DRAFT For Discussion Purposes

MIGRANT FARM FAMILIES...

AND THE MIGRANT HEALTH PROGRAM

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Migrant Farm Families And The Migrant Health Program

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MIGRANT FARM FAMILIES...

AND THE MIGRANT HEALTH PROGRAM

THE GOAL OF THE MIGRANT HEALTH PROGRAM IS:

TO RAISE THE HEALTH STATUS of migratory farmworkers and their families to that of the general population. In order to reach this goal, further sub-goals are:

(1) TO PROVIDE COMPREHENSIVE HEALTH SERVICES WITH CONTINUITY AS PEOPLE MOVE

(a) By extending community services to migratory families
- wherever they are,
- for as long as they stay,
- at times, at places, and under conditions which make the services easily accessible and thus readily used;

(b) By linking the services of different areas serving the same people in order to avoid duplication or gaps in health care.

(2) TO IMPROVE MIGRANTS' ENVIRONMENT in order to assure them of healthful, safe living and working conditions wherever they happen to be.

THE WORKING GUIDELINES FOR THE PROGRAM INCLUDE:

To help the migrant to help himself.

To help communities recognize and assume their responsibility to include migrants in health service planning for the total community.

To promote the development of health services adapted to migrants and the environment in which they live.

To fully utilize available public and private resources.

TARGET POPULATION

1. MILLION MEN, WOMEN, AND CHILDREN - A NATIONWIDE PROBLEM

More than 700 of the Nation's 3,100 counties depend on the labor of farmworkers from outside the local area during the peak harvest season. One million men, women and children move annually in response to this need. Their number exceeds the 1960 population of any one of 15 States.[1]

Migrant farmworkers are not commuters. They travel far enough from their homes so that they must establish a temporary residence in one or more other locations during each crop season. All family members may work when work is plentiful.

The reservoir population from which migrants are drawn includes an estimated one million additional persons. Some enter and others leave the migrant farm labor force each year. The replacements are consistently from among those most afflicted by the social and economic handicaps that characterize farm migrants:

Minority group status - The people belong chiefly to Spanish-speaking, Negro, Indian, and low-income "Anglo" minorities.

Poverty - Migrants' annual income from all sources averaged $1,400 per worker in 1965; that of non-migrant seasonal farmworkers was even less.

Lack of education - About fifth grade has been achieved on the average by migrant adults.

Lack of readily marketable skills - Migrants are typically skilled in agriculture but inexperienced and unskilled in other work.

Poor environment - With minor exceptions, their housing is characterized by slum conditions in both their home-base and their work communities.

Community rejection - Even in their "home" communities, they are often not accepted.

The migrant has the added handicap of mobility. Always a stranger and an outsider, he "belongs" to no community. Even the place he calls "home" often does not consider him as one who "belongs"..

1/ The 15 States include Alaska, Delaware, Hawaii, Idaho, Maine, Montana, Nevada, New Hampshire, New Mexico, North Dakota, Rhode Island, South Dakota, Utah, Vermont, and Wyoming.

MAJOR AGRICULTURAL MIGRATORY LABOR DEMAND AREAS

Winter

Spring

Summer

Fall

"Home-base" areas are not shown unless they are also work areas. Thousands of migrants return to South Texas, New Mexico, Arizona, Mississippi, Alabama, and other Southern States during the off-season. Here they merge with thousands of others like themselves.

EXCEPT DURING THE OFF-SEASON, "HOME" IS WHERE THE CROPS ARE

The number of people involved, multiplied by the average number of times they move each year, is a rough indicator of the scope of the migrant problem. On the average, the people live and work in 2 or 3 locations annually. They may move several times from farm to farm or camp to camp at each location.

In the winter, migrants' work areas are heavily compressed in the extreme south. Some cannot find work at this time and simply return to their homes to pick up whatever odd jobs they can find until the next season starts. Many cannot find employment anywhere.

By April, work opportunities have started to open in some northern localities.

In the late summer and fall, many small northern communities are swamped with "strangers" who have come to help harvest their fruits and vegetables.

TRAVEL PATTERNS OF SEASONAL MIGRATORY AGRICULTURAL WORKERS

Migrants' movement flows north and south with the seasons in fairly well established patterns, generally called "migratory streams." Negroes from the southeastern states comprise the largest single group on the East Coast. They are supplemented by Spanish-speaking migrants from Puerto Rico and Texas, and a few Anglo-Americans.

The Midcontinent and West Coast streams are comprised chiefly of Spanish-speaking families from Texas and the Southwest. South Texas is the population reservoir from which at least 30 other States draw much of their seasonal farm labor supply.

AT EACH OF THEIR TEMPORARY "HOMES" MIGRANTS NEED

ACCESS TO HEALTH SERVICES

A SAFE HOME AND WORK ENVIRONMENT

BUT MIGRANTS' HOMEBASE AND WORK COMMUNITIES ARE TYPICALLY

* RURAL
* ISOLATED
* LACKING IN ECONOMIC RESOURCES
* LACKING IN HEALTH RESOURCES

THE LOCAL SUPPLY OF

-PHYSICIANS
-DENTISTS
-HOSPITAL BEDS

FALLS FAR BELOW NATIONAL AGERAGES
IN MOST OF THE COMMUNITIES.

IN SOME AREAS, LOCAL POVERTY SEVERELY

RESTRICTS HEALTH SERVICES FOR ALL PERSONS -

ESPECIALLY FOR MIGRANTS.

Item	Rural areas[1]	National average
Physicians per 100,000 population	59.1	150.8
Dentists per 100,000 population	27.4	54.1
Hospital beds per 1,000 population(short-stay hospitals)	2.0	3.8
Median family income	$4,400	$5,660

1/ Data for the first three items are for isolated rural areas; for the fourth item, the figure represents all rural areas.

THE TYPICAL "HOMES" MIGRANTS LIVE IN -

ARE SMALL, OVERCROWDED, OF SUBSTANDARD CONSTRUCTION

LACK ADEQUATE FACILITIES FOR FOOD STORAGE AND PREPARATION, DISHWASHING, BATHING AND LAUNDRY

LACK ADEQUATE SEWAGE AND WASTE DISPOSAL

LACK ADEQUATE AND SAFE WATER SUPPLY

ATTRACT INSECTS AND RODENTS DUE TO POOR GARBAGE DISPOSAL AND EXPOSED WASTE WATER

HAVE NO RECREATION AREA OR FACILITIES

THE TYPICAL PLACES WHERE THEY WORK -

ARE EXPOSED TO HEAT, COLD, WIND, DUST, CHEMICALS, AND MECHANICAL HAZARDS

LACK SAFE AND ACCESSIBLE WATER FOR DRINKING OR WASHING

LACK ADEQUATE TOILET FACILITIES

HOUSING - Profile of Camps in One State, 1966

Number of camps	- 760
Number of camps approved	- 432
Average occupancy	- 20 to 25 persons

Deficiencies

Total number	- 717
Camp site (general conditions, safety hazards)	- 79
Building disrepair, lack of sufficient doors or windows	- 56
Poor mattresses, not enough beds	- 28
Absence or disrepair of screens	- 102
Insanitary privies; privies in disrepair	- 245
Insanitary storage and improper disposal of garbage and refuse	- 146
Water supply, improper well construction	- 14
Others	- 47

WORKING CONDITIONS

Usually farm work is done where no water supplies or toilet facilities are available, even though long hours are spent in the fields.

HEALTH STATUS - 1964

Compared with National Averages

Charts comparing migrant and national infant and maternal mortality rates

Even with the improvements in their infant and mortality rates in recent years, migrants still lag far behind the National average. Their infant mortality in 1964 was at the level of the United States as a whole in 1949. Their maternal mortality rate was the same as the national average a decade ago.

HEALTH STATUS - 1964

Deaths from Selected Causes among Migrants

Compared with National Averages

(Charts for three selected causes)

The mortality rate from accidents for migrants in 1964 was nearly three times the U.S. rate. It was 60 percent greater than the U.S. rate 30 years ago.

Lesser disparities are shown in the mortality rates for tuberculosis and other infectious diseases, and for influenza and pneumonia. Here, too, however, the differences are great. Migrants' 1964 mortality from tuberculosis and other infectious diseases was $2\frac{1}{2}$ times the national rate. It approximated the national average a dozen years ago. Their mortality from influenza and pneumonia was more than twice the national rate. It was slightly in excess of the U.S. rate for 1940.

MIGRANTS' HEALTH CONDITIONS REFLECT PERSONAL AND COMMUNITY NEGLECT -

* Untended illnesses and injuries

* Uncared for remediable defects

* Needless deaths

THESE CONDITIONS AND LACK OF CARE ADD UP TO NEEDLESS ECONOMIC AND SOCIAL COSTS FOR MIGRANTS, FOR THEIR TEMPORARY COMMUNITIES, AND FOR THE NATION

THE MIGRANT'S ROAD TO HEALTH CARE IS BESET WITH OBSTACLES

On the side of the migrant --

Poverty
Lack of health knowledge
Isolation
Fear of non-acceptance

On the side of the community --

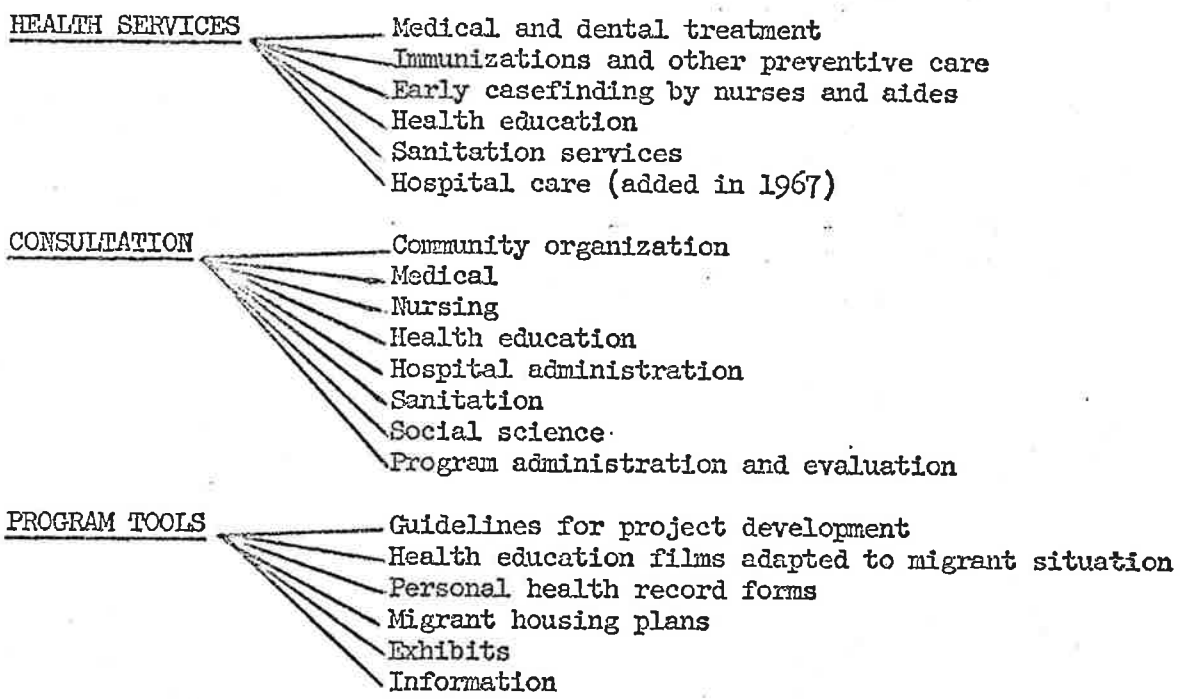
Legal restrictions against
serving nonresidents
Legal exclusion from protective legislation
Health planning priorities that exclude migrants
Inadequate health manpower
Inadequate financial resources
Problems of serving a mobile group
Resistance to minority groups, especially migrants

Many migrants have moved so often that they have lost -- or never gained -- rights to welfare assistance in any community. When assistance is made available, it is typically for an extreme emergency.

Laws requiring that welfare assistance be restricted to legal residents are a statutory method by which nonresidents are discriminated against. However, discrimination against nonresidents is common even when no statute applies. The policies and methods of both public and voluntary agencies may effectively bar the nonresidents from obtaining services that are planned and provided at times, at places, and under conditions which are suited to permanent residents but not to seasonal farm migrants.

Furthermore, migrants' frequent movement, even though fairly predictable, makes it impossible for any single community or State, working alone, to cope with their health problems. Their "health service community" is a chain of communities, rather than a single locality. Many of the people cross several States as well as county boundaries. In some cases they travel more than a thousand miles between jobs.

THE MIGRANT HEALTH ACT PROVIDES ASSISTANCE TO MEET MIGRANTS' NEEDS



Within a year after the first migrant health grant appropriation was made in the spring of 1963, 42 applicants had been awarded migrant health grants to pay part of the cost of health services for migrants. The number of projects more than doubled by January 1967 when 94 projects were in operation.

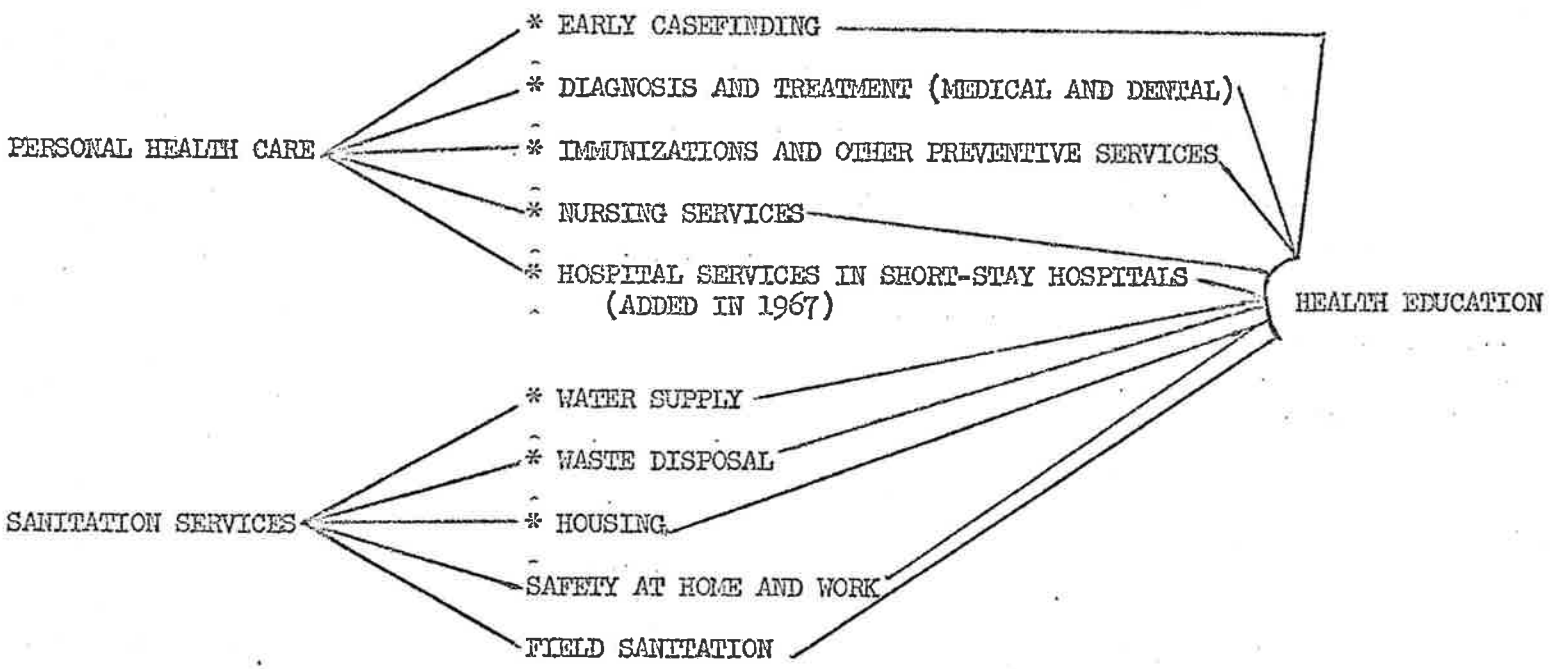
Two-thirds of the migrant health grants have been made to State or local health departments. The other third have been made to local migrant councils, local governing bodies, hospitals, county medical societies and schools of medicine.

One or more migrant health projects operates in 36 States and Puerto Rico. Each project serves migrants in from one to twenty counties.

Services in home-base areas have been emphasized. About 40 home-base counties reporting an estimated outmigration of 200,000 persons are included in migrant health project areas in southern Florida, Texas, New Mexico, Arizona, southern California and the bootheel of Missouri.

Continuity of care becomes more possible as project services are provided at strategic points along major migration routes. Personal health records carried by the migrants facilitate continuity and help to avoid duplication or gaps in services. Project reports indicate that from 10 to 90 percent of the migrants contacted present a personal health record upon request. Project reports are also showing results from the use of inter-area referral forms.

HEALTH SERVICES OFFERED BY PROJECTS AT CAMPS OR OTHER PLACES ACCESSIBLE TO MIGRANTS



Health Services Offered by Grant-Assisted Migrant Health Projects During 1966; estimated projections for '67 & '68

	1966	1967(est.)	1968(est.)
Migrants			
Total number, U.S.	1,000,000	1,000,000	1,000,000
Number in project areas at some time during year	250,000	300,000	350,000
Counties with migrant influx			
Total number, U.S.	726	726	726
Number offering grant-assisted services:			
Personal health & sanitation (combined)	270	280	300
Sanitation only	142	150	150
Personal health services provided migrants[1]			
Medical visits	210,000	260,000	310,000
Dental visits	17,000	27,000	38,500
Hospital patients	0	4,200	5,700
Hospital patient days	0	29,400	39,900
Nursing visits to camps, etc.	160,000	200,000	230,000
Sanitary inspections and follow-up visits	150,000	175,000	175,000
Appropriation			
Health service support	$3,000,000	$7,200,000	$8,100,000
Consultation and program tools	500,000	800,000	800,000

1/ Health education is potentially a part of every service. Data are not separately reported.

Health Services Assisted by Migrant Health Grants -

Geographic Distribution, January 1967

(Map) showing county-by-county

a. Where migrants are located

b. Where grant-assisted health services are offered.

Community-based grant-assisted projects offer personal health care to migrants in about two-fifths (270) of the 726 counties thus far identified as migrant work or home-base areas. They offer sanitation services in most of these and an additional 142 counties.

State-level consultation projects employ one or more persons on the staff of 21 State health departments. These persons provide information and assistance on migrant health matters to persons within or outside the State. They are active in county-level program development, organization or orientation programs for State and local staff members involved in migrant health and related activities, evaluation of project services, operating inter-area referral systems within and between States, and other program matters.

A few State-level projects provide direct services throughout the State wherever a major migrant influx exists. This is most likely to be true in the case of sanitation services.

USE OF MIGRANT HEALTH GRANT FUNDS

Distribution of Grant Dollars by Service

(Chart)

In each fiscal year since the program started, the entire amount available for grants has been awarded. Contributions to projects from other sources have had a reported value of nearly $10,000,000 -- forty percent of total project costs. These contributions include the value of contributed services, equipment, facilities and other items essential to project operation.

Health Service Deficiencies, January 1967

(Map) showing county-by-county

a. Where migrant counties are located

b. Where no grant-assisted personal health care exists.

During 1966, an estimated 250,000 of the Nation's million migrants lived for periods of 3 to 6 months in one or more project areas where personal health services were provided through a system adapted to the migrant situation.

Sanitation services to improve the camp and work environment were also offered.

For continuity of health care and protection, migrants need access to health services in every county where they live and work temporarily. Because geographic coverage by project services is still far from complete, a total of 750,000 migrants had no access to project service. The 250,000 had service for only part of the year.

HEALTH SERVICES DEFICIENCIES

Pie Charts showing Percent
of counties with and without
grant-assisted personal health care
and sanitation services, respectively.

Migrants find health services readily accessible in an ever-increasing number of the counties where they live and work for brief periods. Still only 1 out of 3 counties offers personal health care geared to the special needs of migrants, and only 6 out of 10 counties offer protection of their living and working environment through sanitation services with grant assistance. Lack of continuity of health care will remain a problem as long as many communities have no place to which a migrant can turn with an expectation of finding needed health care available.

HEALTH SERVICE DEFICIENCIES -

Personal health services rendered by projects to migrants[1]

compared with national utilization rates

Medical visits per person per year

Migrants (1966)	- .84
National average (1963-64)	- 4.5

Dental visits per person per year

Migrants (1966)	- .07
National average (1963-64)	- 1.6

1/ Data are for the 250,000 migrants in project areas at some time during 1966.

To gain health status comparable to the national average, migrants need to be able to use health care at at least the levels achieved by the general population. Medical and dental visits by the 250,000 migrants present in project areas for part of 1966 averaged far below national average utilization rates. Furthermore, the acute needs presented by migrants in project areas suggest that they obtained relatively little care elsewhere.

The low migrant utilization rates reflect the intermittent and temporary nature of migrants' access to projects and their services, the newness of some projects which were just getting underway in 1966, and the typical shortage of project physicians and dentists to meet more than emergency needs. Although the general shortage of health manpower was a contributing factor, project services might have been expanded in many localities if additional funds had been available.

HEALTH SERVICE EXPENDITURES PER CAPITA -

Migrant compared with national average

Migrant Average (1967)

Item	Migrant Health Grant Funds	Funds from Other Sources	Total	National average (1965)
Personal health care	$6.48	$4.32	$10.80	$209.40
Sanitation services	.72	.48	1.20	----1/
Total	7.20	4.80	12.00	209.40

1/ Not available.

National per capita personal health expenditures are nearly 20 times the per capita expenditures through grant-assisted projects for the million migrants in the United States. Although some health care is purchased by migrants or provided by communities where no grant-assisted project exists, project experience indicates that such care is minimal. As an example, among 459 persons surveyed by a midwestern project, only one out of four had ever visited a dentist. Yet nearly all showed need for dental care. Twenty percent needed emergency care.

STEPS TO MEET MIGRANT HEALTH PROGRAM GOALS

GOAL

1. Health status of migrants raised to level of general population

STEPS TAKEN

Problem is better identified; tools are being developed for measuring health improvement.

1966 services --
Reached 270 counties having a 250,000 migrant influx.
Included 227,000 patient - visits for medical or dental care;
140,000 nursing visits for casefinding and follow-up;
150,000 sanitation visits to upgrade housing and work environment.

STEPS NEEDED

Improve access of migrants to comprehensive health services.
Improve data system to better define problem; measure program effectiveness; determine needs outside project areas.
Serve potential as well as actual migrant.

The Migrant Health Program is establishing checkpoints and adapting its project reporting system to better measure health improvement. The data system must take into account mobility and population turnover. Some projects report the opinion that many migrants leave the stream but these are constantly replaced by other poor, undereducated, minority group workers and families who have acute health needs but poor understanding or acceptance of good health practices.

Health improvement in spite of high migrant population turnover could be facilitated if the program focussed on the population reservoir from which migrants are drawn. In this reservoir, migrants merge with other low-income seasonal farm workers. They live side by side, do the same work, live under the same conditions, and share the same social and economic handicaps.

STEPS TO MEET MIGRANT HEALTH PROGRAM GOALS

GOAL

2. Comprehensive health care with continuity as people move.

STEPS TAKEN

Local planning has adapted services to migrants in 1 out of 3 migrant counties, and routine casefinding and emergency care systems have been established.

Communication systems are facilitating continuity of care as people move.

Aides (migrant and other) are supplementing scarce health manpower.

More local resources are being used as communities start to accept responsibility.

Migrants are being helped to understand and accept responsibility.

STEPS NEEDED

Expand geographic coverage, continuing to emphasize home-base areas.
Improve level and comprehensiveness of service.
Improve inter-area communication and coordination.
Reimburse hospitals for total costs.
Supplement scarce health manpower by use of aides and in other ways.
Strengthen relationships with other programs and use of their resources.
Intensify community education and orientation of health workers.
Involve growers, migrants, and other appropriate persons to greater extent.

Meeting program goals will require funds more commensurate with the personal health service expenditures for the Nation as a whole. As other programs for the general population develop, they can be encouraged to take over some of the costs for services to migrants who are otherwise eligible. At the present time, however, there is little evidence of the readiness or, in many cases, the capacity of local communities and States to take full responsibility for meeting migrants' health needs.

STEPS TO MEET MIGRANT HEALTH PROGRAM GOALS

GOAL

3. Healthful, safe environment wherever migrants live and work temporarily.

STEPS TAKEN

Sanitation services have been started in nearly 3 out of 5 migrant counties.

STEPS NEEDED

Expand geographic coverage.

Assure safe water and waste disposal in every migrant housing area.

Add field sanitation services.

Improve system for financing housing and sanitation improvement.

Initiate safety program.

Improve work with growers, Employment Service, migrants, Farmers Home Administration, and other groups.

MIGRANT HEALTH PROGRAM ADVANTAGES

TO WORKERS AND THEIR FAMILIES

Better access to health care
Better health understanding and practice
Better health and longer life
Better earning power
Better acceptance in the community

TO GROWERS AND PROCESSORS

Workers who are healthy and productive
Less turnover in labor force
Money saving
Better community relationships

TO COMMUNITIES

Fewer health emergencies
Less tax drain
Money return through increased migrant purchasing power

TO NATION

Healthy farm labor force
Higher level of productivity
Reduction of disability
Saving of lives