MIGRANT HEALTH - 1965 - THE NATIONAL VIEW*

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"The bounty of the earth is the foundation of our economy.

"Progress in every aspect of our Nation's life depends upon the abundant harvest of our farms. ...

"Because our people eat better at less cost than any other people in all the world's history, we can spend our earnings for the many other things which make life rewarding."

Thus the President introduced his message on the farm program in 1965. But he went on to take note of the fact that many rural people face constantly declining opportunity. Their incomes are low, their housing is substandard, they have less access to health services, and their educational opportunity is restricted in quantity and quality.

The President could have continued further to say that among rural people, those at the bottom of the heap are the ones most likely to find their way into the migrant farm labor force.

In this respect the year 1965 is not unlike the year 1940. A writer in the 1940 Yearbook of Agriculture commented that labor had received much

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attention as a cost factor in production, but there was a lag in considering workers themselves as human beings. The Yearbook author expressed the opinion that "National as well as local resources" probably must form the basis for action programs to provide farm laborers with housing, education and health services.

Even in 1940, the Yearbook writer could have looked back 25 years earlier and found testimony on the same problems, the same lacks, and the same type of proposal for combining local, State and national resources.

For a brief period during the early 1940's the Federal Government conducted a nationwide program to serve the health, housing and other requirements of migrant farm workers and their families. The underlying purpose, however, was not to help with the human needs of workers, but to overcome the farm labor shortages resulting from the draining off of farm manpower by the national defense effort. Accordingly, this project stopped with other emergency programs at the end of the war.

Yet the plight of migratory farm labor families remained. In the two decades since the war ended, volumes have been spoken and written about the predicament. Little has been done, aside from the valiant efforts of a few voluntary and public agencies in a few localities.

And so in 1965 we find ourselves gathered here as many groups have gathered before us. BUT NOW THERE IS A DIFFERENCE. Now we are not talking

about how to solve farm labor shortages--although helping with this may be one desirable outcome. Rather, we are talking about workers and their families as human beings, and how we can help. And we are not just discussing the situation. We are reporting on action--already undertaken or proposed.

Furthermore, we are not among a lonely few, scattered over the country. We are one of the many similar State and local groups sitting down together to plan action programs for 1965. From these conferences and workshops we will go to migrant labor camps and to the fields where migrants work to implement our plans.

This shift from discussion of workers as a commodity in crop production to workers as human beings is one of the most encouraging signs of the times in 1965. And the shift from discussion to action is a promising sign for the future, as well as for 1965.

The Migrant Health Act has greatly broadened the opportunities available to health workers in serving domestic migrants. There is no longer reason for communities to complain that they are so swamped with the health demands of local residents, they cannot possibly handle the additional migrant load. Care of injuries and illness among workers and families no longer needs to be delayed to the point of emergency and hospitalization. While overall recruitment may be a continuing issue, cries about lack of funds for health department nursing and sanitation staff shortages are no longer pertinent.

Now communities and States can develop migrant health plans and obtain financial aid, as well as consultation, from the Public Health Service to carry them out.

Up to May 15 of this year, 63 projects in 30 states and Puerto Rico had been granted assistance in providing migrant workers and families with health services. Each project covers from one to a dozen or more counties. Most stress provision of medical care when people are sick or injured. Family clinics are generally held at night in or near large labor camps. To curative care, the projects add immunizations, care for pregnant women to protect the health of mother and unborn child. They add nursing follow-up in camps to help people carry out their clinic instruction and to get medical help to those requiring it.

Educational projects teach migrants how to take better health care themselves and to use local health resources more effectively. Work with owners of camps to improve water supplies, waste disposal and housing that is in disrepair, is the purpose of other projects. Still another is issuance of a personal health record to each migrant seen by a physician or nurse so that he can present the record of his past treatment to the next physician or nurse from whom he receives services.

Some projects make extensive use of volunteers, including migrants themselves, as well as people from the community. Thus the project becomes a meeting ground where the migrant and the community resident

can become acquainted with each other for the first time. Volunteers "baby-sit" for migrant mothers so that they can attend night clinics; they call on migrant families to inform them of the aim and accessibility of clinics, and provide transportation when necessary. Volunteers serve as receptionists, translators and interpreters, and assist with the projector and other arrangements for night meetings. They help prepare for clinics and clean up after the sessions. They act as aides to doctors and nurses.

On a nationwide basis, projects under the Migrant Health Act have helped communities overcome their difficulties in extending services to a temporary group of workers and families, and have helped migrants themselves learn to value and accept modern medical care as well as to take measures for their own health protection.

Perhaps the most effective single type of educational effort to improve migrants' understanding and acceptance of modern medicine has been the way in which health care is provided in many of the night clinics. To those who are accustomed to being "pushed around", referred hither and yon for different services at different times and places, and sometimes served grudgingly or not at all, this is a new experience. The understanding they are shown by project physicians and nurses, and the human treatment they receive--over and above the medical treatment--helps greatly to overcome the barriers of lack of understanding and rejection that have stood between them and their health care in the past.

Although the Act was signed in 1962, funds were not appropriated until 1963. Now--in 1965-- the program is just getting well started. Nationwide, the task is still a big one.

The counties included in migrant health service projects are still only a small proportion of those which depend on migrant labor for their farm production and harvesting. Few projects offer more than a fraction of the required services. Some are doing an excellent job of providing medical care but little to improve the poor camp environment which leads to needless accidental injuries, and sickness among young children. Some have succeeded measurably in assisting mothers and children, but have failed to serve male workers, although men may comprise the bulk of the local migrant population. Some emphasize rather conventional public health services--control of communicable diseases, maternal and child health services, immunizations, and so on--but are weak in providing care for people who are sick or injured.

Many projects lack interim arrangements to handle medical emergencies, which inevitably occur between regular family clinic sessions, and provision for dental care is also missing. Few have gone as far as they might to identify migrants who can help, and ways to involve them in project planning and operation. Few, likewise, have gone as far as they could in gaining community acceptance and sharing of responsibility for

extending services to a population group which returns regularly to fill local labor demands, even though they never stay long enough to gain a sense of belonging or eligibility for services provided to local residents.

While health workers have learned a great deal about more effective ways to extend services to migrants, they are still groping for answers to many questions. Why do some migrants continue to go without services even when it is brought almost to their doorstep? How can the many public and voluntary groups which could contribute to migrant health improvement be brought in so that growers--doctors--nurses--migrants--sanitarians--church workers and others will work together in a single cooperative effort?

How can the flow of information about migrants' health requirements and the services they receive be adapted to the way in which migrants themselves flow from one seasonal crop area to another? How can different crop areas along the same migrant stream plan cooperatively to avoid duplication or gaps in services? How can all the groups involved maintain current information on the numbers of migrants to be served and the times and places where they can be expected as a basis for sound planning, and for keeping services geared to the migrant situation?

The variety of situations migrants encounter as they move from one crop area to another ranges from almost total lack of access to any health services to a fairly complete array of medical, nursing, sanitation, health education, social work, and nutrition services. Confronted by this variety, what can they be taught about caring for their own health which

workers measure their success not only in providing migrants with personal health care, but in helping them to improve their own health knowledge and behavior?

Another unending question is how to measure improvements that may be made in migrants' health status. Many projects report a turnover of 50 percent or more in local migrants during the season, as well as from season to season. Can the project that emphasizes immunization of migrant children in 1965 assume that it can relax its immunization effort next year? Or will the turnover mean a necessity to emphasize immunizations every year?

Even with all the questions that are unanswered or answered only partially, the 1965 situation can be viewed with optimism. There has never been such widespread interest, so many service projects, and such opportunity for expanding the services of existing projects and extending services to new areas. Added to opportunities under the Migrant Health Act are those under the Economic Opportunity Act to provide day care for young children, special education for both children and adults, healthful recreational outlets, and other services which will not only reduce needless illness and injury among migrants but also make their lives more like those of other United States citizens.

In migrant health, as you know, both Houses of Congress have passed bills to extend the grant program beyond the present expiration date of June 30, 1965. We are still unsure of how long or how much the extension will be. We feel farily confident that the program will not only be extended, but that its scope will be enlarged to permit projects to use migrant health grant funds to pay for hospital care, in addition to care outside the hospital. Provision of hospital care for migrants as part of the non-grant contribution to a project has been arranged. However, this has proved to be extremely difficult and costly. We hope we will be able to supplement such efforts and make it a little easier to get migrants admitted to hospitals in the future.

Support for the extension of the legislation has come from the American Medical Association, the American Hospital Association, the State Health Officers' Association, the American Public Health Association, and other groups, Nowhere do we know of any opposition.

With this type of national interest, and such local and State interest as that evidenced here, we look forward to 1965 and future crop seasons with confidence.