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MIGRANT HEALTH PROBLEMS AND PROGRAM ACTIVITIES

By: Jaime L. Manzano

Problems of the Migrant:

It is difficult to imagine any group of people in these United States who are more physically sick, educationally deprived, socially degraded and/or economically poor than migrant farmworkers.[1] Of course, these characteristics are not unique to migrants, poor people, especially in rural areas, share these same deplorable conditions. What makes the migrant different is the relative degree to which he suffers under these conditions and the additional characteristics of his employment that further limit his ability to rise above these circumstances. Among these additional characteristics are: (a) the temporary nature of his stay in an area, and (b) the linguistic, cultural or racial differences that isolate him from the community in which is employed.

Temporary Residence:

For purpose of employment the migrant farmworkers may reside in an area from a few weeks to several months.[2] As a result, whatever health delivery system exists in the area is called upon to be responsive to a peaking workload that the migrant's presence represents. Non-resident status, however, effectively disenfranchises the migrant in the area. Because of the

temporary nature of his stay, the tendency is to reduce or eliminate his claim on the local resources set aside to extend services to the medically indigent. Essentially, these resources are used primarily for the resident poor and not the migrant farmworker.[3]

Linguistic, Cultural and Racial Differences:

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

The impact of these general and unique characteristics of the migrant may be illustrated through a recent situation faced by a migrant family seeking health care. On December 8, 1978, the Dallas Times Herald reported that a migrant couple's infant son had died because the hospital in Dimmitt, Texas, did not admit the child for treatment. The migrant parents appeared at the hospital with their sick child. Because the parents were Spanish-speaking, their needs had to be communicated through a volunteer interpreter. The

hospital staff referred the child to a public clinic. The physician at the clinic diagnosed the condition of the child as bronchitis and severe dehydration. According to the news accounts, the physician administered an antibiotic and told the parents to take the child back to the hospital and he would follow to start intravenous feeding to counter the serious dehydration.

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

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

The parents returned to their labor camp. Apparently,

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

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

MAGNITUDE OF THE MIGRANT PROGRAM

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

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

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

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

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

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

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

lar study was repeated in 1979.

MIGRANT HEALTH PROBLEMS AND OBSTACLES

An extensive list of problems and obstacles lie between the migrant and the health care he requires. The most obvious one is that his access to health care facilities has to be imporved. Where there is no capacity to extend care, it must be developed. Where capacity exists, the attitude of those operating and controlling the capacity must insure that the staff is responsive to migrant's needs and actively seeks to extend him care. And lastly, where capacity and the proper attitude toward the migrant are combined so that the migrant has access to the care, the funds necessary to cover the costs for that care have to be made available.

Capacity:

The U.S. Government has long recognized that many rural areas have very serious problems in establishing and maintaining proper health care for their people. To assist in resolving this problem, the Federal Government has pursued the establishment of primary health care clinics through legislation for a variety of programs.[11] The rural health initiative of the Community Health Center Program has resulted in the development of over 350 comprehensive health cen-

ters in rural areas in the past 3 to 4 years. The National Health Service Corps has also been working to place primary health care physicians in rural health manpower shortage areas.[12] Over 750 rural areas have benefited from this physician recruitment and placement program. Finally, the Migrant Health Program has established or participated in the support of 112 projects or centers that serve substantial numbers of migrant and seasonal farmworkers in migrant high impact areas.[13] These efforts are, of course, supplementary to those of rural primary care practices that voluntarily spring up in needy rural areas based on the efforts and initiatives of private groups and physicians.

Despite these additional health services; the populations in rural areas continue to be medically underserved. If the rural health problems are to be solved, more capacity will have to be developed and the resources necessary to bring the new capacity into being will have to be obtained.

Attitudes Affecting Access:

Where a capacity to extend care exists, it is important that additional efforts be made to reduce the social and cultural barriers that limit migrant access to available care. The migrant must feel wel-

come at existing health facilities rather than alien, rejected or ostracized. In part, this means that, where a cultural or linguistic barrier exists, steps should be taken to ameliorate the condition through the use of staff that can act as cultural or linguistic bridges or interpreters.

Optimally, such staff should be at all professional levels, especially at the points of public contact, e.g., the outreach workers, receptionists, nurses, and providers of health care. It would also be desireable for the medical community to take an active part in resolving problems that the general community might represent in terms of latent prejudices or hostility toward the migrant. The medical leaders could help resolve the social problems that unjustly limit migrant access to care in the communities in which they live.

Funds:

Needless to say, substantial resources will have to be brought to bear on the migrant health problem, if it is to be resolved. Comprehensive care, including hospitalization, costs between $350 to $450 per person per year, including out-of-pocket expenses. Assuming there are 750,000 migrants and dependents, between $262.5 and $337.0 million would be needed to

cover the needs of the migrant and his dependents. Part of these costs are being funded by state and local governments as well as by the migrant himself. It is unlikely that much over $50.0 million is being provided to fund migrant health needs from all Federal sources. The required resources for 2 million seasonal farmworkers and dependents would be approximately $700.0 to $900.0 million. Taking all these amounts into account, clearly a substantial gap exists between available resources and estimated requirements. Until this funding issue is systematically addressed and resolved, the resulting unattended health problems of the migrant and seasonal farmworker will continue.

THE MIGRANT HEALTH PROGRAM

The Migrant Health Program supports efforts to assure access to and provision of a fairly comprehensive level of health care to migrantsand seasonal farmworkers and their families with priortiy in high impact areas. By law a high impact area is one that contains more than 4,000 migrant and seasonal farmwokers and dependents during peak periods of employment for more than two months in any calendar year. Project grants are awarded to public and non-profit private entities to establish and support the continuing operation of centers and projects which provide care

to migrants in their service areas. These services include physician diagnosis and treatment, laboratory, pharmaceutical and emergency services. In addition, where appropriate, home health, dental and hospital inpatient and outpatient care are extended as well as outreach and environmental services. The extend of such services are naturally limited by the availability of funds.

An important additional requirement of the program is that migrant health centers be governed by Boards with a working majority representing migrant and seasonal farmworkers. This reqirements is intended to assure that the care extended to migrants and seasonal farmworkers is responsive to their needs.

Program Budget:

The amount of funds appropriated for the Migrant Health Program in fiscal year 1979 is the same amount received in fiscal year 1978-- $34.5 million.

These funds are budgeted to be used as follows:

Ongoing Projects and Centers - (R.O.)	26,410,000
Service Augmentation (Access Development)	2,605,000
Project Increases in Users Served	(1,250,000)
Increased Enrollment in Entitlement Projects	(855,000)
Migrant Assurance Program	(500,000)
Hospitalization	3,450,000
High Risk Maternity	(1,200,000)
Immunizations	(250,000)
Sanitation Program	500,000
Technical Assistance Projects	440,000
One Percent Evaluation	345,000
TOTAL MIGRANT HEALTH	$34,500,000

Ongoing Projects and Centers:

The Migrant Health and Community Health Center Programs together serve over 195,000 migrant medical and dental users during a 12-month period. During

the same period, about 362,000 seasonal farmworkers and rural users are also being served. The Migrant Health Program supports these ongoing projects with an allocation of $26.41 million.

Service Augmentation (Access Development):

The primary objective of the Migrant Health Program is to extend care to migrants. To assure that priority is given to migrant services, the program set aside $1.25 million for use in expanding the number of migrants served in existing projects. In addition, $0.855 million were set aside for expansion of three entitlement Blue Cross/Blue Shield and prepaid projects which the program has pursued as a demonstration for a limited number of migrants. Finally, the program set aside $0.5 million for use in an advocacy and assurance operation in areas with low densities of migrants. Under this arrangement, care is delivered through local physicians who are paid a reasonable fee for the services extended. In total, about $2.6 million were set aside for service and access augmentation .

Hospitalization:

The legislation supporting the Migrant Health Program

requires that no less than 10 percent of the total Migrant Health Program appropriation be set aside for hospitalization. About $1.2 million of the hospitalization funds in 1979 will go toward covering care for high risk mothers and newborn infants on a priority basis. An additional $0.5 million will be directed toward general hospitalization needs while an additional $1.75 million will be adminsistered through the entitlement programs mentioned above.

Expansion of Service:

A priority concern of the Migrant Health and Community Health Center Programs is health care for mothers and children with particular interest in preventive services. In line with these priorities, the Migrant Health Program set aside $0.5 million for program designed to identify migrant high risk maternity cases and provide them with prenatal care. This care was also linked with hospital maternity care to improve the outcome of these pregnancies (see Hospitalization adove). In addition, $0.25 million was set aside to reinforce Regional and project efforts to assure the complete immunization of migrant children. A total of $0.75 million was provided through these activities to expand services to migrants.

Techinical Assistance Projects:

To assist migrant health projects in expanding and improving their operations, about $0.44 million were set aside for technical assistance on such things as project development, board training, accounting, medical records, patient flow, management information systems, etc. In addition, a technical assistance project supports medical record information and the referral of special cases for care between existing migrant health projects.

Sanitation Program:

The Migrant Health Program is specifically assigned responsibilities in relation to environmental and sanitation hazards confronted by the migrant. The program has supported supplemental efforts of state organizations in their inspection and enforcement activities. In addition, special training is arranged in cooperation with the Environmental Protection Agency to assure that medical providers are familiar with the hazards of pesticide poisoning, as well as the methods of diagnosing, treating and reporting it.

One Percent Evaluation:

The program routinely sets aside one percent of its

resources for evaluation of its operations.

The following table illustrates the anticipated impact of the 1979 estimated budget:

I.	Budget Data	
	Budget Authority	$34,500,000
II.	Workload Data	
	Number of centers	112
	Potential Eligible Population (Total)	2,700,000
	Migrants	(700,000)
	Seasonal farmworkers	(2,000,000)
	Persons Served (Total)	557,000
	Migrants	(195,000)
	Seasonal farmworkers	(362,000)
	Number of encounters	1,114,000
	Cost per person served (from Migrant grant funds)	$61
	Cost per medical encounter (from Migrant grand funds	$32

OTHER MIGRANT NEEDS AFFECTING HEALTH STATUS

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

porarily for purposes of employment. Nutrition lessons are difficult to learn or practice in an environment of poverty. Higher incomes and a change in lifestyle for the migrant probably will have more to do in resolving these health issues than traditional health care. As these examples illustrate, the health of the migrant is only partially resolvable by better health care. Attention has to be given to the broader issues afflicting the well-being of the migrant, namely, housing, water and sewage, education and employment. Health professions can go a long way in providing the necessary leadership and support in giving proper attention to these issues. Clearly, solutions require the continued attention of Government at the Federal, State and local levels as the concern, cooperation and support of the public in general.

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