.D.	6/63					x					
MG-35, Ohio	H.D.	6/63	x				x	x				
MG-05, Ore.	H.D.	6/63	x	x			x					
MG-63, Ore.	H.D.	4/64	x	x	x		x	x				Mental Hygiene
MG-65, Ore.	H.D.	4/64					x					
MG-33, Pa.	H.D.	6/63	x	x	x		x					
MG-26, S.C.	H.D.	6/63	x	x	x		x					
MG-03, Tex.	H.D.	6/63		x	x		x			x		
MG-37, Tex.	H.D.	1/64	x	x	x			x				
MG-42, Tex.	H.D.	7/63	x	x	x							
MG-44, Tex.	H.D.	7/63	x				x	x				
MG-46, Tex.	H.D.	6/63		x	x		x					
MG-41, Va.	H.D.	6/63	x	x	x		x					
MG-19, Wash.	H.D.	6/63			x							
45	- -	- -	25	29	29	2	33	12	4	4	5	Totals

Population

Estimates of the migrant population in the various project areas were based on a definition of the migrant differing according to the availability and reliability of local data. Some areas included home-based families in their definition of the migrant group while others did not; in addition, source data within a particular locale showed marked variations in population estimates.

The figures available from the Department of Labor, Bureau of Employment Security, are the only ones currently gathered on a nation-wide basis which provide the type of local detail that is essential for development of service programs. Farm Placement Offices located in every county of the State are the primary source of statistics on the size and composition of the farm labor force in those counties. Farm Placement estimates usually agree substantially with those of the U.S. Census of Population and the U.S. Department of Agriculture, and are those frequently cited as the most reliable figures available on the agricultural labor force. And yet Farm Placement figures on seasonal workers include local teenagers, housewives, and other persons who are not heads of households or who are not primarily dependent upon farm labor wages for family support. Further, while Farm Placement is concerned with the number of workers required and present during each week, they do not attempt to enumerate the number of different persons in the county from week to week. That is, changes from week to week indicate only cumulative increases in number of workers, so that an estimate of 4,000 workers one week and 7,000 the next may mean that between 3,000 and 11,000 workers have entered or left the county within a two-week period. It seems highly probable that Farm Placement figures underestimate the number of different individuals engaged in farm work as described in the following detailed study.

Since Farm Placement is considered to be the authoritative source on farm labor size, the California Farm Worker Health Service studies questioned farm workers about their use of and experience with Farm Placement. In one very large county it was learned that only thirty-one percent of all those interviewed had been, at any time in their farm work career, to one or more Farm Placement Offices. Of these, twenty-five percent had used the Services in the county studied, while six percent had used offices in other counties or States.

In addition, fully thirty-eight percent of local workers had been to Farm Placement. This finding in itself is informative in that one could assume that local workers would be more familiar than migrants with existing job opportunities and therefore would have less use for the Service. However, since local workers are in the area for longer periods, they rely on the Service when there are no jobs available during the slack seasons or when their own particular work cycle has been prematurely completed.

One must conclude that, in view of the general confusion surrounding a workable definition of "migrant agricultural worker" coupled with the absence of an accurate census, that the actual number of migrants probably comprise a larger segment of the total national population than current migrant labor estimates reveal.

The volume of services actually given was recorded by individual projects, but the absence of reasonably accurate base population figures made it impossible to determine the rate of utilization of services by migrant workers. Moreover, as treatment usually received precedence over recordation in family health service projects, health records tended to be maintained without close discrimination.

In addition, the proportion of total migrants served nation-wide was also impossible to estimate since the persons who received aid at one time in one

project area may also have been treated at another time elsewhere. An unduplicated enumeration is therefore exceedingly difficult to obtain.

Personnel

Project staff members, as a whole displayed high morale and dedication to duty. In only a few instances has there been evidence of major incompetency or inharmonious interpersonal relations. Communication difficulties between staff and migrants have been attributed to linguistic and cultural differences, although the use of bilingual health aides and volunteer interpreters from the migrant camps have helped in some situations. The unavailability of trained personnel occasioned some staff vacancies in projects, and the health clinics were usually understaffed. Thus during periods of local seasonal peak these clinics found it difficult to see all patients and maintain consistently good -quality care.

Ancillary personnel were employed by some projects to assist professional staff in a variety of ways aimed at gaining a better understanding of migrants and ways of extending health services to them. The backgrounds, roles and functions of these personnel varied from project to project, as did the degree of success reported by directors. Ancillary health personnel were utilized to make initial contacts with migrants in labor camps to: inform migrants about available health services; refer patients to family health service clinics; make cursory inspections of labor camp conditions; develop working relationships with crew leaders; collect certain data as directed by the professional project staff and as interpreters.

In general, professional staff members felt that utilization of ancillary

personnel had been helpful and worthwhile, though they emphasized the necessity for close supervision and a clear, exact description of duties.

Facilities

Available facilities varied with locale. In general, project headquarters were established within individual health departments, and personnel other than clinic staff used these as bases of operation. Clinics were situated in school and church buildings, barracks, or in mobile units near camps. In a few cases treatment and preventive services were given in physicians' offices or in existing city or county health buildings. Except for those held in permanent or mobile installations, medical facilities required organization of the site and equipment with each session. Of clinic facilities observed, which had been established by project funds, none was considered adequate for comprehensive medical service. Although the mobile units examined appeared simple in their assembly, they usually served as effectively on location as most "permanent" facilities. In addition, they possessed the added value of closer migrant contact than was possible with permanent facilities located some distance away. One project director commented that "without the mobile clinic we could not do our job". Clinic facilities were occasionally used for other traditionally public health activities in health education and immunization which were available to resident and non-resident alike.

Laboratory facilities were conspicuously absent in project clinics. When such work was necessary or desired, actual tests were conducted at a State or private laboratory some distance from the clinic. Unfortunately, critical time losss, infrequent clinic sessions, and patient out-migration often conspired to

nullify any benefits to be gained from completed laboratory work. Thus a primary element of the diagnostic phase of clinic evaluation was severely restricted, and it appears that this phase will require further development as the program continues.

Family Health Service Clinics

The delivery of services varied with the type of project undertaken. However, initial migrant contact was made by project personnel in all cases. Successful attempts were made to hold clinic sessions, educational meetings of all types, and family visits at times and places considered by project personnel to be convenient for the majority of migrants. In this respect, clinic services were made available to workers in the evenings when it was felt they would be better able to attend. Some project staff indicated, however, that in some localities women and children could possibly attend during the day, and that workers requiring emergency attention could take time during the day for medical services. Patients referred by nurses as having special problems requiring treatments unavailable in clinics were seen in physicians' offices.

Attempts to evaluate the quality of services rendered in each clinic are made difficult by the lack of comparative standards. Yet based on criteria developed by specialists in the medical care field the family health service clinics have provided, with few exceptions, a general practice-type care to a variable degree, although a few projects having arrangements with established clinics in their areas were equipped to offer more adequate service.

It was obvious in most family health clinics that the demand for and cost of drugs was not given sufficient consideration in the original project

application, with several projects depending almost exclusively on samples obtained from salesmen and physicians. Other projects dispensed certain commonly used and/or inexpensive drugs but were unable to pay for more expensive medications when needed. In one area where migrants were occasionally given prescriptions for moderately expensive drugs, these prescriptions rarely were taken to the pharmacy because the farm workers could not afford to have them filled. As medication may mean the difference between cure and chronicity and may be the only means of returning the worker or family member to normal activity, it appears imperative that such medication be within the purchase and geographic reach of farm workers and their families.

While the Study Team was unable to measure or evaluate the work of all specialized personnel provided through project grants, sufficient information was obtained about their specific accomplishments to indicate substantial contributions toward improving health conditions among migrant agricultural workers.

Environmental Sanitation

The addition of sanitarians provided more intensive coverage of camps and field areas, enabling several state and local projects to investigate every known camp within their jurisdiction--some for the first time. Many specific improvements in environmental sanitation have been made, thus reducing the likelihood of disease development and transmission. Improvements in housing and environmental sanitation were especially notable with those projects whose nurses, sanitarians and health educators worked in close rapport with growers.

Nursing

Under the provisions of the Act, it has been possible to supplement and extend concentrated public health nursing services to migrants. Public health nurses visited labor camps to provide nursing care for the sick, counseled mothers regarding maternal and child care, made referrals to family health service clinics, and provided follow-up services where indicated. Public health nurses also served in many family health service clinics, assisting physicians and providing other services for which their skills were required. It was evident that public health nurses played a major role in the provision of health services to migrants.

Health Education

Health education services to migrants have been extended substantially through provisions of the Migrant Health Act. Over seventy-five percent of the projects requested funds for this purpose, more than for any other type of service. Emphasis and efforts in this regard varied among projects. Health education specialists are everywhere in short supply, so it more frequently became necessary to develop educational activities as a part of the duties of other project personnel. Nurses and sanitarians were particularly active in health education programs, as were those dentists, and nutritionists who participated.

Health education was carried out primarily on a person to person basis with some group instructions in infant and child care, pregnancy, nutrition, general sanitation and personal hygiene. The use of leaflets and posters were apparent

in some projects with questionable effectiveness in view of the low literacy rate of the migrants. Project staffs frequently indicated that printed educational material still required person-to-person interpretation. Visual aids seem to be the most effective but are at present the least available. Although it was evident that health education is everywhere considered of extreme importance; it is probably the least organized or equipped of the various health services and will undoubtedly demand even greater emphasis in future programs as well as critical evaluation of methods and results.

Summary Statement

In general, the program has added staff and funds to health departments, resulting in the provision of services previously unavailable to migrants. Health departments themselves have increased the range of their concern to include medical service problems which had been considered beyond their scope. Though the grant supported projects vary widely and none is without problems, each is making a significant contribution to the health condition of the domestic migratory farm labor force.

Problems Encountered

The short seasonal nature of some projects, location of others, and variations in social and professional climates, have contributed to difficulties in recruiting personnel. The concept of delivery of medical service through clinic arrangements has been rejected by medical societies in some localities. In some areas growers and employers have been apathetic or unconcerned about establishing

or furnishing adequate housing and sanitation which meet minimal requirements.

Living in substandard quarters, families in transient status lack facilities for the preparation of nutritional meals in sufficient quantities. This problem is compounded by cultural barriers, poor knowledge of proper food-stuff preparation, and frequent exploitation of migrants by local grocery stores in camp vicinities.

More than half the projects have created Family Health Service Clinics, although others lacking formal clinics do offer medical service. In either situation, the incidence of inconveniently located clinics and infrequent clinic sessions adversely affect the quality of G.P.-type services. Clinics are sometimes held in improvised quarters with minimal privacy and equipment. Projects are impeded as well by strict adherence to traditional relationships at both the intra- and inter- organizational level and in the areas of project-migrant contact. In the first instance, bureaucratic behavior is characterized by a continued compliance with the rigidities of regular health department procedures and functions, absence of cooperation among local government officials, and minimal communication between projects. In the second, the project-migrant breakdown is evidenced in the cultural and linguistic differences which limit proper understanding of health and health-related problems, and occasional negative attitudes held by staff.

Continuity of Health Services

Lack of health service continuity was of major concern to project directors and personnel. Problems connected with providing health service continuity on an inter-state basis to a highly mobile population group are not simple and

have not been ignored among the projects. But there was little evidence suggesting any successful efforts toward solving this long-recognized problem.

Project staff expressed frustrated concern over not being able to determine types of health services migrants have had in other regions. More often than not, migrants were unable to produce any type of health record to indicate services previously received. Therefore, project staff had little choice but to assume that migrant patients have had little or no health service in the immediate past. Consequently, migrants received blood tests, chest x-rays, and immunizations upon several separate occasions during a yearly migration cycle.

In addition to not having the benefit of knowing what health services migrants have already had, there was considerable difficulty in referring migrant patients to other areas for completion of indicated health services. In this connection, several problems were evident. Types of health services for migrants varied considerably from state to state, from county to county, and from project to project. Widely varying concepts of "comprehensive services" may have, in part, contributed to problems associated with lack of health service continuity. Health service activities through public health departments, such as medical care for migrants, were considered to be entirely appropriate in some communities but inappropriate in others. Apparently, lack of common understanding as to what services are to be provided, in terms of migrant health needs, has resulted in the need to consider development of basic service program reasonably common among regions attracting migrants. This, however, does not suggest the establishment of a highly uniform and inflexible program but looks toward common agreement upon basic categories of services, with guidelines sufficiently flexible to be practical, based upon recognized migrant health needs.

Another barrier to health service continuity was the lack of readily available

information as to what health services were available to migrants in the various areas they go and to which places migrants might be instructed to go for health services.

The Migrant Health Branch has been successful in developing a list of persons within the fifty state health departments who have been designated by respective state officials to act as contact persons on matters concerning migrants, a much needed step toward improved inter-state communications and patient referral.

At the present time, however, no satisfactory system of inter-state referral of migrant patients is in operation. A referral system developed in Florida is being experimented with on an inter-state basis involving Florida, South Carolina, New York and Virginia. Initial efforts appear to hold promise, but it is too early to determine whether or not this system will be successful.

The imperative need for health service continuity expressed by project personnel suggests that the basic foundations for continuity must be laid at the direct service level. In most cases this would be local, county or district levels. In the planning stages of migrant health service projects, there is need to consider types of services to be offered in terms of regional and national characteristics of the migrant labor phenomenon in addition to those characteristics fairly local in nature. If such considerations were made, it may become possible for projects to complement each other in their service efforts, providing a basic framework for health service continuity.

The exclusion of the migrant and his family from hospital care was the most frequently mentioned deficiency in the program by all projects visited. The exemption was felt to be the principal deterrent to the provision of adequate care. Local residency requirements, transient status, and insufficient family funds, conspired to disqualify the migrant from rehabilitation, guidance training, and

preventive and emergency dental services. While the Act does not specifically prohibit the use of grants to pay hospital care, such use was excluded by Congressional intent. The impact on the migrant of this exclusion is exemplified in the following exerpt from an interview:

> "Husband, age 18, eight-month pregnant wife, age 17, and 9-month old child, travelled from M, Texas to K County, California in the back of a pick-up truck to find work. Baby was delivered as premature in Delano, transferred to K General Hospital, and placed in an incubator. Wife says family must remain in K County "for two or three years" to pay off hospital bill of $27 a day for post-natal treatment of child. Baby weighs 2 lbs. 3 ounces, and parents were told it might not live. Woman received no pre-natal care in Texas or in California. Family resides in rented trailer."

The provision of family clinic services was at times considered to be illogical, as without hospital care a follow-through to provide definitive medical services was impossible. While the cost of providing necessary emergency hospitalization and rehabilitative care not now available is impossible to predict accurately, it is felt that such prediction might follow from experience gained through projects specifically devised for feasibility study.

GEOGRAPHIC AREAS NEEDING SERVICES BUT WITHOUT PROJECTS

It was impossible in our alloted time of study to visit or obtain specific reasons for the non-establishment of projects in the many areas of the U.S. having relatively large numbers of migrants during their crop seasons. However, from discussions with State Health Department Staffs, visits to certain "non-project" areas and testimony before Congressional Committee hearings on the Migrant Health Act, the Study Group was aware of the many reasons, both positive and negative in nature, which have precluded the development of projects in some localities.

A positive appraisal reveals regions wherein there is a general feeling locally that adequate health services are already provided for the migrant agricultural worker. Yet a close examination of these areas indicate that in none of them are truly adequate services available. The familiar observation that the migrant can avail himself of any health service "if needed" actually is reduced to provision for "emergency services only", and that on condition the migrant knows where, when and how or has the funds to apply for and receive services. The following data from an interview reveals that even migrants who have attempted to establish residence are faced with this problem.

> "Female farm worker, resident for two years, rushed her child who had swallowed furniture polish to the "X" Medical Center, as the County Hospital was 20 miles away. She was asked if she had the money to pay for the child's treatment, and when she replied that she did not, she was told the baby could not be seen and "to take it to County". She explained the baby was very sick and the General Hospital too far away. Still she was refused. She then called the Fire Department, which looked at the child, concluded that it was an emergency and ordered the Medical Center to admit it, which they finally did. Woman was billed for services and refused to pay. Child survived."

Local medical officials in certain of these areas have operable and effective programs for public assistance recipients, but recognize that migrants are excluded by law from coextensive coverage, barring the rare instance when such a migrant can accumulate enough months in a particular geographic area to be considered a "legal resident". Other local officials prefer not to recognize or appear unwilling to admit ignorance of the fact that migrants are ineligible for these services, and thus a few are able to receive medical care in spite of the legal restrictions.

In the majority of instances where projects would be helpful in improving health services, the fact that applications have not been made can be attributed to general apathy within the community or state and to definite resistance on

the part of politicians, medical societies or other local groups.

Private apathy and professional conservatism are usually reflected in such statements as "We have gotten along in the past, why change?" Such opinions arise chiefly in areas in which migrants are in residence for short periods of time and the demand upon local health care resources is therefore not significantly increased. Officials in such areas feel that indicated services may be postponed until the migrant moves on once again to another county or another state. This attitude is ingrained in the very core of community life itself a nd has persisted for a span of many years in some locales with short peak-season of in-migration. Apathy and resistance also characterize some home-base areas. Yet significant changes have occurred in a number of apathetic communities through the dedicated and persistent efforts of such church groups as the Migrant Ministry and the Bishops Committee, who well know that an apathy anchored in indifference toward the farm laborer can be transformed into a genuine willingness to provide needful help, if local leadership can arouse community action.

In some areas without projects, but in which health officers considered projects desirable, definite opporsition arose to application for funds. Animosity expressed usually came from politically biased officials. Some local medical societies opposed family health service clinics, while in other areas health officers with-held this service from the project application for fear of possibly antagonizing the medical society. In some cases this fear was unfounded since no efforts had been made to solicit approval or participation of local physicians.

Some states failed to establish any projects because of opposition at the state level against any program operating through individual project grants. Several State Health Officers, including some with projects, felt that grants to

States on a formula basis would permit greater flexibility in program operation. However, the point seems debatable as a number of states with projects appeared to be operating as effectively and with as much latitude as under formula-grant programs. Study of non-project areas indicated as great or greater need for help through project grants as did areas with projects in operation. In many localities where the small number of migrants have not stimulated project applications the health services were found to be totally inadequate or unavailable.

RURAL HEALTH PROBLEMS

Existent Rural Health Services: A Summary of Findings

In an effort to explore the nature and extent of health services available to rural residents, one of this Study's staff consultants sampled by questionnaire appropriate agencies in those twenty-seven states which employ a minimum of 5,000 migrant workers at their peak seasons. Recognizing that the results obtained must be regarded with the usual precautions applicable to the methods applied, the data received appeared nonetheless of sufficient value to deserve incorporation into this report.

In most states, with the exception of those in which special medical programs exist for recipients of federally subsidized welfare aid, public medical care remains largely a responsibility of local government. Public provision for health care in rural areas varies not only from state to state, but often within the boundaries of the states themselves. While environmental health services and preventive medical care are usually provided by local health departments where they exist, the quality and availability of these services depend greatly upon the perception of local health problems. Those rural indigents who are fortunate enough to be eligible for one of the categorical aid programs are, of course, likely to have some medical services paid for through state and federal funds. To qualify for federal funds, state programs must be uniformly applied throughout the geographic area of the state involved, and thus persons in rural areas who are eligible for these programs have the same rights to medical services provided in the state plan as persons in urban areas. Ineligible medically needy residents, however, become the responsibility of county governments whose services vary from "none" to "limited". One outstanding exception

to this pattern is the State Welfare Department of New York, which shares the costs of comprehensive medical care programs for both recipients of the categorical aids and general assistance, needy persons who are not eligible for one of the federally subsidized programs, and for the medically indigent as well.

The above description presented is not intended to indicate that most rural areas are without any health services. Of the twenty-seven states surveyed, sixteen reported activities of voluntary agencies in rural areas. Health associations---tuberculosis, heart, cancer, diabetes and others--- often sponsor clinics in rural areas. Agents of the agricultural extension service in most states frequently promote rural health by use of educational and informational programs. Service clubs and fraternal organizations, units of the Migrant Ministry, county medical societies, and individual practitioners often make therapeutic services and drugs available for low-income families. And of course persons who can afford to pay for care do not have difficulty in travelling to centers where such care may be found.

Public insurance programs such as workmen's compensation and temporary disability, are rarely applicable to farm workers. Although some states permit voluntary coverage by employers, only California provides compulsory workmen's compensation for farm workers on the same basis as coverage for laborers in other industries. Temporary disability insurance benefits are provided for individuals in California, New Jersey, New York, and Rhode Island, and of these, only California includes farm workers under law.

Private insurance coverage for persons living in rural areas is usually very much less extensive than in urban centers. Although there is a perceptible movement toward such coverage, it has barely touched the agricultural worker or other low-income rural resident. Premiums, even on a group basis, are usually

too high for low-income families to bear, unless a substantial portion is paid by the employer. Insurers, moreover, are reluctant to cover a floating population because of the high administrative costs involved.

Those respondents who discussed existing barriers impeding the extension of rural health services to agricultural seasonal workers, most frequently cited the following: non-availability of personnel, insufficient funds, absence of local interest and employer concern, residency regulations, and administrative apathy. While none of these problems is unique of itself, it is significant that a uniformity of opinion exists reflecting the prevalence of such obstacles throughout the nation.

Agricultural Seasonal Workers: Resident and Migrant

The intent of legislation included in the Migrant Health Act has aimed at providing public health and medical care services for those Americans defined as "migratory". The misfortunes of the migrant worker cannot be singled out as more far-ranging or severe than those of less publicized resident farm laborer. Both occupy the lowest socio-economic status and are equally lacking in medical care. Both are by circumstance alienated from the mainstream of American life and are deprived of the most basic benefits enjoyed by other laborers. They have been seriously affected by social, economic, and technological change. And as no true distinction can be drawn between their needs, neither is it possible to effectively distinguish between their ability to meet these needs. A program of comprehensive medical service for all seasonal agricultural workers without regard to their residency status is indicated.

Those who serve migrant farm workers are agreed that the greatest impact of services given thus far has been in the area of traditional public health activities. They are likewise agreed that the greatest deficiency of the present program lies in the area of hospitalization and therapeutic medical care. No adequate provision is presently made for such coverage, and this exemption is felt to be the principal deterrent to comprehensive medical services for the migrant and the resident farm worker as well.

The heavy caseloads and pressures exerted on full-time physicians working in county hospitals and other facilities make difficult the care of both hospitalized and ambulatory patients. It thus becomes increasingly clear that the quality, type, and extent of medical services available to farm workers in remote, labor-intensive counties depends in the final analysis upon the ability of such counties to assume additional financial responsibility for

increased patient load. An evaluation of the present status of this situation in agricultural areas would appear to be indicated in the achievement of solutions involving the extension of comprehensive medical care coverage to seasonal farm workers. A systematic study is required of the numbers of physicians available in major crop areas, the type and quality of medical institutions, the complexities of residency restrictions on public medical care, the dearth of medical and paramedical personnel, the fragmentation of tax-supported services, and the attitudes and responses of rural citizens to indigent persons -- all factors directly bearing on any planned attempt to conscientiously improve medical care for all agricultural laborers. The finding may dispel the widespread opinion in some rural communities that adequate health services are provided for both resident and migrant workers. Indeed, services may be available but they may not be used either for reasons based on definition of residency, or on other factors shared in common by all seasonal agricultural workers.

For example, some migrants manage to accumulate sufficient months in a particular county to be considered "legally resident". But, barring the rare instance when a resident achieves the sophistication so necessary to avail himself of his legal rights, the term itself confers far fewer rights than is commonly believed. It is widely thought, for instance, that the establishment of legal residency entitles one to a broad range of public health services, both preventive and restorative, which are denied the non-resident --- but in fact the distinction is often only academic, as technical eligibility is no guarantee of benefits derived.

As an example, in California, the State law requires that a county hospital must admit <u>any</u> expectant mother who is unable to pay for her care and <u>any</u> person "in need of immediate hosptialization on account of accident or sudden

sickness or injury". Beyond this, State law also requires that counties provide aid to the medically indigent who are lawful residents.

However, the question of residency is more complex. In California legal residence is defined as three years in the State and one year in the county of application. Should an applicant for assistance have no county residence, then the county where he last resided continuously for one year immediately prior to application is considered responsible for his support. Theoretically, therefore, if a medically indigent State resident becomes ill in a county of which he is not a resident, the responsibility for his care must be assumed by a county in which he has had the longest period of residency. However, official policy bears little resemblance to official procedure, and any facility personnel would hesitate to give care on the verbal assurance of the applicant himself if there appears any doubt as to the legally responsible county. They are well aware that their bills will not be honored by the allegedly responsible county unless legal residence is verified. When the applicant appears to be a migrant or resident of another county, local officials sometimes feel that indicated treatment should be postponed until the migrant moves on to another county or state. Thus residency requirements are frequently invoked as an instrument of exclusion by cost-conscious county administrators.

To illustrate in more detail the common problems facing the migrant and resident agricultural worker and administrators involved in projects concerned with seasonal agricultural workers, it may be informative to examine the results of one of the few intensive studies of farm workers in two selected counties in California.

The California Studies -- The Farm Workers Health Service of the State of California Health Department undertook an attempt at new methods of enumerating and describing the client group it was charged to serve under the Migrant Health

Act. Two Summer Studies during 1963 and 1964 were conducted in two labor-intensive California counties during their peak seasons. Seven hundred and seventy-seven interviews by bilingual field workers were obtained based upon a scientific random sample of all farm worker families employed during the peak season in these counties.

Identifying the status of migrancy and residency has been faced by the workers as well as by administrators. In this regard, the Farm Placement Service classifies farm workers by determining the relation between a worker's present residence and his home-base, and grouping these workers into local, intra-state, and inter-state. However, attempts to identify these groupings reveals that the classification is oversimplified and impractical. In the Study workers were grouped into seven categories of relative migrancy, each designed to encompass some degree of travel status. These categories were: local, no travel; local out-migrates; seasonal in-migrant, intra-state; seasonal in-migrant, inter-state; seasonal in-migrant, international; permanent in-migrant; and settled.

In one California county, approximately thirty-nine percent were initially classified as "local workers". However, some of those included in this class were persons whose "homes" were so far away that they did not return to them during the off-season. These included in the "permanent in-migrant" group, were originally from Texas or Mexico, and hoped to remain in the county. Although these workers considered this county their home, they were not legal residents. Some workers and their families who had residency rights reported that their true home was in Texas, but that in fact they wintered in Mexico because it is cheaper to live there, which in fact, identifies them as international migrants.

Farm Placement figures do not distinguish between local legal residents and permanent in-migrants. In one county studied, for example, less than half of the persons who would have been identified by Farm Placement as local seasonal workers were actually residents of the county. New in-migrants who are engaged in farm labor migrate from place to place within the state, and thus most local workers interviewed had migrated at some time in their life. New migrants were younger than local workers. As they marry and raise families, become more familiar with local job opportunities, they tend to stop migrating, preferring to live on less when necessary to avoid travelling.

It is the supposition of Federal and State programs for farm workers that families or individuals who are migratory suffer from special problems, unique within the definition of "migrant", which are more severe than those affecting the domestic local worker. These "special problems" often relate to personal income rather than indigency. From the survey materials it was possible to compare the incomes of migrants with local non-migrants. It was found that sixty-two percent of local families who did not travel reported earnings of less than $2,000 a year; while fifty percent of those who out-migrated, and only forty percent who migrated intra-state, earned less than $2,000 a year. Thus, there were more local workers in the lowest income level than any one type of migratory worker. Additionally, it was found that there were more workers in the highest income bracket among out-migrants than among local workers. For farm workers in these counties, migrancy was not uniformly allied with indigency. Workers who remained at home-base all year in an effort to stay with their families, tend their homes, and keep their families in school, paid an economic price for their decision.

Recognizing that an adequate evaluation of medical-health status and care is an extremely complex task, the California survey restricted itself to a series of basic questions on knowledge and use of public health-medical facilities. The survey was interested in measuring how many of what kind of farm workers were aware of available medical care services and what experience they had had with them. In addition, many farm workers also volunteered information about symptoms, methods of treatment, and evaluation of services received. This information was thought valuable, not because it was an accurate description of symptoms or of services rendered, but rather because it represented the farm worker's opinion about himself, how he felt professional health people treated him, his responses and reactions to agency contact.

All farm workers interviewed were asked if they knew where the county hospital was located, and whether or not they had ever been there. The data compiled showed that sixty-six percent of all workers knew of the location; forty-four percent knew because they had been confined there as patients, or had accompanied other in-patient members of their family. Twenty-two percent knew where the hospital was located but had not had occasion to go there. Thirty-four percent could not tell the interviewer the city in which the hospital was situated. Responses to this question differed sharply between local workers and in-migrants. While the great majority of local farm workers had been to the county hospital at some time in their past, the use of hospital services by migrant workers was extremely low. Sixty-three percent of the migrant workers interviewed had no knowledge of the hospital's location; twenty-one percent knew or thought they knew but had never been there, and only sixteen percent had ever been inside the hospital.

The Study results suggests that people do not routinely learn where the

hospital is located, and substantiates as well the fact that most migrant workers do not use the county hospital, at least during peak season work periods. As workers in the sample were asked whether they had ever used the county hospital, the question should have elicited responses from migrant workers based upon many years of experience as perpetual in-migrants. Therefore, one must conclude that: 1) migrants seldom become sick in the county sampled; or 2) most migrant workers use private doctors; or 3) farm workers do not have time to seek medical care even if they are ill during the harvest season.

Fewer people knew of and used family health service clinics than they did the county hospital. Of those interviewed, twenty-five percent had visited the family health clinics -- forty percent of the local workers had used them and ten percent of the in-migrant workers reported use. Another thirteen percent of the workers knew where clinics were held, but had never used them. Fully sixty-two percent of the workers -- forty-seven percent of the local workers and seventy-six percent of the in-migrant workers -- did not know of the existence of any county health clinics.

The health insurance plan is considered to be one method through which medical care for seasonal agricultural workers can be financed. The insurance concept is foreign to most persons living in a marginal socio-economic status and its many facets must be explored for its maximum utilization. In this respect the California Studies, in their research into the clients' knowledge about and usage of work compensation and disability insurance reveal some of the problems involved.

Agricultural employees have the second highest work-related accident and injury rate of any industry in California. For several years farm workers

have been covered by Workmen's Compensation Insurance and by State Disability Insurance. The DI program is financed jointly by employer contributions and a one percent deduction from worker wages. The California Study was interested in determining how many farm workers were aware of this insurance coverage and the number who had actually used this program. These questions were prompted by statistical reports from the State Capitol which indicated that on the basis of DI claims filed, agricultural workers have one of the lowest rates of disabling illness of any industrial group.

Fully forty-nine percent of the workers interviewed were aware that they were covered by workmen's compensation and disability insurance. Another nine percent of the workers knew that one percent deductions were made from their checks for some kind of insurance, but no more than this. A substantial forty-two percent had no knowledge of their policy coverage and were not even aware of why deductions for "DI" were made. California-based workers were much more likely than out-of-state workers to understand the state insurance plans. When workers were asked about their knowledge of the two insurance programs, the difficulty of easy explanation of the complex policies and procedures of these programs became quickly apparent. Many workers pointed out that they had had work-related or disabling illnesses and injuries. Most, however, had not reported their condition to anyone; others were uncertain of their work history during previous quarters and it was impossible to determine their eligibility. As nearly as the study could determine, exactly half of those who had had workmen's compensation-covered injuries and accidents had received benefits from these; the other half had not. Approximately forty percent of those who had had disability-covered illnesses and injuries had received some benefits; the rest had not filed or had not been awarded any benefits when

they filed. The results are instructive in that they point out that the mere existence of a service does not guarantee knowledge about or usage by either local residents or non-resident agricultural workers.

In summary, many farm workers share equally with migrants the paucity of available services and their limited utilization. With membership in the same low socio-economic class and/or ethnic groups, characterized by low educational attainments, language barriers, cultural differences, and limited social experience in the wide society, they lack knowledge about available services, or understanding of the procedures to obtain these services within their legal rights. The problems of resident farm and migrant workers cannot be separated and to distinguish one group from the other in designing and implementing medical and other service type programs is felt by the Study Group to be discriminatory.

World War II Health Program

In visiting certain projects now in operation under the Migrant Health Act, there remained evidence of the program supported by the Federal government to provide health services to migrant workers during World War II. Several of those who were directly responsible for the creation and administration of this program served as advisors to the present Study. It is with this in mind that we believe that a brief review of the composition and accomplishments of that program should be of interest to those who are concerned with the health of seasonal farm workers.

Due to farm labor shortages in the early war years, the War Production Board deemed it necessary to protect and conserve the health of this nation's

agricultural work force. The Board, working with the Department of Agriculture and the Public Health Service, organized health services through subsidies to six non-profit Agricultural Workers Health Associations, which covered the entire nation. These programs, directed by Public Health Service Officers, provided needed health and medical services to migrant agricultural workers, integrating in their approach the talents of both local personnel and federal officers.

The Agricultural Workers Health Associations provided comprehensive health services including preventive and therapeutic medical care, surgical, hospitalization and dental care, nursing, environmental sanitation, and nutrition services, as well as drugs. Eligibility requirements were restricted to 1) employment in agriculture, 2) low income status, and 3) non-residency (since only residents were considered eligible for welfare assistance.) Under this definition, almost the entire migratory farm worker population was eligible for service.

Negotiations for services were conducted at local levels. Physicians and dentists were paid for on a fee-for-service or fee-for-time basis. Hospital rates were decided at the local level as well, eliminating the complex and time-consuming processes inherent in governmental procedures. About 250 health center clinics were set up throughout the country in areas of seasonal labor concentration. Due to the migratory habits of workers, many of these clinics were mobile and tended to conform to work stream patterns. The program appeared to be successful and far less costly than initial estimates indicated. However, with the end of the War, funds were withdrawn and the accomplishments made possible under the program ceased to continue.

SUMMARY OF CONCLUSIONS

General

1. The Migrant Health Act (PL 87-692) is the first effort by Congress specifically to meet the health needs of domestic migrant agricultural workers.
2. The program under the Migrant Health Act has operated completely within Congressional Intent.
3. The Act has permitted local groups to initiate projects to improve health services to migrants.
4. The continuation of the Act will permit increasing the inter-state cooperation already in evidence, and the development of greater continuity of health care for migrant agricultural workers.
5. Applications for project funds have been greater than the amounts appropriated, indicating increasing interest among health officials and others about migrant health problems and related areas of unmet need.
6. The Migrant Health Act has demonstrated that the small initial appropriation allotted to attack a large national problem is totally inadequate. Extensive field activities by both local and State personnel have demonstrated with dramatic clarity that health needs and ability to meet such needs are as a rule virtually identical with migrant and non-migrant alike.
7. Due to delay in appropriation, the Program began a year late and has not been able to demonstrate fully its potential benefit to migrant workers.
8. Program operations have broadened the public health services in many areas to include early medical care as part of the preventive services afforded migrants.

9. Through demonstrations in several projects it has become apparent that the training of personnel in migrant health work deserves additional attention in the subtleties of cross-cultural understanding and communication.
10. While it was hoped that the financial responsibility for on-going projects would gradually be assumed by local support, experience in most areas discloses that withdrawal of Federal funds would seriously undermine the program.

Benefits of Program

1. The program is providing services that would not be available without the Migrant Health Act.
2. It has stimulated greatly local interest in migrants throughout the country.
3. It has resulted in marked improvement in communication among health workers, growers, and migrants.
4. It has brought into focus the need for continuity of health services in dealing with a highly mobile population.
5. It has resulted in improvement of housing, general sanitation, working and living conditions in a large number of localities.
6. It has encouraged the establishment of family health clinics or other means of providing medical care for migrants which in turn has led to better utilization of traditional public health services.
7. It has provided medical and health services not previously available in many rural areas, and in many instances has extended these services to local impoverished rural residents supported by local funds.
8. In some areas where projects did not extend coverage to other than migrant

workers, local residents have requested that equivalent services be established for other local poor.

Limitations of Program to Migrants

1. Slightly more than 50% of projects established the family health service clinics which were the primary goal of PL 87-692.
2. Health service clinics now operate only once or twice per week and are unable to offer comprehensive medical service.
3. Inability to pay for hospitalization and private medical care often restricts or negates potential benefits from clinic service by preventing patient follow-up on necessary additional medical care in both emergency and rehabilitative situations.
4. Staff-patient communication especially in projects having Latin-Americans in both clinical and related health activities is conspicuously ineffectual except when interpreters or bi-lingual health personnel are included as members of a project team.
5. Due to population fluctuation, clinic facilities are not always easily accessible, necessitating the use of available but inadequate resources within a circumscribed area.
6. The absence of any transportation in many areas prevents effective clinic use and nullifies benefits of referrals to more distant medical centers.
7. Clinics are not always held at times and places most convenient to the worker and his family.
8. All but a few clinics reveal definite understaffing of physicians, nurses and auxilliary personnel.

9. Projects which include "studies" have been restricted by intent of the Act. Any yet, without this feature, certain accurate essential information can not be gathered against which programs might be evaluated.

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