MIGRANT HEALTH - FUTURE OUTLOOK

Paul Q. Peterson, M.D.
Assistant Surgeon General
Deputy Director
Bureau of Health Services
U. S. Public Health Service

Into whatever community a migrant goes, his status is the lowest in the social scale. His labor is welcome, but he is not. The harvest needs him, but the community prays that it may get by without having its town polluted, its civic pride soiled, or its resources burdened by relief or health cases.

The problems of the migrant are not unlike those of the low income resident of a rural community. His situation, however, is aggravated by the nature of his living and working conditions. He is driven to migrate by economic necessity; his constant travel heightens his accident risk; he is more exposed to communicable disease; his poverty places him among the poorest fraction of the population--the fraction with the highest illness rates.

Yet the migrant receives even less care than the needy resident of a rural community. The typical

---

Presented before the Western States Migrant Health Conference, Los Angeles, California, June 26, 1967.

> farm community is completely unprepared to meet the expanding needs he presents. Limited local facilities, restricted tax support, and insufficient medical and nursing personnel are among the obstacles to providing him adequate care. Added to these are the restrictive laws, practices and attitudes that severely limit medical aid to the nonresident.

To some of you it may be a shock to know that the statements just made are paraphrased from reports of 30 years ago. The fact that they so accurately describe the current situation presents to us a unique challenge, and an opportunity to prove that the migrant health problems of today, carried over from yesterday, need not be the problems of tomorrow. We have the knowledge, the tools, and the wealth to create change. In the future, machines may take over many of the jobs migrants are now doing. But the people are here now, and their problems must be met today. Moreover, their number has not diminished in recent years.

MIGRANT HEALTH PROGRAM

Our major working tool is the Migrant Health Act. The Act was designed to extend health care to persons who move one or more times each year beyond normal commuting distance of their homes, and who must establish a temporary residence away from home to work in agriculture. This definition includes both workers and their nonworking family dependents.

Under the Act the Public Health Service is authorized to make grants to either public or private nonprofit groups to pay part of the cost of setting up and operating projects to make health services accessible to migrants. The term "accessible to migrants" as applied by the Migrant Health Program has packed into it a variety of factors to overcome the obstacles they have faced in the past in seeking and obtaining needed care. These factors include:

> The scheduling of services at a time and place convenient for ready use without lost time from work or need for costly transportation;
>
> The concept of a "one-stop" service center to provide health care for all family members for whatever needs they may have;
>
> The orientation of professional workers to the group to be served, and to modifications of their own attitudes, behavior, and approach that are essential if migrants are to be served effectively;
>
> Recognition of migrants' need for understanding, respect and treatment as fellow human beings.

The last may be the most important, since the personal touch seems to be the magic wand that wins migrants over to the use of modern health care, once it has been made accessible in other respects.

The grant-assisted projects are community-based in the fullest sense of the term. The philosophy of the program is to encourage and to help the community recognize and assume its responsibility to include migrants in its planning and provision of health service making whatever adaptations are necessary to serve them effectively The role of the Public Health Service is viewed as <u>helping</u> the community--not doing the community's job.

State health agencies are encouraged to play an active role in community migrant health program development. Each grant application comes to the Public Health Service with written advice from the State health officer. Nearly all States have named one or more staff members to assist in local community project development and coordination of effort. Public Health Service regional and central office staff members backstop these State-level consultants and facilitate the coordination of services along major migratory streams from the Mexican border to the Canadian border.

ACHIEVEMENTS

The achievements of the national program are the achievements of the grant-assisted projects. To summarize briefly, they include:

1. So organizing and delivering community health services as to start bringing into the mainstream of medical care a group long characterized as "hard-to-reach".

In calendar year 1966 an estimated 250,000 migrant workers and family members had access for at least a few months of the year to project services in one or more project areas scattered over 36 State and Puerto Rico. Migrants made 165,000 visits for medical treatment, 18,000 visits for dental care, and additional visits for services such as immunization, family planning, prenatal care, well child care, and communicable disease screening.

Project nurses made 100,000 visits to migrants' homes, and to

schools and day care centers attended by migrants' children. Sanitarians made about an equal number of visits for housing inspection and follow-up.

2. Spanning the gap that has too often existed between private medicine and public health.

About 135 multipurpose health service centers are providing treatment and preventive care to workers and family members during their periodic stay in local communities. Centers in the home-base areas usually operate on a year-around basis. The local medical society has initiated the effort in some cases, bringing in public health workers to assist. In others, public health workers or other groups took the initial step, and invited interested physicians to participate.

3. Establishing a multi-discipline approach to migrants' problems.

Physicians, nurses, sanitarians, health educators and other health workers all have a part in the team effort.

4. Encouraging and assisting migrants in adopting improved health practices.

Some project nurses have noted an increasing number of migrants coming to them with their problems, instead of waiting for the nurse to seek them out. "Many," according to one project report, "are now aware that good medical care is not out of their reach. They often ask if a nurse comes to their camp. They appreciate that she is someone who will listen to their problems and make every effort to help them find solutions."

5. Utilizing scarce health manpower effectively by bringing back into practice retired or semi-retired persons; selecting, training, and using a variety of volunteer or paid "aides" from the resident and the migrant community; and organizing service to make the most effective use of professional time.

Project aides often not only perform tasks that would otherwise have to be performed by a professional worker, but also bring to the situation special language skills and understanding which can help the professional worker of a background different from that of the migrants to establish better communication and rapport.

6. Focusing on migrants the many public and voluntary agency resources that have a potential contribution to make to the improvement of their health status and care.

Migrant health projects funnel the resources of many public and private agencies--local, State, and national--to migrants. Only a few examples can be cited here of the resources tapped for migrants through grant-assisted projects. Lion's Clubs provide eye-glasses for migrant children. The United Church Women recruit volunteers for clinics. Local health departments provide consultation and direct services. Local physicians, dentists and hospitals provide care at reduced or, in some cases, no cost. Migrants themselves assist in preparing the temporary clinic quarters. VISTA workers help with casefinding and patient transportation. The vocational rehibilitation and crippled children's programs accept referred patients for care. Local extension agents assist in homemaking and nutrition education classes. Local growers encourage their workers and families to use project services and in some cases

provide a building in the labor camp where night clinics can be held.

Some projects have recognized other needs of migrants for which the Economic Opportunity Program has grant resources. In other cases the reverse is true, and projects which started with an OEO grant for education, day care, or other services have turned to the Migrant Health Program for funds for health care. (Dr. English, of course, will be speaking at greater length about OEO-supported programs.)

7. Entering into full local-State-Federal partnership in Migrant Health Program development and operation.

One measure of the extent to which a full local-State-Federal partnership has been established in the Migrant Health Program is the value of contributions in cash or in kind from non-Federal sources compared with the Public Health Service grant. These contributions from other sources have amounted to about 40 percent of total project costs from the time the program started in 1962.

In early 1967, when hospital care was added to the scope of service eligible for grant assistance, specific requirements were set forth for the first time for the contribution from other than grant sources. The high cost of hospital care and the acute shortage of migrant health grant funds made it essential to develop an equitable system for dealing with hospitalization requests from projects throughout the Nation. The State Medicaid percentages under Title XIX, geared to each State's financial capacity as measured by average per capita income, seemed logical for program use. Accordingl

the program applies the Statewide Medicaid percentage to the total estimated hospital costs for project budget purposes, and asks that each project apply the same percentage to each bill paid under the Program. The maximum for which migrant health grant funds can be used is the Medicaid percentage.

8. Establishing communication within and between project areas in order to improve continuity of care as migrants move.

Just a few years ago, providing continuity of care as migrants moved from place to place was only a dream. Many migrants changed "homes" so rapidly that needed medical care could never be completed. Now this picture is changing. As one nurse reports, "When a family moves on, the information regarding its problems is forwarded to the next destination. It has been extremely gratifying to have received so many replies from other States telling us they found the family referred and are continuing the medical recommendations."

CASE HISTORIES

Case histories reported by projects indicate what all of this means to individual migrants. For example, follow-up care for one small boy who had cleft palate was delayed for 7 years, in part because of his family's great mobility. Communities in three States were finally involved in his care.

The boy was found in Oregon in early May when his family came to pick berries. His lip had been repaired in Phoenix, Arizona when he was only two weeks old. Now -- 7 years later -- he had not had the

follow-up care needed, had never attended school, and spoke a baby's jargon, understood only by his mother. At the family's previous work location in California, he had been scheduled for cleft palate repair but the family left too soon.

The Oregon project staff obtained records from the California county, and surgery was again arranged. Just when the boy was again scheduled to enter the hospital, his parents were ready to leave for beanpicking. This time they were persuaded to stay until the boy was admitted. One of the nurses and a student assistant agreed to substitute for his family and visit him in the hospital during his parents' absence.

Another project reported a migrant woman with severe headache and pain in her left eye who was diagnosed as having acute iritis, probably super-imposed on a neoplastic condition. The project director referred her to an eye specialist who confirmed this diagnosis. No local facilities were available for her care. However, arrangements were made with a medical center 200 miles away, a voluntary agency furnished transportation, and the woman was hospitalized within 24 hours. The project nurses helped her maintain contact with her crew throughout her hospitalization. One month later she was back with her crew, with a prosthesis to replace the eye she had lost

This year, as you know, was the first in which payment could be made for hospital care using Migrant Health grant funds. The first baby born in a hospital with the bill paid by a migrant health

project arrived in Case Grande, Arizona, early in April. Her parents had moved from Texas to an Arizona labor camp in January. Her mother, 7 months pregnant, had stopped going to a doctor because the family had no funds. The project nurse found her on a routine visit to the camp, arranged for further prenatal care, and finally for admission to the local hospital. There a normal, healthy baby girl was born.

CONTINUING PROBLEMS

Even with the progress made, many problems remain.

1. Health manpower shortages characterize the rural areas where migrants live and work and severely limit the range of services projects can offer.

2. Migrants are widely dispersed in many small camps in some of the northern work areas. This makes visits to their homes, or transportation to a central point for care, time-consuming and expensive.

3. Migrants in a home-base situation do not live in a camp or other definable area but are interspersed with many other impoverished persons living and working under similar conditions. Resources for serving the rural poor are extremely meager in many of the areas migrants consider "home."

4. Effective communication is a general problem. Even when English is the language of both migrant and professional health worker, their speech may be so different that neither really understands the other. The migrant's "Yes, Yes" may simply mean an effort to be agreeable,

not a sign that he understands and will follow suggestions.

5. The lapse of time between the origin and destination of a referral within or between areas is often so long that the patient is lost.

6. Overcrowded, inadequate housing and poor sanitation make communicable diseases and parasitic infestations a continuing problem.

7. The continued lack of project-sponsored personal health services in 2 out of 3 of the Nation's migrant-impact counties means continued lack of access to project services at any time for about two-thirds of the Nation's migrants and lack of year-round access for the great majority.

8. High levels of health need among the migrant population are reflected in infant and maternal mortality rates which are one-fourth higher than national averages. They are also reflected in mortality rates from two to three times the national averages for tuberculosis and other infectious diseases, influenza and pneumonia, and accidents.

9. The continued turnover in the migrant population makes it extremely difficult to measure progress toward the major goal of raising migrants health status compared to that of the general population.

10. The average per capita funds available for the health care of migrants amounted to $12 in 1967, considering estimated funds from all sources. The national average funds per capita for personal health care during 1965 amounted to $209, more than 16 times the average for migrants. The program is trying to purchase $200 worth of care with only $12 per migrant to spend, taking account of funds from all sources.

THE FUTURE

Five years of program-building is a short time in relation to the many years of neglect migrants have experienced. A beginning has been made. A look into the future suggests that more rapid progress can be expected.

Especially hopeful elements today are the new legislative authorities for comprehensive health service planning for the total communit under Public Law 749, and for improved medical care for the needy under Title XIX of the 1965 Social Security Amendments. Both of these new authorities are just beginning to be implemented. Congress declared the purposes of PL 749 to be as follows:

> ...promoting and assuring the highest level of health attainable for every person, in an environment which contributes positively to healthful individual and family living....
>
> ...(establishing) an effective partnership, involving close intergovernmental collaboration, official and voluntary efforts, and participation of individuals and organizations;
>
> ...(using) Federal financial assistance---to support the marshaling of all health resources--national, State, and local--to assure comprehensive health services of high quality for every person...

These goals for health planning for the national population are essentially the same goals as in the Migrant Health Program for the migrant population. Migrant health projects may well be able to point directions for the broader program as it seeks to bring all community elements into an effective partnership for the health of all our people.

Certainly for rural America, migrant health projects have demonstrated ways to establish systematic "outreach" services; more effective organization and delivery to make health services accessible; and ways to use available health resources more effectively. This experience should be fully applied as we plan for health care for other rural residents.

Title XIX of the Social Security Act Amendments of 1965 establishes an improved program for medical care for the needy. The law specifies that by January 1, 1970, all States must have implemented Title XIX or forfeit Federal matching funds for their medical programs. The effect of durational residence requirements as a barrier to the receipt of needed medical care is removed by the law. However, States in implementing their program define "residence" in different ways. Accordingly, some States are including the migrant for the duration of their stay and others exclude them as people "who are just passing through." The States are expected to move progressively toward a comprehensive medical care program for all ~~needed~~ needy persons by 1975.

In addition to progress that can be expected under these new legislative authorities, progress in the area of economic concerns seems likely in the future. Agriculture as an industry may even at some time in the future join with other industries in the extension of fringe benefits to its employees.

At this time, however, the Migrant Health Program is still the key mechanism which will assure that the needs of migrants will be met. The people are voiceless and voteless. They are isolated from communities. The majority are only transitory residents anywhere. Their health service community is actually a series of communities, often in different States. They work in an agricultural setting in which the extension of "fringe benefits" - including health care - is almost impossible. They are the people most likely to be overlooked in community health service planning. Their health needs are so compelling that the task the Migrant Health Program has undertaken must not be abandoned.

I would like to conclude in the way that I started by paraphrasing the report of 30 years ago:

> The right to move may seem a poor substitute for real security, but it must not be forgotten that for many of our citizens it has proved the road to increased well being. They are in search of a job not a hand-out.
>
> Migrants' health needs are undeniable. They will not stop having these needs, or moving, because they are forgotten. The only answer will come from uninterrupted attention.

Our task as health workers now is to assure migrants that they and their health needs will not again be forgotten, and that our promise to them of good health through good health care will be realized in a near tomorrow.

Sources:

1. U. S. Congress, 77th Cong., 1st session, House Report No. 369. Interstate Migration. Report of the Select Committee..., House of Representatives, pursuant to H. Res. 63, 491, 629 (76th Cong.) and H. Res 16 (77th Cong.) Washington, U.S. GPO. 1941. 741 pp.
2. 1965 - Year of Legislative Achievements in Health, Education, and Welfare. Reprint, Health, Education, and Welfare Indicators. April 1965-February 1966. Washington, U.S. GPO (See p. 166 ff. Medical Assistance Program, Title XIX of the Social Security Act.
3. Comprehensive Health Planning and Public Health Services Amendmen of 1966. PL 89-749. 89th Cong. S. 3008, November 3, 1966.
4. Robert Coles, The Migrant Farmer, Atlanta, Ga., Southern Regional Council, 5 Forsyth Street, N.W., Sept. 1965. 32pp.
5. Annual Progress Reports, Migrant Health Projects in Virginia, Oregon, Pinal County (Arizona), Cameron County (Texas), etc.
6. William Koch, Dignity of Their Own, N.Y., Friendship Press. 1966