HEALTH CARE FOR MIGRANT WORKERS

Health problems are particularly acute among the estimated 250,000 farmworkers and their families who migrate from South Texas. Low income, poor housing and sanitation, hazardous working conditions, and a migrating life style each contribute to severity of health problems and present barriers to delivery of health services.

Several national or state funded programs address conditions among migrant farmworkers, and conditions no doubt have improved in recent years. However, migrant farmworkers are estimated to be among the groups in the nation with greatest risk of poor health.

An estimated 250,000 migrating farm workers live in South Texas[1], of whom almost all are Mexican-Americans. Both because of their numbers and the severity of their health problems, health care for migrant workers and their families deserves special attention in any account of health care for Mexican-Americans in South Texas. We first discuss, so far as possible, the health problems of migrants in South Texas and the contest in which these health problems arise. We then review existing programs for migrants and suggest additional initiatives for public consideration.

HEALTH PROBLEMS OF MIGRANTS

The health problems of migrant workers and their families are related to their low level of income (median family income of migrants in South Texas was estimated to be below $4,000 in 1975), to poor housing and sanitary conditions, to the nature of the work itself, and to their migratory life style. A Field Foundation survey team in 1970 conducted medical histories and

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[1]Governor's Office of Migrant Affairs, Migrant and Seasonal Farmworkers in Texas, Austin, Texas, 1976.

physical examinations of 1400 migrant and seasonal farmworkers and their families in Hidalgo and Starr Counties.[2] This survey found dental problems to be virtually universal, malnutrition to be common, and undiagnosed cases of many treatable diseases rampant. In regard to the severe degree of malnutrition among children examined, Dr. Raymond Wheeler said:

> In one tiny rural settlement, with a medical student assisting me, I spent an entire day examining one family after another. It was a shattering experience.
>
> Their dietary histories were all the same--beans, rice, tortillas, and little else. The younger children, especially, were undersized, thin, anemic, and apathetic. The muscles of their arms were the size of lead pencils--a sign of gross protein malnutrition. Many had evidence of multiple vitamin deficiency....
>
> The children we saw that day have no future in our society. Malnutrition since birth has already impaired them physically, mentally, and emotionally.
>
> They do not have the capacity to engage in the sustained physical or mental effort which is necessary to succeed in school, learn a trade, or assume the full responsibilities of citizenship in a complex society such as ours.[3]

Since the inception of migrant health centers, some of this deprivation has no doubt been reduced. However, there is still evidence that health care problems are common to the migrant population which are uncommon for most others. A primary problem for many migrants, both in the home base area and in the migrant stream, is the quality of the housing, water, and sanitation which is available to them.

In the home base areas in South Texas many migrants live in colonias--unincorporated, poor, rural communities which usually are isolated, made up of small and generally inadequate dwelling

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[2]United States Congress, Senate Committee on Labor and Public Welfare, Subcommittee on Migratory Labor, Hearings on Migratory and Seasonal Farmworker Powerlessness, 91st Congress, 1st and 2nd Sessions, Washington, D.C., Government Printing Office, 1970.

[3]Ibid, p. 4988

units, and for the most part do not have access to clean drinking water or to sanitary sewage disposal. Researchers in 1976 identified 65 colonias in Cameron and Hidalgo Counties. With an average household size of 5.5 persons, the total colonia population in these two counties was estimated at 34,000.[4] In sampling of all of the colonias identified it was discovered that:

> An estimated 57 percent of all colonia houses do not receive treated water, although 45 of the 65 colonias identified in the study had access to treated drinking water. Of the households surveyed, 46 percent obtained water from a public supply system, 40 percent from wells, 6 percent from irrigation ditches, and 7.5 percent from other sources. Of the households surveyed, about half disposed of sewage by cesspool or septic tank and about half by outhouse. None of the colonias has access to a sewage treatment facility.[5]

People choose to live in colonias because they are inexpensive, provide a way to live near relatives, and permit the acquisition of some equity in land and house. Although the conditions in many colonias are deplorable, they are not nearly as bad as the colonias across the Rio Grande in the municipios of Reynosa, Matamoros, and Rio Bravo.

For many migrants the sanitary conditions in the labor camps and other available facilities on the migrant stream may be worse than the conditions in the colonia or barrio. Migrant labor camps in Texas since 1975 have had to be registered and inspected annually by the Texas State Department of Health Resources. Since then several camps have been closed and it is estimated that of perhaps 400 camps, 171 have licenses.[6] In the migrant stream out of state, conditions can be even worse

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[4]LBJ School of Public Affairs, "Colonias in the Lower Rio Grande Valley of South Texas: A Summary Report," Policy Research Report #18, 1977, p. 5.

[5]Ibid, p. 9.

[6]Good Neighbor Commission of Texas, Texas Migrant Labor: A Special Report, submitted to the Governor and Legislature, Austin, 1977, p.

with migrants often living out of cars, isolated from neighboring communities, and not having even the minimal support system available to them in the colonias at the home base area. Further migrants often find places of accomodation along the road difficult to find and overly expensive to use. The only overnight rest stop in the country is in Hope, Arkansas and it is extensively used by Texas migrants, who happen to be travelling on that stream.[7]

A study of migrant housing in a South Carolina labor camp uncovered a host of gross living conditions (Landhue and Hurst, 1974). Of the 366 migrant housing units inspected, 62 percent had dirt floors, 60 percent had no sanitary sewage disposal facilities, 69 percent shared a common bathroom with the rest of the camp, and 56 percent had no indoor plumbing (Ibid.). Gross violations of health conditions in migrant labor camps continue despite Federal regulations that prohibit them (Interview with Troy Lowry, January, 1977).

Migratory farmwork is a hazardous occupation. Migrant farmworkers may travel thousands of miles during the course of a work season thus risking injury through auto accidents. However, the principle hazards of migratory farmwork are in the fields of harvest and in the food processing industry. The death rate for persons employed in agriculture are a third after mining and construction (Accident Facts: 1974). Between 800 and 1,000 farmworkers are killed annually during the course of their

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[7] Ibid. pp. 78-79.

work, according to the Food and Drug Administration, and as many as 90,000 are injured each year by pesticide poisonings (Pierce, 1974).

Farmworkers also suffer two times the occupational disease rate of workers in all other industries (U.S. Congress, Senate, Hearings on Migrant and Seasonal Farmworker powerlessness: 1970). The extensive use of pesticides has often been mentioned as a likely cause. Pesticides, in particular the improper use of these chemicals, are a serious threat to the health of migrant workers. Pesticides can be easily absorbed through the unbroken skin or they may be inhaled or injected. There are several documented cases of growers totally disregarding the safety of farmworkers by allowing laborers to prematurely enter the recently sprayed fields or allowing the fields to be sprayed while the workers are in them (Baumheier: 1973).

Migrant children are constantly exposed to the same hazards that their parents encounter plus a few others. Children who work in the fields are exposed to the rigors of the work, which may leave them fatigued and very susceptible to diseases. Further, because migrants do not have access to day care facilities, children are often left at home unsupervised, or they may be left in a locked car and suffer the ill effects of heat (Bauhmeier, 1973). Finally, migrant children are often more susceptible to accidents involving farm equipment since they are less familiar with them than their parents; this is particularly true of children who are left unattended.

Table 2. Texas: work injury survey 1970 summary

Major industry	Frequency rate*	Severity rate**
Agriculture	24.90	1,606
Mining	17.52	1,722
Construction	26.02	2,090
Manufacturing	14.99	853
Transportation	26.23	2,468
Communication	2.74	128
Utilities	6.14	1,411
Wholesale Trade	8.46	784
Retail Trade	6.52	314
Financial, Insurance, Real Estate	2.78	101
Services	8.34	529
All Industries (except agriculture)	13.94	979

Source: Texas Department of Health, Division of Occupational Safety. Annual Report 1971 (Austin: Texas Department of Health, 1972).

*Frequency rate - number of disabling injuries per million exposure hours

**Severity rate - number of days lost as a result of work injuries per million exposure hours

Farmworkers are vulnerable to various other types of occupational hazards. According to Robert Gomez, Director of the Migrant Health Project in Hidalgo County, Texas, (1977), disabling back injuries are frequently diagnosed among migrants who do stoop labor and among migrant food processors who do much heavy lifting. In addition, many accidents and some deaths occur from mishaps involving agricultural equipment; in 1974, 87 farmworkers in Florida were injured and one killed in accidents involving farm equipment (Pierce: 1975).

In Texas, agricultural work ranks a close third behind construction and transportation as the occupation having the highest disabling injury frequency rate (Texas Division of Occupational Safety, Annual Report of 1971, 1972).

In addition to the direct impact of poor housing, low incomes and bad working conditions upon health, there is the indirect impact of poor health habits and limited education regarding nutrition and sanitation. Commenting upon the causes of malnutrition and other health problems in Cameron and Hidalgo Counties, one member of the Field Foundation survey team said:

> For every case of health hardship we saw involving lack of physicians, inadequate funds, or improper food, we saw a balance of patients who, for socio-cultural reasons or lack of educated health "awareness" failed to seek care. Perhaps in the culture of poverty, failure to seek reflects in the hopelessness of poverty, the apathetic despair of a culture which had done without for so long that even the aspiration for care is lost.[8]

Lack of knowledge about preventive health care and lack of resources for improved hygeine are problems which many still

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[8] Hearings on Farmworker Powerlessness, op cit, p. 5097.

face.

It is difficult to characterize exactly who the migrants are. Traditionally, migrants were thought to be a mix of both native born persons and recent immigrants, many illegally. Many immigrants from Mexico still do settle just across the border; but many travel directly to Chicago, the Pacific Northwest, or Los Angeles without going through the traditional transition in the Lower Rio Grande Valley.[9] Similarly, for many, the pattern of migration has changed. Not only has the demand for migrant labor abated substantially with increased mechanization, and one suspects with the increased regulation of its use. But, also, the classic description of the choices facing large families is altered:

> Apparently size of family is associated with the need to migrate. When the family becomes too large for the earnings of one worker to support all its members, the household head looks for work that will permit other members to contribute to the family income. Conversely, families stop migrating when enough members obtain local employment and it no longer pays to migrate. They are as likely to obtain permanent employment in one of the work areas as at the home base.[10]

While economic needs are still a major factor in decisions to migrants, many of the opportunities and options have changed at least somewhat. This has been noted in the Annual Report of the Cameron County Migrant Health Program which states:

> There appears to be a numerical decline in the migrant population. This may be due to increased aspirations and to increased stable job opportunities. For example, while the husband may wish to earn money "up north", the wife may want to keep her children in school and her life less disrupted. Economic necessity does not now appear to have the great overriding pressure

[9] Vernon Briggs, Walter Fogel, and Fred Schmidt, The Chicano Worker, University of Texas Press, Austin, 1977.

[10] Walter Metzler and Frederic Sargent, Migratory Farmworkers in the MidContinent Stream, Agricultural Research Service, USDA, in co-operation with Texas Agricultural Experiment Station, Washington, D.C., 1960, p. 2.

> it once was in nearly every Migrant family. Now it is possible for the migrant to move to Houston and obtain work or possibly to stay in the Valley and obtain steadier work. The Lower Rio Grande Valley is not noted for its high wage scale compared to other urban areas, but now work appears less seasonal and somewhat more available.[11]

Another factor must of course be increased non-cash assistance such as food stamps and school feeding programs which reduce the amount which must be earned to obtain the bare necessities of life. For example, local growers were much opposed to the initiation of the Food Stamp program in South Texas, at least one reason being that the program reduced the need of farm-workers to borrow money from growers during the off-season. In some cases repayment was promised in the form of future labor, an illegal practice.

Similarly the migrant health projects and some other programs have improved the lot of migrants. However, poor conditions are not yet resolved and it is not yet appropriate to be sanguine. In the late winter of 1977, a team from the Area Health Education Center at the University of Texas Medical Branch at Galveston carried out a medical screening program in an elementary school in the town of Hidalgo in Hidalgo County. As can be seen in Table____, the results are somewhat worse than would be encountered in the average middle class school district. To these statistics must be added the realization that these were the children who were well enough to go to school.

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[11] Cameron County Health Department, Annual Progress Report-Migrant Health Program, 1976, Brownsville, Texas, 1977, p. 8.

Table _____

Health Problems in Hidalgo School Children*

Selected Problems Identified	Grades (N=242) K-2		(N=137) 3-4		(N=86) 5-6	
	#	%	#	%	#	%
Dental Problems	114		78		42	
Ear Problems	60		33		30	
Orthopedic Problems	41		32		12	
Obesity	27		20		23	
Developmental Delay	1		19		40	
Lice	27		25		14	
Short Stature	26		12		10	
Skin Problems	22		10		8	
Well Child	20		4		12	
Urinary Problems	19		14		11	
URI	27		7		0	
Opthalmologic	12		7		12	
Scabies	10		11		6	
Genital	13		5		7	
Blook	10		2		6	
Thyroid	1		13		4	
Behavior	11		2		3	
Hard of Hearing	4		3		2	
Poor Hygiene	3		1		1	
Other**	30		27		13	

*Source: Area-Health Education Center, Galveston

**Other includes speech defect, heart murmur, seizure disorder, muscle weakness, tonsilitis, school problems, allergies, nose bleeds.

HEALTH PROGRAMS FOR MIGRANTS IN SOUTH TEXAS

Because so many of the migrant farmworker's health problems are rooted in living and working conditions, medical care delivery programs alone are not sufficient to adequately address the health problems of these people. Accordingly, in any discussion of health care programs for migrants, some attention must be paid to activities of a more general nature. So that lines of authority and organization may be better understood, we will look first at State programs which may have some impact upon migrant health in Texas and subsequently at federal programs.

State Programs: State Agencies involved with migrant farmworkers in South Texas include the Governor's Office of Migrant Affairs (GOMA); the Texas Good Neighbor Commission; the Texas Employment Commission; the Texas Rehabilitation Commission; the Texas Department of Health Resources and the Texas Education Agency.

Both the Good Neighbor Commission and the Governor's Office of Migrant Affairs are authorized to coordinate the work of Federal, State, and local agencies to improve the delivery of services to migrant formworkers. Although each agency is also responsible for carry out other functions, their principle activities are in the area of migrant affairs and all of a coordinative nature. A redundancy in agency responsibility is evident between these two entities.

. The Texas Employment Commission (TEC) offers a full range of services for rural residents including migrant farmworkers. Counseling, testing, placement, referral to training and manpower programs, referral to agencies, and follow up services are available.[12] In addition, TEC offers an "Annual Worker Plan" for migrant farmworkers. This plan provides assistance to framworkers in planning itineraries to facilitate their movements from one crop to another and thus continue their work for the longest possible duration. During the eight years that this program has operated, both the number of job openings, and the farmworkers placed as a percentage of that figure, have fallen drastically. This indicates that both the demand for and the supply of migrant farmworkers is declining. However, it is conceivable that employers of migrant farmworkers are hiring more local farmhands or legal (greencard holders) and illegal aliens.

TEC also registers migrant crew leaders and attempts to acquaint them with Federal regulations regarding recruitment, employment, or transportation of migrant farmworkers.[13] Many crew leaders, in the past, have failed to comply with the requirements of the law. As a result, the Department of Labor in 1975 began to enforce and file a suit against violators.

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12. Good Neighbor Commission of Texas, 1975 Texas Migrant Labor Report, 1975, p. 51.

13. Ibid., p. 44.

This led to a significant increase in the number of crew leaders registered in that same year.[14]

.The Texas Rehabilitation Commission provides vocational rehabilitation services to farmworkers (both seasonal and migrant) who have a physical or mental disability, are vocationally handicapped, and are employable.[15] The type of services presently offered include:

* medical evaluation, surgery and treatment;
* psychological evaluation;
* vocational and academic training;
* work motiviation and work adjustment training;
* on the job training;
* maintenance and transportation;
* vocational counseling;
* job placement; and
* follow-up counseling

Approximately 500 migrant farmworkers are being served by this program.[17] Most migrants receive physical restoration services for chronic injuries such as back injuries, hernias, leg injuries, and respiratory illnesses. The Texas Rehabilitation Commission presently coordinates these services with other State agencies in Colorado, Idaho, Wisconsin, and Minnesota. However, coordination has been difficult because of the constant movements of these migrant farmworkers. Continuity of services is a major problem with this program since a migrant's itinery is subject to sudden changes. Also, once in the stream, migrants are probably reluctant to leave their jobs for any extended period of time since that is a loss of their potential earnings.

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14. Ibid.

15. Ibid., p. 59.

16. Ibid.

17. Interview with Delvin Sparks, TEC, April 12, 1977.

Present funding for migrant rehabilitation services amounts to approximately $200,000.[18] Funding for the next year should amount to $150,000. This program may be terminated in the near future.

.The Texas Child Migrant Program of the Texas Education Agency provides comprehensive educational services to migrant school children throughout the State. While the primary purpose of this program is to provide educational services to migrant children, health services also are provided. Each enrolled migrant child is screened by a registered nurse for visual, auditory, dental and other deficiencies. In addition, each child is given a comprehensive physical examination and appropriate follow-up. If any medical treatment is needed, the child is referred to an available medical facility. Forty-nine nurses and forty-five nurse's aides are employed by TEA to provide these examinations.

.The Texas Department of Health Resources historically has offered only one service directly to migrant farmworkers - inspection of lobor camps. The General Sanitation Division is responsible for insuring the provision of safe, adequate, proper usage, and maintenance of temporary labor camp housing for farmworkers and their dependents. The Division also is responsible for insuring the provision of adequate, safe, proper usage and maintenance of environmental health facilities of raw vegatable packing sheds.

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18. Ibid.

Five labor camp inspectors are employed to inspect the 171 licensed migrant labor camps in Texas. Total expenditures for the labor camp inspection program amount to approximately $26,000 not including the salaries of the five inspectors.

According to Troy Lowry of the General Sanitation Division, 37 labor camps voluntarily closed because of the present regulations, and, presently, there are six labor camps in gross violation of standards. One of these camps has been charged by the Department of Health Resources of violating regulations of the Labor Camp Inspection Act and brought to court. Hopefully, this suit will motivate other violators to comply with Department regulations.

In addition, TDHR recently secured federal funds to organize a Migrant Labor Camp Sanitation Assistance Program. This program involves identifying places migrants reside, determining the major health problems, and helping the community obtain help where possible. This would include improvement of sanitation practices, health education programs, and documentation of environmental conditions which correlate with with migrant afflictions requiring medical or dental services.

Federal Programs: The federal government also is involved in co-ordinating programs for migrants and in the direct delivery of health services for migrant workers.

In education, supplementary funds for the education of migrants are available under Title I of the Elementary and Secondary

Education Act (ESEA), Public Law 89-10, as amended by the Migrant Amendment, Public Law 89-750.[19]

Nationwide Migrant Student Record Transfer System

The Office of Education (DHEW) developed the Nationwide Migrant Student Record Transfer System to facilitate the transfer of school records of migrating school children. The system was developed to store and provide a student's cumulative academic and health history while attending up to four schools.[20] The heart of the system is a central computer data bank in Little Rock, Arkansas, that can trace each child as his or her family migrates from one harvest to another. The record system is available to any school district which serves migrant children, and provides a quick response "critical data record" containing the information needed immediately by a school in order to enroll the student. Each participating school is assigned to a nearby terminal for all transactions to and through the central data bank. Each record contains the child's name, sex, birthdate, and birthplace, and medical history for continuity of the child's health care. A child's record can be supplied to school officials and health authorities within 4 to 24 hours after a request is made. Besides vital health information, the record also provides information concerning the most recent physical examinations and a history of the child's immunization and innoculation record.

The Texas Migrant Council (TMC), which is funded by the Indian and Migrants Programs Division of DHEW provides a variety

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19. National Committee on the Education of Migrant Children, "Wednesday's Children: A Report on Programs Funded under the Migrant Amendment to Title I of the Elementary and Secondary Act," Albany, N.Y., 1971.

20. Ramos, p. 22.

of social services -- education, nutrition, manpower and employment, health and referrals -- to migrant farmworkers in the State of Texas.[21] TMC has established homebase centers in 16 different cities in South Texas. These homebase centers are open from September through May each year. During the summer months TMC mobile units follow the migrant populations into the stream, principally into the midwest -- Michigan, Illinois, Wisconsin, Indiana, Iowa -- but also into Washington and Oregon.

In the area of health, TMC provides health and nutritional education including first aid, medical screenings, dental examiniations, psychological support services, and medical referrals. A physician extender, under the direction of a physician, offers primary care services at different clinic sites when there are no local services available. A nurse is assigned to each TMC center in South Texas. TMC presently serves between 1200 to 1600 migrant children in South Texas. Centers are located in the following South Texas towns:

Brownsville	Harlingen
Carrizo Springs	Hereford
Cotulla	La Grulla
Crystal City	Laredo
Del Rio	Mission
Dilly	Pharr
Eagle Pass	San Benito
Edinburg	Uvalde

21. Ann: Opportunity to Choose, 1977.

22. Interview with Mike Trevino, April 4, 1977.

.The National Migrant Referral Project began nationwide operation in July, 1975, and is currently funded by the ~~Bureau of Migrant Health~~ (DHEW). All HEW funded migrant clinics participate in the referral system, which was created to facilitate the continuity of health care for migrants and their families. Referrals are made on an agency-to-agency basis, so that providers in one locality may provide services to the migrant who requires follow-through health care. In 1975 the project initiated a total of 4,452 referrals, of which 2,556 were completed and processed. The total number of referrals appears to be relatively small, given the scope of the referral project and the total number of migrants nationwide. The small number of migrants availing themselves of this service may be due to a small number of migrants knowing about the service from an unwillingness of individuals or clinics to forward information through semi-official channels, from established un-official care the migrant receives outside of the home-base area, or from the uncertainty of the migrant's destination and time table due to bad weather, automotive breakdowns, or unusually good or poor crops, all of which may cause him to alter his plans.

There are eleven federally sponsored migrant health projects in South Texas. Most of the funds to operate these projects come from the U.S. Department of Health, Education, and Welfare; although Catholic Charities, does provide substantial funding to one migrant project (Su Clinica Familiar). Collectively these health projects receive $4,000,000 from DHEW for their operations

and serve approximately 67,000 migrant farmworkers (See Table 2). Obviously, only a portion of the total migrant labor force is being served by the health projects. These projects were established both because of a shift in orientation away from the "classic" migrant program upstream to larger more comprehensive clinics in the home base area and because care for ~~non-categorically entitled~~ categorically needy individuals and families ~~was almost~~ is non-existent under the state Medicaid program.

The operations of these projects -- including services, personnel and operating hours -- vary from site to site. The larger projects, such as Su Clinica Familiar, the Hidalgo County Health Care Corporation and Laredo-Webb County Migrant Health Project, provide many more services and are more innovative than the smaller projects. Despite the differences in project operations, these health care providers encounter essentially the same problems. Without exception, their clients are overwhelmingly poor Mexican-Americans and, except for the Southwest Migrant Association in San Antonio, most clients are from rural areas.

Migrant health projects also share a common need for certain services. Hospitalization funds are always limited or in some instances unavailable. The Laredo-Webb County Migrant Health Project, which has an experimental program with Blue Cross/Blue Shield funded by the Federal Government, ~~is the lone exception~~. The larger projects are very limited on the number of patients they may hospitalize within a fiscal year. Smaller projects tend to be severely short on, or completely lacking in, hospitalization funds,

and are thus dependent on local charitable contributions.

Financial constraints limit the hours that many projects can operate. Most projects do not offer their services during the evening hours or on weekends. Also, emergency care usually is available only during regular operating hours. Again, migrant health projects must depend upon the availability of local health facilities on the volunteer efforts of their own staff to provide these services.

As previously mentioned, the range of health services differs from project to project. The Laredo-Webb County Migrant Health Project offers its clients virtually all types of health care services including hospitalization. The ~~La Salle County Migrant Health Center~~ South Texas Rural Health Services, by contrast, provides little more than outpatient clinical services.

The principal emphasis of these health projects appears to be curative rather than preventive health care. Although the larger projects have a preventive health care component that includes nutrition and sanitation education, family health care and environmental services, most projects do not. Most migrant health projects -- even the large ones -- tend to emphasize the treatment and cure of illness symptoms. This is understandable given the environment that migrants must cope with and the constraints of the migrant health ~~projects~~ centers. The programs are limited in funds and personnel and they often receive little or no help from local and state health officials in combating the root causes of migrant problems. A coordinated effort by these

officials could do much to educate the migrant population on sound nutrition and sanitation practices and to reduce some of the environmental causes of health problems.

Selected Programs: A number of new and innovative migrant programs and services developed by these federal projects appear to be particularly effective in addressing some health problems of migrants. These services and programs include: The Migrant Hospitalization Demonstration Program; the Certified Nurse Midwife Project; the Mobile Medical Service Outreach Program; and the Home Health Services Program. With the exception of the ~~Hospitalization~~ Laredo Webb Demonstration Program, all of these programs are pioneered in Texas by Su Clinica Familiar.

The ~~Migrant Hospitalization Program~~ Affirmative Action Law, created in March of 1973, ~~is an experimental pre-paid insurance package for eligible~~ migrants. The ~~program provides them with~~ ambulatory care and hospitalization; ~~coverage is provided by Blue Cross-Blue Shield Insurance.~~[23] ~~Presently there are 10 such projects in operation throuout the United States.~~

All types of services provided by local migrant clinics (general medical, preventive medical, dental care, etc.) are available to enrolled migrants without their incuring financial liability. Specialist services that are not available at local clinics are provided by private physicians on referral -- 100 percent of the usual, customary and reasonable charges will be paid by Blue Cross-Blue Shield health insurance.[24] Patients

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23. "Experiment in Prepaid Insurance: Its working For Migrant Families' Texas Medicine, Vol 72, February 1976, pp. 101-105.

24. Ibid. p. 103

who prefer to go to their own private physician when the same treatment was available at the migrant center will incur 25 percent of the usual customary fee the physician charges, the rest will be paid by Blue Cross-Blue Shield.

Migrants are also covered by this insurance plan when they travel upstream. Blue Cross-Blue Shield issues identification cards to them along with information covering coverage, nature of services and reimbursement methods. While they are upstream, migrants receive 100 percent reimbursement for private physician visits and hospitalization.

Enrollment into this program is limited. Only those individuals who meet the migrant status requirement, as defined by HEW regulations, may qualify for enrollment. Further, no families with medical insurance (medicaid, medicare, employee benefits, or private insurance) may qualify.[25]

The migrant hospitalization program appears to be the ideal solution to prevision of health services to migrants while they are home based; in addition, the program also appears to be ideally suited to addressing the problem of continuity of health care. The program could, however, encounter two major obstacles.

(1) physicians or hospitals that are unwilling to accept these migrants

(2) lack of adequate health facilities in remote labor camps or farms.

Presently, the results of the program indicate that the migrants enrolled are not being rejected by physicians or hospitals upstream. It should be pointed out that 100 percent of all upstream billings,

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25. Ibid.

26. George Walker, with Maurice Click, Migrant Health Care Utilization and Costs: The Laredo Experience, Universtiy of Texas Health Sciences Center, Houston, 1976.

COUNTY	PROJECT	SCOPE OF SERVICE	HEW FUNDING	FARMWORKERS SERVED	MEDICAL PERSONNEL
Bexar	Southwest Migrant Asso.	I	$275,000	7,500	1 Dentist; 2 L.V.N.'s; 1 Health Administrat; 2 Dental Assistants; 2 Community Aides; 2 R.N.'s; 1 Lab Technician; 3 physicians
Jim Wells	Jim Wells County Migrant Health Project (Federal)	II	60,973	812	1 Project Director; 2 L.V.N.'s; 1 Medical Director(M.D.); 1 Nurse Aide; 2 Physicians; 1 Sanitation Aide
LaSalle Dimmit Frio	South Texas Health Services, Inc. LaSalle ~~County Migrant Health Project~~	~~IV~~	$202.000 ~~42,288~~	654	1 Administrative ~~Assistant (R.N.)~~; ~~4~~ physicians; 1 Public Health Nurse; 1 Nurses Aide
San Patricio	Coastal Bend Migrant Health Project	I	299,619	3,664	1 R.N.; *1 Dentist; 2 L.V.N.'s; 2 Physicians
Cameron	Cameron County Health Project	III	120,670	*3,500	30 Nurses; 3 Sanitarians; 1 Nutritionist; 4 Sanitarian Inspectors; 1 Physician
Cameron Willacy	Su Clinica Familiar	I	2.200,00 ~~1,362,509~~	~~15,602~~ ~~40~~ 25,000	1 Nutritionist; 3 Nurse Practitioners; 11 L.V.N.'s; 4 Physicians; 5 Certified Nurse Midwives; 10 Social Service Assist; 2 Pharmacists; 4 Lab Technicians; 4 Social Workers; 2 X-Ray Technicians; 6 Family Health Aides; 2 Pediatric Health Nurses; 2 Public Health Nurses; 3 Family Nurse Practitioners
Hidalgo	Hidalgo County Health Care Corp.	I	888,268	15,343	5 L.V.N.; 1 Caseworker; 3 Lab Assistants; 1 Health Educator; 2 Physicians; 4 R.N.'s; 2 Nurses Aide; 1 Pharmacist; 1 Lab Technician; 1 Nutritionist; 1 Pharmacist Assistant

COUNTY	PROJECT	SCOPE OF SERVICE	HEW FUNDING	FARMWORKERS SERVED	MEDICAL PERSONNEL	
Starr	Rural Health Initiative	I	$275,000	7,500	1 Executive Director 1 Medical Director 1 R.N. 1 Nutritionist 2 Nutrition Aides	3 L.V.N.'s 1 Clinician Assistant 1 Health Educator 2 Sanitarians 2 Health Aids
Val Verde	Del Rio Val Verde County Migrant Health Project	III	58,364	2,142	1 R.N. 1 L.V.N. 1 Certified Nurse Aid 1 Physician	
Webb	Laredo-Webb County Migrant Health Project	I	682,048	6,253	1 Executive Director 1 Sanitarian 1 Health Educator 2 Physicians 1 Engineering Technician	2 Health Assistants 1 Pharmacist 1 Medical Technician 1 L.V.N.

In order to facilitate the description of services provided by the projects, the following classifications are utilized. It must be noted, however, that these classifications are not all inclusive. The designated codes shown for each project should be interpreted as being generally reflective of services provided and not as a precise measurement of all the specific services offered.

I. FULL TIME COMPREHENSIVE HEALTH SERVICES

A comprehensive range of diagnostic, therapeutic, and follow-up medical services offered by the project on a daily and year-round basis by a full-time medical staff in a center setting. Provisions for dental care, health counseling and outreach services, as well as adequate provisions for preventive services are offered either inside or outside the center.

II. SCHEDULED COMPREHENSIVE HEALTH SERVICES

A scope of medical services similar to those listed above are offered by the project, but through intermittently scheduled clinics (e.g. one or two times a week encompassing two or three hours per session). In general, these clinic sessions are backed by referrals of patients by nurses outreach workers to local physicians on a fee-for-service basis at times when clinics are not in session. Provisions are also made for caring other health needs such as dental care, health counseling and outreach services in addition to preventive services. Environmental health activities are also an element of the project.

III. SCHEDULED MEDICAL SERVICES

Although the project offers complete diagnostic, therapeutic and follow-up medical services through intermittently scheduled clinics with referral to private physcians during non-clinic hours, provisions are not necessarily made to offer dental care services, and other health services mentioned above. Environmental health activities may be an element of the project.

IV. SCHEDULED CATEGORICAL HEALTH SERVICES

The project focuses upon clinics for specific diseases or categorical emphasis (e.g. tuberculosis control, venereal disease control, maternal and child health, immunizations, etc.) and does not offer a broad range of medical services in a clinic setting. General health care is provided through referral by nurses and outreach workers to private physicians and dentists on a fee-for-service basis. Camp sanitation inspections, and efforts to correct deficiencies may be a component of the project.

V. NON-SCHEDULED HEALTH SERVICES

All general health care is provided by the project through a fee-for-service referral system to private physicians, and, in some instances, to private dentists. Nursing services provided are primarily outreach and follow-up. Camp sanitation inspections, and efforts to correct deficiencies may be a component of the project.

VI. LIMITED CATEGORICAL SERVICES

The project has a specific objective, usually limited to environmental health services only, and is not directed to the provisions of direct general health care. Environmental health activities usually involve camp inspections, enforcement of state codes, and coordinating efforts with other local sanitation programs.

VII. ADMINISTRATIVE-CONSULTATIVE SERVICES

The project does little, if any, in the way of providing direct health care and devotes its efforts to consulting and coordinating the direct health care activities of other groups.

to date, are from private providers. The reasons for this situation are unclear. It is possible that public medical facilities (including migrant health projects) are not billing Blue Cross-Blue Shield for services rendered to these migrants. Perhaps, however, migrants perceive private health care to be more suited to their needs and are thus procuring their services. If the latter assumption is correct, expansion of the ~~hospitalization program~~ would cause drastic alterations in the operations of present migrant health clinics.

The Certified Nurse Midwife Maternity Project was developed by Su Clinica Familiar, 1972 a migrant health project in Harlingen, Texas. ~~The new~~ This program uses certified midwives to provide ~~basic maternal services~~ prenatal, delivery, post partum to migrant mothers and their babies. The program was created because of the large number of children that were being born outside of hospitals or clinics, resulting in infant mortality and morbidity rates for the area being among the worst in the nation.[27] The addition of nurse midwives to the staff of Su Clinica Familiar led to significant increases in natal and postnatal care,[28] and has relieved other staff members of some of the burden of providing these services (maternal, child, prenatal, etc.). Midwives are available twenty-four hours a day, seven days a week at this project to assist in the delivery of babies; ~~physicians~~ OB GYN are on call in case of complicated deliveries ~~they are needed.~~

The use of certified midwives is an innovative concept that could alleviate a problem endemic to all migrant health projects -- the lack of trained medical personnel. Migrant health projects

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27. American Friends Service Committee, 1976, p. 2.

28. Interview with Dan Hawkins, February, 1977.

can increase their services to migrant mothers and babies and can be less dependent upon the presence of a physician.

Presently, the University of M'ssissippi's Nurse Midwifery training program is cooperating with Su Clinica Familiar to train some of the clinic's personnel as midwives. Meanwhile some students who have completed basic program instruction are interning at Su Clinica Familiar. The project is aimed primarily towards women presently delivering through untrained local midwives or at home.

Project MANO (Medical and Nutritional Outreach) provides health screening and nutritional education to homebased migrants in isolated rural areas. These rural areas historically have been medically underserved. Outreach operaitons such as Project MANO are one method in which health services can be effectively delivered to rural indigents. However, a Mobile outreach unit has serious limitations including:

(1) the number and scope of services it can deliver;

(2) the number of visits it can make to an area and the amount of time it can spend at any one site;

(3) the amount of personnel it can extend to these units;

Project MANO is temporarily suspended because the mobile van is no longer in working condition. Attempts are being made to raise funds for a replacement.

Although mobile clinics have had relatively little success in

29. Su Clinica Familiar Annual Report, 1976.

meeting the health needs of some rural communities in this country, Project MANO was investigated and endorsed by the staff of the federally funded Task Force on Southern Rural Development.[30]

Su Clinica Familiar also developed the Valley Home Health Agency, which extends health treatment to patients in their own homes. Home health nurses, clinic physicians, and local private physicians are involved in the delivery of health services to these individuals. Home nursing services are available every day of the week, 24 hours a day. Specialized care is available to patients during regular hours and on weekends and evenings for emergency cases. The success of the Valley Home Health Agency in securing such funding has stimulated both the Cameron and Hidalgo County Health Departments to initiate services. A substantial proportion of this program's clients are over 65 years of age and ordinarily would not have access, either for lack of transportation or finances, to medical care. This service is not sponsored by HEW migrant health funds, rather it is maintained through third party reimbursements (principally Medicare and Medicaid) and private contrubutions.

Home Health services is a relatively new concept in the area of migrant health and it is one that is vitally needed. Many migrants reside in isolated areas removed from health facilities; others may be devilitated to the point that intermittant home care is better than institutional care.

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30. Ibid.