NEW DIRECTIONS UNDER THE MIGRANT HEALTH ACT

The chronicle of migrants' needs is an old one, often retold. The chronicle of efforts to meet these needs is just beginning.

In the field of health, the new chronicle started with the signing of the Migrant Health Act in September 1962. Unlike most legislation, this Act was neither long nor complicated. It simply authorized the Public Health Service to issue grants to public or voluntary nonprofit groups to pay part of the cost of carrying out approved project plans. To be approved, a project would be required to set up and operate family clinics in or near points of labor concentration, or carry on other activities to improve migrants' health conditions and services. The Act further authorized expanded effort by the Public Health Service to aid and supplement the efforts of these public or voluntary agency-sponsored health projects.

The target group includes persons who earn a major part of their annual income from seasonal work in agriculture and their families. They may be temporary in-migrants to the community or they may consider the community "home", moving out periodically to work in other crop areas for a long enough period to necessitate setting up a temporary residence. The group includes persons moving within States as well as those moving across State lines.

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Persons who move as often as most farm migrants do can lose legal residence status in one place without regaining it in another. Migrants can live their entire lives in a kind of limbo, unable consistently to gain the necessities of life through their own efforts and also unable to qualify anywhere as legal residents. Thus they are ineligible for the health and welfare services available to other needy persons.

For the migrant, mobility may add further to the stigma that some community residents attach to poverty. The connotations of "vagrant" -- shiftlessness, thick-wittedness, and outright laziness -- often closely associated in the public mind with the term "migrant." Reflecting such attitudes, a professional worker observed: "If they wanted to, they could better themselves." He made this comment in a southern home-base community at a time when a severe freeze had killed the winter crops the night before. Growers were rapidly starting to plow under their frozen vegetables, as they prepared to replant in the hope of recovering part of their losses. But the migrant workers and their families shifted restlessly around the crowded camps. They had little or no funds, no place to go where their skills were needed, no way to make up their losses, and little hope for more than the most meager welfare relief to tide them over until they were needed again.

In the event of a health emergency, migrant workers usually delay seeking professional help until the last possible moment hoping that somehow home remedies will make them well again. The results of this behavior are reflected in the 1962 records of a local hospital in a migrant-impacted area. Of 38 deaths among adult migrants during a three-month period, 21 were dead upon arrival at the hospital. Of 20 deaths among infants, four were dead upon arrival at the hospital.

Some professional health workers have attributed this type of behavior to migrants' ignorance or stupidity. Instead it may well be evidence that they have learned all too well the lesson that those without funds find it extremely difficult to obtain health care in many places. As one migrant said when asked why he did not go to the local hospital outpatient department as he had been instructed -- "There they do not like the poor."

Changes in long-established attitudes and practices do not occur overnight. But changes are taking place as a result of the Migrant Health Act.

Nationwide, 78 grant-assisted projects are in operation -- each covering from one to a dozen or more counties. Service to people is the keyword in project development. The service is provided in ways that will increase migrants' acceptance of service, and eventually their health understanding and self-responsibility. To do this requires that project planners consider how to make services accessible to people --

typically
who cannot pay for care and cannot meet local residence requirements for services to the indigent;

who have no transportation of their own and no funds to pay for public transportation -- if it is available;

who cannot take a day from work without losing a day's pay from an already meager income;

who may be puzzled by the strange behavior that often characterizes public health physicians or nurses who turn them away when they are sick and urge them, instead, to come to public health clinics when they are well;

who do not understand conventional community health practice which separates different types of services from each other, thus making it necessary for one family member to come to one place at one hour and on one day for one type of health service, while other family members must go to other places at other hours and on other days for other types of service, with the whole process requiring family members to lose many hours from work, and make repeated outlays of funds to reach the various places at the appointed times;

above all, who may fear rejection, and thus may fail to take responsibility for meeting their health care needs by going to a clinic or hospital.

The 78 projects are scattered over 36 States and Puerto Rico. Each is locally planned and differs in some respects from all others. They operate night clinics, employ nurses to visit labor camps on a regular schedule, employ sanitarians to work with campowners and migrants to improve camp housing and environment, and involve volunteers from the community and from among the migrants in a host of activities. The services of volunteers range from providing medical or dental care at the night clinic to simple but necessary chores such as visiting camps when the season starts to let migrants know about project services, providing transportation for patients, "babysitting" so that mothers can leave their children in capable hands when they visit the family clinic, and translating for patients who cannot speak English.

To the migrant, service to relieve pain has meaning. To the professional health worker, immunizations, well-child care and other preventive measures may be major objectives. The approach used in a western project illustrates the way in which the needs of both have been met.

According to the project director, "When we first started our Migrant Health Clinic, only 10 - 12 persons came, but next time there were over 20, then 40, and now up to 80 patients attend each clinic session. The reason...was that we listened carefully to each person's complaints... and tried to help him with his problems first. Then we asked the patient to come back and started...with immunizations that were needed, health education in nutrition or prevention of diarrhea, or whatever (preventive services) would be of special importance to this particular patient.

"This approach has been used in all our clinics: First listen to the patients' complaints and try to alleviate them, then when we have gained their confidence is the time when talks about health education, immunizations and other preventive measures may succeed."

This "one-door" policy for treatment and preventive care makes sense to the migrant. It provides ready accessibility to a wide range of curative and preventive services for all family members at a single multipurpose unit.

Moreover, the human treatment he receives in situations such as the one just described may be as important in many cases as the medical treatment.

The "one-door" policy is also making sense to professional health workers. They find themselves starting to attract some of the hard-core among the so-called "hard-to-reach" groups--people long bypassed by community campaigns for immunization, X-ray, and other special purposes.

Sanitary conditions are also being improved in migrant labor camps and in the fields where migrants work. Again a flexible approach has to be applied to reach the desired end. In an urban setting, the health department staff can work with relative ease. Backed by the pressure of public opinion and by laws and regulations, they can get sanitary improvements made. In a migrant labor camp situation, laws and regulations may be far less than adequate. Community opinion may be based on a laissez-faire or even negative attitude. The opinions of the migrants may count for little since they do not "belong" in the community, and have no real voice to express their opinions.

As a result, the sanitarian finds himself relying heavily on educational techniques in his work with camp owners -- sometimes in an effort to persuade them to go beyond inadequate laws or regulations in order to make the camps meet minimal standards for human occupancy. And his approach to migrants must be wholly educational in his efforts to persuade them to maintain camps in a livable condition, once an owner has made improvements.

Commenting on his experience with migrants during his first crop season in the migrant health project, one sanitarian said: "A surprising number did remember what I taught them...Some claimed most of the people in a given camp try desperately to keep things clean and only a few are the culprits. This I found to be true."

Growers, also, cooperated after they were convinced that the project staff would work with camp occupants to improve maintenance once the camp owner had complied with requirements. One grower reluctantly installed garbage cans with tight lids. He insisted that he had done this before, but the lids only disappeared and the garbage again was strewn over the premises. The project director bargained to work with the migrants to see that the garbage cans were properly used if the grower would once more take the necessary first step. In mid-season, the lids were still on the cans, and the cans were being properly used. No longer did garbage litter the camp grounds as it had in the past.

These improvements were only part of the positive gains in a project that had brought community volunteers and migrants together, and that made the migrants feel they were a wanted, welcome part of the community while they were there, eligible for community services which were brought to the camp in order to make them truly accessible. As a byproduct the families living in the camps lost the sullen, dejected expression they had worn in previous years.

Education is a part of the total effort in each of the grant-assisted migrant health projects. The educational effort typically is pointed in two directions. Among community residents, a major purpose is to improve local understanding and acceptance of the migrants as people. Among migrants, a major objective is to develop understanding of the health services offered by the community, and of ways in which the people themselves can protect their health.

In some projects the educational effort directed to migrants takes the form chiefly of friendly advice given by physicians and nurses in the night clinics, or by the nurses and sanitarians on their visits to workers and families. In others, the project employs a health educator who assists staff members in making their educational effort more effective, and also works directly with migrants. The involvement of migrants in actual project operation has been one way in which migrants learned more about their health needs and ways to improve their health situation.

The educational effort directed to the community has taken a variety of forms, including the involvement of community members in the planning and conducting of projects, orientation to improve understanding of migrants as people, and enlistment as volunteers.

In some projects, the use of migrant and ex-migrant people as liaison workers has been an educational experience for professional health workers and others in local communities. Such liaison workers taught one community important facts about the cost of so-called "free" care offered by the county to migrants who resided in camps about 50 or 60 miles from the county seat town where the care was provided.

The liaison workers simply went through the process that a migrant woman had to go through to make and keep one appointment at the "free" clinic. The liaison workers lost two full work-days, paid two bus fares each way, on both days, and paid for lunches on each of the days. They also demonstrated the discomfort of having nothing to do but sit on hard benches for two days, while waiting to make and complete an appointment.

For the community this demonstration furnished a convincing answer to one of the questions they had asked--"Why don't the migrants use the free services we make available?"

During the fiscal year starting on July 1, 1966, we hope to get started on a new venture--that is, the provision of inpatient hospital care as a part of the services of migrant health projects. This enlarging of the scope of services was authorized under the amendments to the Migrant Health Act passed by Congress last year. Unfortunately, our appropriation last year was not large enough to enable us to start providing projects with funds for inpatient hospital care as well as the outpatient medical treatment and full range of preventive services they had been providing before. This year we have requested the full $8 million authorized and we hope that within the next 6 to 8 months we will have an appropriation that will make it possible for projects to start providing the broadened service.

Our general guidelines and emphasis will remain the same. In line with the intent of Congress, we will continue to emphasize the provision of early casefinding, diagnosis and treatment before

an illness or injury becomes serious enough to require hospital care. We will also continue to emphasize supportive nursing, sanitation and health education services. Inpatient hospital care will be considered the last resort rather than the first service emphasis.

Projects which desire assistance to pay hospital bills must first have a systematic arrangement for provision of outpatient medical care at times, at places, and under circumstances which make the services truly accessible to the migrant worker and his family. We hope that the majority of hospitalized cases will be found and referred by the project, so that the migrant will carry with him to the hospital the verification of his eligibility for payment of his bill from migrant health project funds. If he is a "walk-in", we expect that the project will have negotiated an arrangement with cooperating hospitals for notification within 48 hours so that the designated project staff member can verify migrant status as a condition for the payment of the hospital bill. Without such verification of migratory agricultural work status by the project, no bills will be payable.

A further ingredient in the project hospitalization plan will need to be provision for contact with the patient while he is in the hospital wo that adequate planning can be done before his discharge. Such planning can prevent the likelihood that his hospital care may be prolonged beyond the period necessary, or that he will again have to return to the hospital because conditions for his care are inadequate in the "home" to which he will return.

The project nurses will probably be heavily involved in this predischarge planning, learning the problems of the patient, acquainting

themselves with the situation in the labor camp or other place to which he will return, teaching family members how to care for the patient if he will need continued care after release from the hospital, arranging with the sanitarian for follow-up on poor environmental conditions if these are part of the underlying problem that led to illness or injury, and doing the many other things that may be required to assure that the patient has an opportunity to be fully restored to good health, without risk of undergoing the same hazards that sent him to the hospital in the first place.

The 78 projects and their services may be only a drop in the bucket as far as meeting the health needs of migrants is concerned. But project reports show gains in services provided to migrants, and in knowledge of the people and of ways to serve them more effectively. They also indicate growth in cooperative efforts involving many segments of local communities--and the migrants themselves. And they show that the projects are starting to identify the sources and the destinations of migrants, and to take steps toward better coordination of effort with other communities which serve the same people.

The enlarged program will keep the same persons as before in the front line of migrant health -- the nurse, the sanitarian and the health educator -- to work with the migrant family and with the community to assure the greatest health achievements possible. In the long run, the program will make people healthier and thereby help to relieve the economic poverty that is the basic underlying problem of migrant families. It can also do much to relieve the migrant's poverty of services and of human spirit by reducing the extent of his long isolation and bringing him closer to being part of our national community.