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ABSTRACT

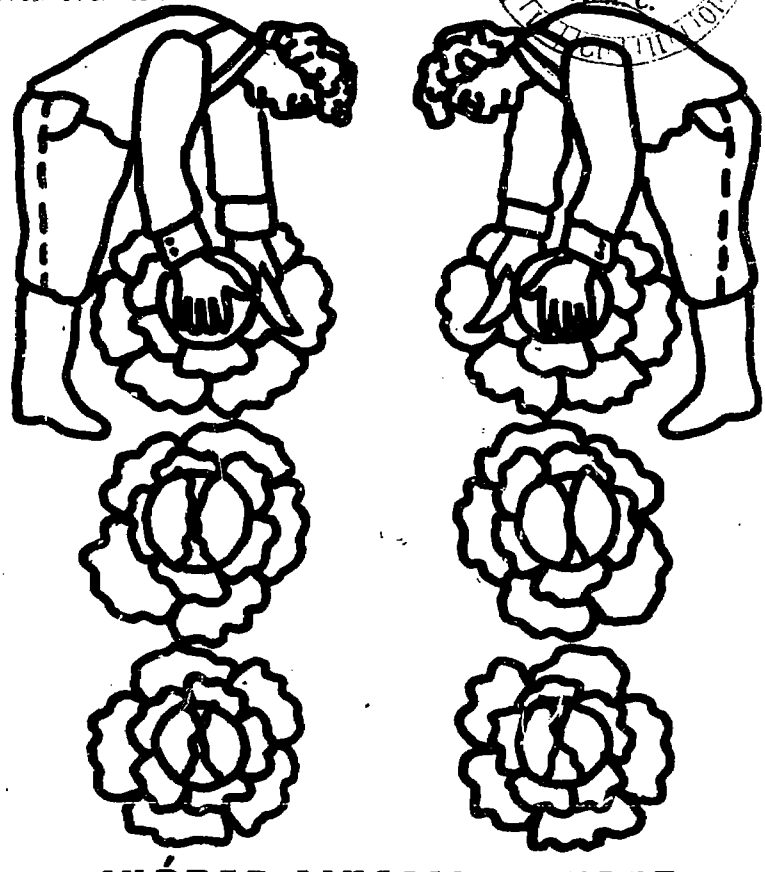
The Public Health Service Act was amended in 1962 to authorize grants to establish family health service clinics for domestic agricultural migratory workers and to improve the health conditions of these workers and their families. Approximately 100 programs currently provide migrant health services. As a result of the low level of funding of these programs, it was administratively determined by the Department of Health, Education, and Welfare that hospital costs would not be covered by the Migrant Health Program and inadequate funding has made it difficult to provide services that are essential to a comprehensive care facility. It was found that 4 areas need legislative attention: the inadequacy of the funding level, the need for earmarked hospital funds, the need to reaffirm Congressional commitment to consumer participation, and the need to develop a strategy for integrating migrant workers into a larger health care delivery system if such should develop. (PS)

# MIGRANT HEALTH LEGISLATION AND PROGRAMS











JUÁREZ-LINCOLN CENTER
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# M I G R A N T  H E A L T H

## LEGISLATION AND PROGRAMS

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## WHAT ARE MIGRANT HEALTH PROGRAMS?

In September 1962, the Public Health Servi Act was amended to authorize expenditures of funds as grants for the establishment of family health service clinics for domestic agricultural migratory workers, and to improve the health conditions of such workers and their families.

Currently, there are approximately 100 programs providing health services to migrants in the U.S. They provide a variety of services which have been classified according to seven major categories by the Health Services and Mental Health Administration, U.S. Department of Health, Education and Welfare. By no means are the classifications all inclusive, but they do give a general description of the types of services migrants can receive. Each program receiving funds can provide either one single service or a combination of the services described below.

Full-time Comprehensive Services - diagnostic, therapeutic and follow-up medical services offered on a daily and year round basis by full-time medical staff. Dental care, health counseling and outreach services are also provided.

Scheduled Comprehensive Services - diagnostic, therapeutic and follow-up medical services provided

intermittently through scheduled clinics. Dental care, health counseling and outreach services are provided with referrals on a free for service basis.

Scheduled Medical Services - diagnostic, therapeutic and follow-up medical services through intermittently scheduled clinics with referrals. Dental care, health counseling and outreach services are not necessarily provided.

Scheduled Categorical Health Services - specific disease or categorical emphasis on preventive medicine are provided by clinics. Could include clinics for Tuberculosis control, immunizations, maternal and child health, etc.

Non-Scheduled Health Service - general health care provided by project on a referral system of fee for service. Nursing services provided as part of outreach and follow-up.

Limited Categorical Services - focus on environmental health activities, such as camp inspections, state code enforcement and coordination of local sanitation programs.

Administrative Consultative Services - consultation for and coordination of direct health care activities of other groups.

Less than half of the projects currently funded provide scheduled comprehensive services while only about 15 projects provide full-time comprehensive services.

## LEGISLATIVE HISTORY

(Excerpts from "A directory of Migrant Health Projects", U.S.D.H.E.W.)

While the Migrant Health Act was initiated in 1962, the authorizing legislation extended for only three years. In August 1965, the Migrant Health program was extended for an additional three years and added necessary hospital care as an available health service under this program. In October of 1968, the Migrant Health Program was extended for another three years with a broadened scope. The 1970 version included the seasonal agricultural worker and his family under the services covering the migratory agricultural worker. The table on the following page illustrates the expansion of the funds available to migrant health programs since its inception.

FEDERAL MIGRANT HEALTH FUNDS *

| Fiscal Year | Authorization (000's) | Appropriation (000's) |
|---|---|---|
| 1963 | $ 3,000 | $ 750 |
| 1964 | 3,000 | 1,500 |
| 1965 | 3,000 | 2,500 |
| 1966 | 7,000 | 3,000 |
| 1967 | 8.000 | 7,200 |
| 1968 | 9,000 | 7,200 |
| 1969 | 9,000 | 7,200 |
| 1970 | 15,000 | 15,000 |
| 1971 | 20,000 | 15,000 |
| 1972 | 25,000 | 17,900 |
| 1973 | 30,000 | 23,700 - (Requested) |

MIGRANT HEALTH LEGISLATION

In June 1973, the legislation authorizing grants for migrant health will expire. Legislation has been introduced to continue the migrant health program, yet the outcome is uncertain.

The uncertainty stems from activity in Congress. Some U.S. Legislators have reported that Migrant Health is one of several services which the Department of Health, Education and Welfare is considering consolidating into a health revenue sharing package, allowing the individual state to decide how health monies will be spent and placing the responsibility of maintaining migrant health

* The authorization figures differ from appropriations because authorized funds are the total sum which Congress authorized to be spent. Appropriation is the amount of money that Congress has given to the program to be spent.

programs on the individual states. However, individual states have neither been able nor willing to provide adequate health services to migrant and seasonal farmworkers in the past. In spite of the services provided under migrant health, the situation of the migrant and seasonal agricultural farmworkers have improved minimally.

The State of Texas serves as an example. In 1970, the Field Foundation conducted a study in Hidalgo County on the health status of Mexican-American migrants. The following table illustrates their findings.

FINDINGS IN FIELD FOUNDATION STUDY, HIDALGO COUNTY

1970

| | |
|---|---|
| TOTAL EXAMINATIONS: | |
| ADULTS | 502 |
| CHILDREN | 731 |
| TOTAL FAMILY GROUPS WITH ABNORMAL FINDINGS: | |
| FAILURE TO THRIVE | 23 |
| TUBERCULOSIS (BY X-RAY) | 13 |
| SPECIFIC VITAMIN SIGNS | 35 |
| PROTEIN DEFICIENCY SIGNS | 5 |
| GOITRE | 7 |
| RICKETS | 4 |
| PELLAGRA | 1 |
| ANEMIA (BY LAB) | 21 |

HIDALGO COUNTY FINDINGS (Continued)

| | |
|---|---|
| PARASITES (BY LAB) | 11 |
| ACUTE OR CHRONIC OTITIS | 23 |
| ACUTE OR CHRONIC DIARRHEA | 3 |
| BIRTH DEFECTS | 4 |
| MENTAL RETARDATION | 12 |
| "RETARDED BY LANGUAGE" | 4 |
| CRETINISM (UNTREATED) | 1 |

On a more general level, the testimony presented by Dr. Raymond Wheeler before the Senate Sub-Committee on Migratory Labor affords a clear perspective.

"A few statistics substantiate our observations. The migrant has a life expectancy 20 years less than the average American. His infant and maternal mortality rate is 125% higher than the national average. The death rate from influenza and pneumonia is 200% higher than the national rate and from tuberculosis, 250% higher than the national rate. The accident rate among migrant farm workers is 300% higher than the national rate...."

In 1969, the Colorado Migrant Council conducted a study in the "Nutritional Status of Preschool Mexican-American Migrant Farm Labor Children". The results of the study stated:

"The general lack of medical care prior to and following delivery is reflected in the high mortal-

ity rate in the first year of life. In this study, the Mexican-American migrant infant mortality was found to be 63 per 1000 live births. The 1968 infant mortality for low income areas served by the Neighborhood Health Centers and the City Hospital in Denver was 23.4 per 1000 births. This was greatly reduced from the 1964 Denver figure of 33.1 per 1000 live births taken prior to the onset of the neighborhood health program in 1965. The migrant neonatal mortality figure of 63 deaths per 1000 live births is comparable to a similar figure for the overall United States in the year 1930. The high infant mortality may, in part, be due to the lack of hospital delivery of newborn infants, most of whom would be considered "high risk" because of the lack of prenatal care, the poor housing and sanitation, inadequate nutrition, and the need to travel with a small infant. It is conceivable that rural neighborhood health programs, as recently proposed for migrant health care, could greatly reduce the neonatal mortality in this population. A program for hospital care will also be necessary, however. Migrant families do not qualify for Medicaid benefits in most states because they must first qualify for some program of categorical assistance. These commonly include Aid to Dependent Children, and programs to assist the blind, disabled, or aged. Thus, while residency

has been eliminated as a requirement for Medicaid, it has been of little use to the migrant."

According to HEW there are approximately 1,000,000 migrants and dependents. Also there are approximately three million seasonal farm workers who are eligible for service under the Migrant Health Program. HEW estimated that the budget request for fiscal 73 would reach approximately 284,000 farm workers, or less than 10 per cent of the target population.

Although in 1972 the Migrant Health Act authorized allocation of $25 million, the actual appropriation of funds was only $19 million. The DHEW indicated that the total cost of providing both comprehensive care and hospital services to the farm worker population eligible under the Act was $600 million, some twenty times greater than the 1973 authorization of funds.

As a result of this low level of funding, it was administratively determined by HEW that hospital care costs would not be covered by the Migrant Health Program. The result has been virtually no hospital care for migrants. With the exception of the State of Michigan, which pays for migrant hospitalization through State funds, no Federal, State or local payment programs have been identifiable. Although it was "hoped" that Medicaid

would assist migrants in obtaining hospital care, all investigations have revealed that few states provide any medical assistance under Medicaid for migrants. An OEO report in 1971 indicated that in a survey of migrants in Florida, only 3.2 per cent were covered by Medicaid. When migrants leave their home base states they are faced with the problem that they are not residents of the states in which they are temporarily working, and thus are excluded as non-residents from that state's Medicaid program, despite the fact that it is partially funded with the Federal dollar. Under revenue sharing, when the Federal dollar is not earmarked, but is given to the states to spend at their absolute discretion, it can reasonably be expected that migrants will not be included. They have not been in the past.

Furthermore, inadequate funding has resulted in the fact that most projects have found it difficult, if not impossible, to provide services that are considered essential to a comprehensive care facility. Transportation for an effective outreach program is not developed, projects close before the migrants leave an area, approved projects never receive funds, and geographic areas with seasonal workers never obtain Migrant Health projects. In the testimony before the Committee on Labor and

Public Welfare on the extension of the Migrant Health Act, August 1972, Sister Cecilia Abhold, S.P., Administrator of the East Coast Migrant Health Project, testified that out of 94,000 migrants covered by that project, the project was only able to deal with 20,000 workers. She also stated that according to HEW, there are almost 900 counties that have a seasonal migrant impact; some 700 of these counties are not covered by the current program.

The Senate Committee on Labor and Public Welfare, in reporting out the bill in the Summer of 1972, affirming the belief in the need for continuation and expansion of the Migrant Health Act, found that four areas needed legislative attention:

1) The inadequacy of the funding level;
2) The need for earmarked hospital funds;
3) The need to reaffirm Congressional commitment to consumer participation;
4) The need to develop a strategy for integrating migrant workers into a larger health care delivery system if such should develop.

In June 1973, provisions for funding Migrant Health programs will expire. The Legislative preoccupation cited above is still valid; however, the time frame is different. In 1972 migrant health programs were a reality for at least one year. This year they are being closed down as their program year ends.