Oral Health Care for Migrant Agricultural Workers in Monroe County, New York

Louis P. Gangarosa, D.D.S., Ph.D.*

There is an increasing need for the dental profession to engage in community action programs. Formerly, care of the indigent has been accomplished on a private basis and through institutions such as hospitals, universities and endowed clinics. Philanthropy by the economically privileged was an important factor in the development of these programs. Creditable as these efforts were, they were unable to cope with an overwhelming problem. It appears therefore that a more organized effort coupling the present structure with government support is necessary to supply the dental needs of the indigent.

* Assistant Professor, University of Rochester School of Medicine and Dentistry, Rochester, New York.

Some progress toward increasing health care to the indigent has recently been made through projects supported by the Public Health Service, the Office of Economic Opportunity, Social Security, and other agencies. Recently, the American Dental Association advocated a comprehensive dental care plan for children. This plan calls for the use of presently available programs, as well as development of new federal, state, and private plans to accomplish the goal of optimum dental health for the American child.[1]

An agency which is currently supporting health care for indigents through federal grants (Migrant Health Act of 1962, PL 87-692) is the Migrant Health Division, Community Health Program, Department of Health, Education, and Welfare.[2]

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This paper will deal with the experiences of a dental team at the University of Rochester, School of Medicine and Dentistry. Migrant dental care in Monroe County, New York, was accomplished through partial financial support of the Migrant Health Act in close cooperation with a medical team interested in an overall preventive medicine program. The departments of Preventive Medicine, Pediatrics, Dentistry and Dental Research, and others worked very closely in order to deliver this health service. At the same time, a research attitude toward the program was maintained by interested faculty members and students.

SOCIAL CONDITION OF THE MIGRANT

Migrant agricultural workers constitute one of the most impoverished groups in the United States today. Socially they are accepted as a necessary evil in farming communities where they are given labors considered unacceptable by the majority of workers. Culturally they suffer from general racial problems. Also, nonacceptance by the community is apparent because of the migrants' itinerant life and the nature of their occupational endeavors. Educationally, a very low level has been achieved by the average Negro migrant, while his itinerant life is a stumbling block in schooling for his children. Economically the agricultural worker is compensated at a low level, while many working days are lost yearly due to travel from place to place and due to slack seasons. The average income of a migrant in 1965 was approximately $1400 a year.[2] These factors, plus many others which are beyond the scope of this report, have been summarized in several recent books.[3,4]

Aside from social problems, the health situation of itinerant farm laborers and their families is of serious concern to the community. The migrant is a potential vector in the spread of diseases because of impoverished living conditions, lack of medical attention and his handling of food. Tuberculosis, gonorrhea, syphillis, parasitism and intestinal diseases are rampant among migrant workers.[2] This becomes alarming from society's viewpoint especially because of the migrants' food handling activities and their requirement for travel. Health care and education for migrant workers will therefore be of great benefit not only from a personal standpoint, but also for society in general.

THE NEED FOR DENTAL CARE

Approximately 800–1,000 southern Negroes migrate to Monroe County, New York each summer and usually return to the southern Atlantic seaboard states in the late fall. Very few of the adults had seen dentists except for emergency care. Many of them were found to have episodes of acute or chronic pain due to dental conditions. Periodontal disease and severe caries were obvious. As a result, many adult migrants had discomfort and pain with a loss of productive time from work. In 1966, during the course of 22 clinical sessions of three to five hours each, two dentists working together were completely occupied with emergency care for adults.

The oral health of migrant children was also neglected. Many of the children surveyed at Monroe County day-care centers in 1966 were in need of immediate dental care. Painful conditions due to caries and abscesses were quite common. Severe caries with crown destruction and retained roots were a common finding. Oral hygiene was generally poor and many of the children did not have a toothbrush. In a survey conducted on the Monroe County migrant children, only seven fillings were found in 1530 teeth.[5] This finding, which agrees with a similar result reported by Abrams and Tappen,[6] illustrates the absence of dental treatment in this population.

In was felt by both physicians and dentists in our program that dentistry was one of the most pressing health needs of the migrants.

ACCOMPLISHMENTS

The migrant health program in Monroe County was entirely voluntary in 1965. Eighty-four patient visits were made at nine clinics (three to five hours in duration) representing 54 hours of dentists' time and 108 hours of auxiliary personnel time.

In 1966, the migrant program was about 50 percent supported through Public Health Service and 50 percent voluntary. The financial support enabled us to conduct four dental clinics per week over a 13 week period.

Adult dental clinics were always conducted at night in conjunction with the medical team at a migrant camp setting or a nearby school or church. The medical team performed physicals, emergency treatments, pediatric care, immunizations, and other medical care. They were also helpful in referring cases to the dental team. A health educator also participated in the health clinics by holding classes on various health and hygiene topics. These classes were very popular with the migrants and seemed to be productive in creating health consciousness. In 1966, 168 patient visits were made by 77 adult migrants. A detailed list of procedures performed on adults is included in Table 1.

The children spent many of their waking hours at day-care centers. By working closely with the staffs of two vicinity day-care centers, the dental team was able to eliminate acute and chronic dental pain in all of the cooperative children as well as to accomplish operative procedures and preventive measures such as fluoride treatments, prophylaxis and health education. In 1966, there were 90 children examined and treated in 210 visits. A listing of procedures performed in the children's dental clinics is included in Table 1. The effectiveness of the Monroe County Children's Program was determined by comparing the number of survey teeth treated to the number of defective survey teeth. This data is shown in Table 2. During 45 clinical hours (15 three hour clinics) the dentist and his assistant were able to accomplish 25 percent (94/371) of needed treatments of teeth in addition to examinations and other procedures. Abrams and Tappen stated that each migrant child would need about three hours of treatment.[6] Using this hourly factor, the 66 Monroe County survey children would have required 198 hours. It can be calculated that about 25 percent (45/198) of this time requirement was actually used. This data would therefore confirm the accuracy and usefulness of the observation made by Abrams and Tappen.

By 1967 the day-care and adult clinics were continued and the program was expanded to include private dental office treatment. In two small suburban towns

Table 1

Migrant Patient and Treatment Data—Monroe County, New York, 1966

	Adults	*Children*
Patients treated	77	90
Patient visits	168	210
Procedures accomplished*	220	344
Exams	43	90
Preventive and restorative	17	153
Surgical	135	80
Other	25	21

* A procedure is defined as a service which can be accomplished by a dentist in a short visit such as one surface filling, an extraction, etc.

Table 2

Comparison of care needed with treatment rendered for survey group. (Day-care centers, Monroe County, 1966)

Ages 5–12	
Children examined	66
Decayed teeth	371
Restored or extracted teeth	94
Percentage of needed work accomplished	25%

near Rochester and close to migrant housing areas, one dentist in each area opened his office one night a week to migrants. The University health team worked closely with these private dentists in their office environment and in publicizing the clinics. This extension of services was well received by the migrants who seemed to appreciate the private office situation. The Public Health and Welfare Departments of Monroe County were very cooperative and some of the dental work in the private offices was paid for by Medicaid.

OTHER MIGRANT HEALTH PROGRAMS

There are many other migrant health programs throughout the country. These are sponsored by state or local health departments, universities, church groups, etc. In 1967, the Public Health Service sponsored 115 migrant health programs and 65 of these had dental components.[7] The types of dental components attached to the health teams seem quite variable according to some correspondence we had with dental directors of these programs in 1966. Most of these dental programs employed part-time dentists and auxiliary personnel. Some programs merely arranged appointments with local dentists while others had regular clinics in camp settings, hospitals, or in mobile units.

SUMMARY

In Monroe County, New York, the University of Rochester engaged in a health care program for migrants. Dental services were provided by a team working very closely with a medical team. The dental program emphasized: (1) close cooperation and interchange with the medical team; (2) comprehensive dental care for migrant children; (3) relief of pain for adults and as much follow-up as possible; (4) dental health education; (5) research activities such as caries scoring and analysis of services; and (6) experimentation with different ways of delivering service (in camp clinics, day-care centers, and private offices).

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250 Crittenden Boulevard
Rochester, New York 14620