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ABSTRACT

Because ill-clothed, sick, or hungry migrant children learn poorly, the Task Force has emphasized the migrant health situation in 1979. Migrant workers have a 33% shorter life expectancy, a 25% higher infant mortality rate, and a 25% higher death rate from tuberculosis and other communicable diseases than the national average. Common among farmworkers, diabetes and hypertension are chronic problems requiring continuous medical care, which is unsatisfied by the fragmented nature of available health services. While not intentional, migrant child neglect is often evident, usually resulting from parental lack of knowledge or resources. Handicapped children remain officially unidentified and unaided because family mobility precludes program eligibility. Among the prime causes of migrant health problems are poor living conditions which are not improved by the often anachronistic relationship between grower and worker. Appropriations are meager for the large migrant health program and complicated eligibility requirements routinely exclude migrants from available Title XIX and XX services. Basically there is little in the way of migrant health resources, insurance, or policy leadership. The Task Force recommends establishing a national task force on migrant health, providing Migrant Student Record Transfer System (MSRTS) health records to physicians and clinics to promote service continuity, and initiating a needs assessment for exceptional children. (SB)

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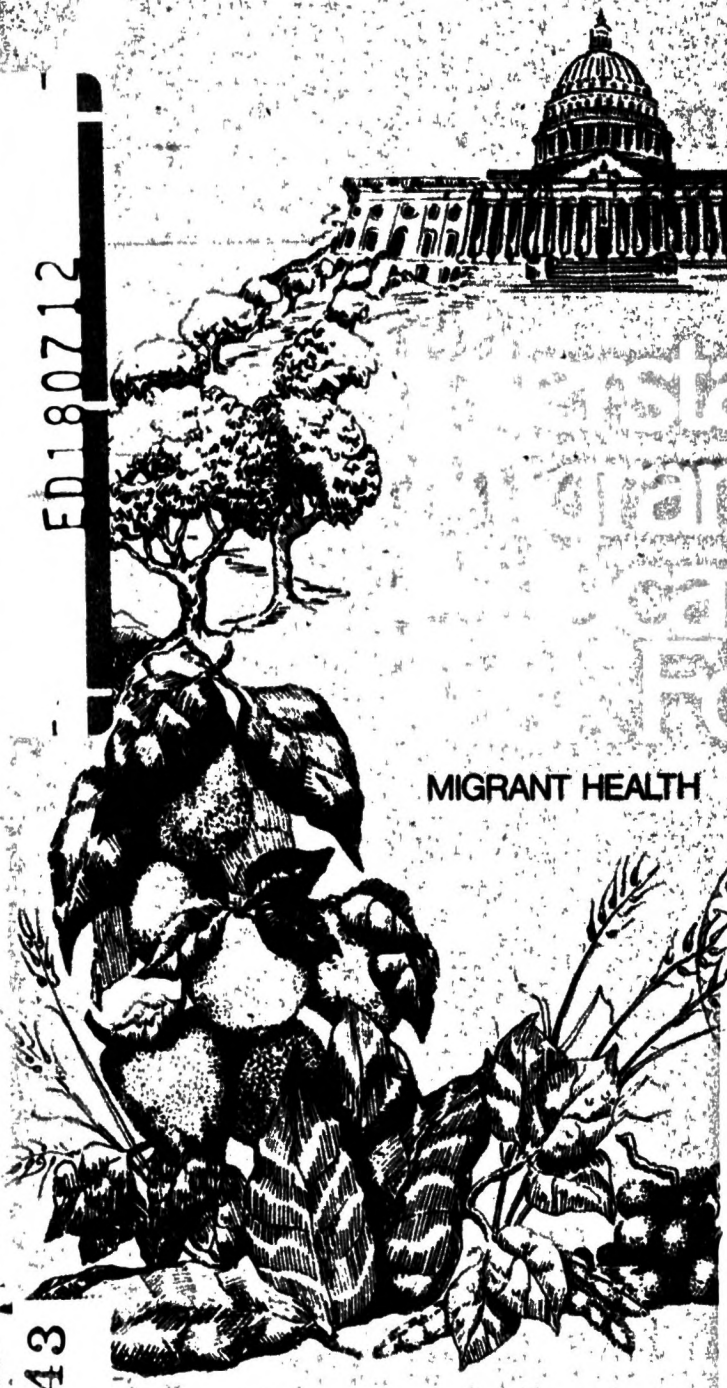

state migrant education force

MIGRANT HEALTH

JAN 1980

U S DEPARTMENT OF HEALTH, EDUCATION & WELFARE
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Interstate Migrant Education Task Force

MIGRANT HEALTH

Education Commission of the States
Denver, Colorado
Warren G. Hill, Executive Director

Report No. 131

November 1979

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FOREWORD

When the task force took upon itself the investigation of the avenues of health care available to the interstate migrant, few of us realized the hidden discrimination that exists against this segment of society upon which we all depend for the food on our tables. This same discrimination exists to some extent even against the intrastate migrant inasmuch as many states offer only minimal services to all people who are at the poverty level, and one state – Arizona – has never implemented the Title XIX medical services.

Not only did we find a lack of concern for this most impoverished group of citizens; but, in many instances, states refused to make available monies that could have been expended had they wished to assume responsibility for the health and welfare of the migrant family. When we tried to ascertain what services were available and who was responsible for such, we were shuffled from agency to agency, to the extent that we soon became lost in the ever-increasing maze of bureaucracy.

There is a solution to this problem, and this solution lies in the heart and conscience of those individuals in positions of responsibility at all levels of government and private industry. Although their livelihood depends on migrant "stoop labor," the packers and growers of this nation have never taken it upon themselves to assure their employees the benefits that are made available to the employees of other businesses.

If we would all think of these families and, particularly, the children, their health and education, as we look upon our families, the solution would be simple: we would "do unto others as we would have them do unto us."

The picture is not entirely bleak. There are pockets of enlightenment, but these are miniscule in comparison to the whole. There are the means to improve the lot of the migrant. True, we need more money to bring these "tillers of the soil" up to a level of humane existence. Surely, a nation that prides itself on its stand on "human rights" can and will find a way to solve this embarrassing situation that has existed for so many years.

Our nation and the world is faced with many seemingly insurmountable problems, but none are so great as the indignations suffered by "The Children of Sanchez."

The health component of the task force would like to give credit to Jim L. Gonzales and Judi Worker for their devotion to detail and the long hours they spent on the development and completion of this report. We would have been unable to accomplish our tasks without their endeavors.

Robert A. Tidwell, M.D.

EXECUTIVE SUMMARY

One of the continuing concerns of the Education Commission of the States Interstate Migrant Education Project since its inception in 1976 has been the health of migrant workers and their families. Although the health of migrant children and their families has not been emphasized per se, due to the educational focus of the project, the task force has generally agreed that this is an area of vital concern, particularly as it relates to successful participation in education programs. As expressed in early task force deliberations, the rationale for addressing migrant health needs is that it is difficult to effectively educate migrant children if they are sick, hungry, poorly clothed or housed, or if any members of their families, particularly their parents, are ill. While this statement is applicable to the education of any child, it is particularly relevant for the migrant child because of the inherent life-style of the interstate migrant family. The life-style of the interstate migrant farmworker and his family is characterized by frequent moves, substandard housing, inadequate plumbing, and limited access to quality medical and dental services.

The task force has found that accurate information pertaining to migrant health is generally unavailable or buried in a myriad of agency files and reports. Much of the information is unsubstantiated. Nevertheless, several recurring themes appear in reports available on the health status of migrant workers. For example:

- The migrant's life expectancy is 49 years, compared to the national average of 73.
- The infant mortality rate among migrants is 25 percent higher than the national average.
- Birth injuries result in many cases of cerebral palsy and mental retardation.
- The migrant death rate from influenza and pneumonia is 20 percent higher than the national average, and deaths from tuberculosis and other communicable diseases are 25 times higher.

- The migrant's hospitalization rate from accidents is 50 percent higher than the national average.

- The migrant's two most chronic conditions are diabetes and hypertension, both of which require continuous care and followup.

- Poor nutrition causes pre- and post-natal deaths, anemia, extreme dental problems, and poor mental and physical development of the children.

- The largest outbreak of typhoid in recent history occurred in a migrant camp in Dade County, Florida, in 1972 and was traced to a contaminated water supply.

Some of the major findings of the task force in the health area are:

- The health needs of migrants in all service areas, including preventive education, nutrition, dental, routine checkups, treatment and emergency medical care, are critical.

- There are many entities with specific mandates or that purport to serve migrant health needs. Yet, those needs continue to be unmet.

- Data, programs and related information suggesting provision of service to migrant children with special needs, such as handicapped children, are largely unavailable.

- A large percentage of the health problems identified among migrant families is attributable to unsanitary and unsafe working conditions.

- At the federal level, the meager health care delivered to migrants is, for the most part, provided by services through the migrant health program, although prospects for improvement appear brighter.

- Migrants are routinely excluded in most states from services available through various entitlement programs contained in Titles XIX and XX through a tangle of residency and annual income eligibility requirements.

- Agricultural farmwork benefits as an industry in that the health care of its workers is paid by the federal govern-

ment as opposed to the industry itself.

- There is no clearcut leadership for development of sound policy relating to migrant health in the United States.

- Many alternative approaches that warrant further study and support have been initiated at the state and local levels.

As a first step toward the resolution of the unmet health needs of migrant workers and on the basis of its findings, the Interstate Migrant Education Task Force maintains that:

The migrant farmworker and his family are entitled to parity health, economic opportunity and educational access. Optimal health is important to educational achievement and overall development of all children and should, therefore, be equally emphasized for the migrant child. The task force urges that the following alternatives be considered for future action in the area of health services for migrant farmworkers and their children:

1. Appoint an oversight committee on migrant health. This committee would report annually on the status of migrant health to the U.S. House of Representatives Committee on Education and Labor.

2. Establish a national task force on migrant health to develop recommendations for the secretary of the Department of Health, Education and Welfare.

3. Continue to evaluate migrant health clinics periodically and prepare recommendations for modifications in services, funding procedures and program administration.

4. Encourage counties and states to establish the health needs of migrant farmworkers, fishers and loggers as a priority service population, particularly as those needs can be served through Titles XIX and XX.

5. The MSRTS health records of migrant children who reside in non-Title I project areas be made available to private physicians and migrant health clinics to promote continuity of services.

6. Migrant children be specifically listed in existing and any new health legislation.

7. Place a new emphasis on prevention in migrant health and provide resources to develop capacity to extend health care and carry out initiatives in this area.

8. Initiate a study in the areas of exceptional migrant children, including gifted, handicapped, abused and neglected, to determine what the needs are in these areas and to find out whether these needs are being met by federal, state and local programs.

9. Determine avenues whereby the agricultural and fishing industries can take a more active role in the health and welfare of migrant workers and their families.

10. Identify methods whereby national health organizations, such as the American Academy of Pediatrics and the American Medical Association, can, in conjunction with federal, state and local programs, e.g., USOE Title I Migrant, Head Start, Comprehensive Employment and Training Act, Farmers Home Administration, and Titles XIX and XX, foster joint planning for coordination purposes and thereby assist in resolving migrant health needs.

The remainder of this report (Part I) contains the detailed findings of the task force in the area of migrant health. The separate appendix (Part II) contains valuable materials for individuals or agencies that may wish to have an indepth explanation of information contained in the main report.

PART I

Introduction

The subject of migrant health services has been an issue of the Education Commission of the States (ECS) Interstate Migrant Education Task Force since its inception in 1976. Health-related concerns have been expressed by task force members over this period, yet a sustained effort pertaining to health has never been undertaken. The task force has expressed its awareness of the importance of optimal health as it relates to the education process, as evidenced by the following statement contained in the First Interim Report:

> The Interstate Migrant Education Task Force has determined the critical issue to be the improvement of the education system, as well as social and health services, to meet the unique needs of children of migrant workers and their families. Improvements in education must be made for children whose lives are characterized by poor general health, lower-than-average scholastic achievement, low family income and much mobility.

Although the health of migrant children and their families has not been emphasized per se, the task force has generally agreed that this is an area of vital concern, particularly as it relates to successful participation in education programs. As expressed in early task force deliberations, the rationale for addressing migrant health needs is that it is difficult to effectively educate migrant children if they are sick, hungry, poorly clothed or housed, or if any members of their families, particularly their parents, are ill. While this statement is applicable to the education of any child, it is particularly relevant for the migrant child because of the inherent life-style of the interstate migrant family. The life-style of the interstate migrant farmworkers and their families is characterized by frequent moves, substandard housing, inadequate plumbing, and limited access to quality medical and dental services.

The importance of optimal health and the implications of having healthy students in the classroom cannot be overemphasized by the Interstate Migrant Education Task Force, yet improved health delivery to migrant families continues to present many perplexing problems to decision makers and is oftentimes viewed as too controversial for examination.

Nevertheless, good health is an integral part of the education process; therefore, health care services and needs must be addressed by the task force.

The following sections contain preliminary findings of the task force in this important area.

The Problem

A recent report by Ramirez (1977) highlighted some of the major statistics concerning migrant health problems. Among the findings she presented were the following:

- The migrant's life expectancy is 49 years, compared to the national average of 73.
- The infant mortality rate among migrants is 25 percent higher than the national average.
- Birth injuries result in many cases of cerebral palsy and mental retardation.
- The migrant death rate from influenza and pneumonia is 20 percent higher than the national average, and deaths from tuberculosis and other communicable diseases are 25 times higher.
- The migrant's hospitalization rate from accidents is 50 percent higher than the national average.
- The migrant's two most chronic conditions are diabetes and hypertension, both of which require continuous care and followup.
- Poor nutrition causes pre- and post-natal deaths, anemia, extreme dental problems, and poor mental and physical development of the children.
- The largest outbreak of typhoid in recent history occurred in a migrant camp in Dade County, Florida, in 1972 and was traced to a contaminated water supply.

The President's Commission on Mental Health (February 1978) reiterated many of these findings and concluded that:

> While the panel believes that much of the data frequently quoted in reports on the health needs of farmworkers is suspect, and there is a lamentable tendency to pass along such data from one report to another without current documentation as to its validity, what does emerge from the available statistical data, as well as from testimony before various Congressional committees, is one clear fact: *that the health needs of farmworkers are substantial, are urgent and are largely unmet by current programs.*

As indicated by the President's commission panel, much of the data frequently quoted is suspect and data have been passed along without validation from one report to another. First-hand data are indeed difficult to obtain, since few scientific investigations and followup have been conducted on the health status of the migrant population. This may be due, in part, to the difficulties inherent in gathering data on a mobile population, plus the added difficulties of identifying the target population.

The University of California at Davis conducted a study of the health and developmental status of several thousand migrant children between the years 1971 and 1975. The mobility of migrant families was evident in the results of the study, as demonstrated by the three different populations of preschool children identified. Nearly half (about 43 percent) of the migrant children ages 3 to 6 years were enrolled less than two consecutive weeks in child care centers. According to the report, this was too short a time for a comprehensive evaluation of their health and developmental status, and for any significant health or educational intervention. One-quarter of the migrant children ages 3 to 6 years were enrolled more than 2, but less than 10 weeks. Approximately one-third of the preschool children remained at a public housing camp for 10 weeks or more.

The California study used the Thorpe Developmental Inventory (TDI) as the diagnostic and evaluation tool for children ages 3 to 6 years enrolled in 32 day care/preschool programs at migrant children's centers located in migrant housing units. The TDI is an inventory of developmental skills that can be administered in Spanish or English by a trained adult in approximately 20 minutes. Health history information, e.g., birth weight, illnesses and so forth, was also collected on each child. Health status, vision and hearing, need for dental care, immunizations, height and weight were assessed during physical examinations.

A total of 2,785 3- to 6-year-old children were enrolled in the

migrant day care programs for at least two weeks, long enough for a pre-test assessment of their developmental and health status. According to the California report, nearly half of this number did not remain in a single housing camp long enough for a proper assessment of their health status. The authors indicate that the estimates from the pre-post test sample of who stayed at least a minimum of 10 weeks and whose attrition rate was only about 10 percent are probably more representative (than the total original enrollment sample of 2,785) for California migrant children as a whole.

The results of the California study indicated that the proportion of significant health problems in the representative group ranged from 13 percent at the youngest age level (3.0 to 3.5 years) to 18 percent at the oldest age level (5.6 to 5.11 years). The overall rate of significant health problems among California migrant children was 15 percent for preschool age boys and 13 percent for preschool age girls. Significant health problems in the project referred to children with a history of health problems or with current health problems, e.g., vision impairments, hearing impairments, severe illnesses with developmental implications, such as encephalitis or meningitis, which were serious enough that they could affect normal development. Among chronic debilitating health problems, the researchers found diarrheal infections, respiratory infections and skin infections. The authors noted that this is a disease pattern presently prevalent in developing countries of the Third World and in Europe and the United States some 100 to 150 years ago.

The primary findings of the California study are listed below:

Young migrant children in California, as in other great migrant streams in the United States, have a number of health problems that are apt to affect their development and school performance:

1. They have a poor record of immunization and dental care.

2. The height and weight measurements of a sizable proportion of migrant children show the stunting effects of poor or marginal nutrition.

3. The health histories and physical examinations reflect the synergistic interaction of marginal nutrition, diarrhea, chronic respiratory and parasitic infections, as well as exposure to repeated accidents and injury.

4. Singly, and in combination with a higher-than-average incidence of vision and hearing problems, poor health and nutritional status have a cumulative effect on the children's development.

5. Together with frequent changes of residence that deprive them of health care and followup, and lack of exposure to the English language, those health problems are apt to lead to difficulties in school.

Findings similar to those reported by Ramirez and the California studies have also been reported in a 1976 InterAmerica Research Report, a 1978 Department of Health, Education and Welfare (HEW) Region X report and an HEW status memorandum on migrant health released in October 1978. Additionally, Dr. Robert Tidwell, private pediatrician and task force member from the state of Washington, had an opportunity to see the health needs of migrant children during the summer of 1978 on a first-hand basis. He left his Seattle, Washington, practice for six weeks to work in a health screening project for migrant children in the Yakima Valley. He reported that he knew he would encounter a lot of health problems, but what he did not anticipate was the scope of the problem:

> I'd say 80 to 90 percent of the children I've seen have something wrong with them, something that's treatable. Another 10 percent have a potential life-threatening problem such as high blood pressure or something wrong with their heart. . . . During the first month of a six-week screening program, Tidwell said he has run into problems such as hearing loss from constant colds, numerous dental problems, chronic tonsilitis, malnutrition and anemia . . . (Lester, 1978).

One of the major deterrents to effective health care delivery is the fragmentation evident among the various involved entities. In a followup statement issued by Dr. Tidwell, he described the problem as follows:

> Migrant children might be screened and/or medically treated by private physicians, public health clinics, medical schools, hospital outpatient departments, community clinics, Head Start, farmworker clinics or under the auspices of Title I migrant education funds by pediatric nurse practitioners or physicians. Unfortunately, there is no communication between these groups, nor is there access to previous treatment records unless it is done on a person-to-person basis. This approach is time consuming and frequently the child is out of the area before the information is received.
>
> Those children under the direct sponsorship of Title I migrant education are tied into the Migrant Student Record Transfer System (MSRTS) and therefore have the advantage of immediate access to the past and present medical history and treatment regime. This information is ongoing and is assembled in a computer bank located in Little Rock, Arkansas, from the day the child is first enrolled in the migrant education system.
>
> Because of this fragmentation of care, the migrant child is frequently over- or undertreated. Chronic conditions are over-

> looked or ignored. Until such time as the migrant child's health record is made readily available to those individuals involved in his/her medical management, there will always be mistakes made which could be detrimental to the health and welfare of the patient.
>
> This fragmentation is unnecessary, particularly with those encounters which are federally funded. The Migrant Student Record Transfer System computer has the capability of serving all these groups if they would tie into the system.
>
> In order to give this segment of our pediatric population the best of medical care, it is imperative that this linkage be established as soon as possible (Tidwell, February 1979).

Through interagency type agreements, MSRTS presents an excellent opportunity to resolve many interstate coordination problems relating to sharing of information for children of interstate migrants. This same potential should be explored for inclusion of adults, as well as school age children. The MSRTS has the capacity and the experience for such interagency sharing, yet other agencies must find methods whereby data on their respective service populations can be included in the system.

Such coordination through MSRTS could be invaluable to interstate migrants, as well as the health welfare of the general public. This was demonstrated in 1972 when the system was instrumental in preventing a major outbreak of typhoid. MSRTS, in conjunction with Florida health authorities, assisted by identifying the instream location of migrant families suspected of contracting typhoid. MSRTS was used to provide immediate identification and the whereabouts of many migrant families who had left Florida. The families were then contacted by health providers and given appropriate inoculations and treatment.

An effective exchange of data between the states and many agencies is one possible avenue for resolving much of the fragmentation and duplication evident in migrant programs. Williams (1979) conducted an investigation of the question, "Can there be an effective data exchange between the states concerning migrant children and the education programs provided them by the states?" To answer the question, he examined all sections of the following: 1) The 1974 *Family Educational Rights and Privacy Act*, 20 U.S.C. 1232 g; 2) Part 99, *Privacy Rights of Parents and Students*, 45 Code of Federal Regulations, 99.1 et seq.; 3) State statutes in the eight states of the task force; and 4) Recent articles in law and law-related journals. After examining these items, he

concluded that, yes, there can be an effective data exchange, although there are some minor problems. He noted, however, that the problems are subtle and certainly do not amount to proscriptions against such an exchange (see Appendix A).

Currently, efforts are under way to revise the MSRTS student health profile to more closely match disease categories and coding used by other health service providers. According to Dr. Tidwell (February 1979), the MSRTS:

> . . . transfers the student's education profile, as well as his/her ongoing health history and treatment. Health information that pertains to learning is transmitted on the educational component, while a second component (health) is transmitted to the appropriate medical personnel.
>
> The entire health component is being revised. The original disease coding was developed without previous experience, inasmuch as there were no programs to call upon to ascertain those medical entities associated with the migrant child.
>
> The new health component revision will be in concert with the international disease code. This coding is recognized and used by third party insurance, federal and state programs, as well as internationally. In the future, the coding will change only if there is an international change or as new disease entities are identified.
>
> The physical exam component will meet the requirements of federally-funded programs (Head Start, Title XIX, etc.) so that, if and when the migrant child is allowed into the mainstream of the federally-funded social programs, there will be no need to change this segment of the MSRTS in order to meet their requirements.
>
> The examination form will also contain information regarding pre- and post-partum care, newborn period, family history and immunizations.

As can be noted, opportunities exist and are being undertaken to reduce the amount of fragmentation evident in health care delivery to the interstate migrant child and his family. Yet, despite these efforts, many gaps remain to be solved. Without exception, investigators report that the health needs of migrants are great, that the conditions that produce these health deficits are many and that migrant health needs are grossly underserved. Although unsubstantiated at this time, such may be the case for migrant children with special needs discussed in the next section.

Migrant Children With Special Needs

On the basis of the health status findings reported, one would also anticipate some information pertaining to two categories of exceptional children; that is, children with handicapping

conditions, and abused and neglected children in the migrant population. Concrete data, e.g., incidence statistics, of these phenomena among the migrant population could not be identified. This is attributable to numerous factors. Migrant children may not be separately identified as such when schools or agencies conduct counts in the areas of handicapped, abused and/or neglected; or, migrant children may not remain in a district/community long enough to be identified as eligible for assistance as an exceptional child. Another possibility is that exceptional migrant children may remain in the family's home base state. If this is the case, the child would then be included in census counts, not as an interstate migrant child, rather as though he were part of the permanent population.

During proceedings of the task force meeting held in Little Rock, Arkansas, in November 1978, the membership raised the issue of the need for special education services for handicapped migrant children. Specifically, the task force recommended that:

> Special education information, including student individualized education plans (IEP's), be transmitted on the Migrant Student Record Transfer System to insure that handicapped migrant children are served according to the provisions of Public Law 94-142, the Education for All Handicapped Children Act of 1975.

Subsequent review of the act and discussions with administrators in the state by project staff revealed that no special provisions nor mention is made of migrant children. Since migrant children, due to their particular circumstances, may not benefit fully from the rights and provisions of the act, it seems reasonable that attention should be directed toward this group of handicapped children, as well as children in the general population with special learning needs.

Part of the reasoning behind the task force's concern in this area is that children of migrant farmworkers and fishers often come from disadvantaged social and economic backgrounds, and include many racially and culturally different children. While there are many problems in provision of education services for nonmigrant handicapped children, resolution of these problems for migrant handicapped children is more difficult due to the varying education delivery systems and the mobile nature of the family.

In view of these factors, the requirements of recent federal laws for the handicapped should be reviewed in terms of their applicability to migrant children. Specifically, the provisions of Public Law 94-142 and Section 504 of the Vocational Rehabilitation Act of 1973 should be reviewed to determine responsibility for provision of special education services for migrant children.

Like the area of handicapped, little specific information, guidelines or legislation are available on child abuse and neglect in the migrant population. Information, when available, tends to deal in generalities, as evidenced at a workshop that focused on the prevention and treatment of child abuse and neglect among migrant farmworkers sponsored by the Texas Migrant Council in March 1978. The Texas Migrant Council assembled people from throughout the country, representing a variety of disciplines, to address these issues. For discussion purposes, the problems were broken down into several subcategories and recommendations were then developed by the participants. Subcategories included were: services for preschool age children, services for school age children, special children, emergency services, health services, mental health, housing, employment opportunities, legal services, and coordination/increased service provision and migrant advocacy.

Based on the experiences and perspectives of the participants, the consensus of the workshop was that "Because of the prevailing conditions under which migrant farmworkers exist, it is most difficult to conceive child abuse and neglect in a traditional sense" (Redlinger, March 1978). In effect, the participants concluded that it is a difficult and complex process to delineate between the circumstances, life-style and pressing needs of the migrant farmworkers, and the inadequate service delivery systems, or lack thereof, as all of these variables relate to child abuse and/or neglect. The health group noted that child abuse is an intentional act; and child neglect, particularly among migrants, is most often an unintentional act. As viewed by the work group, child neglect is a much more prevalent problem among migrant farmworkers than child abuse. The work group identified problems such as malnourishment, poor hygiene and low school attendance as examples of child neglect, which often result from lack of resources and knowledge.

In an analysis of the workshop proceedings, Redlinger (1978)

indicated that conferees repeatedly noted that the vast majority of neglect cases among migrants were unintentional neglect, most often due to lack of available resources, adequate housing, and lack of adequate knowledge about nutrition and health: "That is, parents do not *want* these conditions, but cannot do anything about it." One of the general conclusions reached by the workshop was as follows:

> With regard to child abuse and neglect, and migrant child welfare in general, the services needed are not so much traditional child welfare services (i.e., foster homes), but vastly more so services such as day care, health care, adequate housing and education. Traditional child welfare services cannot provide what migrants and their children actually need, and it appears that current programs do not adequately meet the demand for needed services (Redlinger, 1978).

The workshop report provides recommendations in each subcategory discussed, e.g., housing and employment, and concludes with general recommendations calling for increased coordination of programs, service provision, continuity of services and militant advocacy.

It appears appropriate that some determination should be made concerning the migrant family's needs in this area, as well as the overall area of health. Health is integrally related to a child's overall development, particularly in the early years, and is thereby related to the presence or absence of handicapping conditions. Similarly, child abuse and/or neglect are phenomena with substantial sociomedical implications and warrant further study.

Contributing Conditions

Housing

It is difficult to ignore the living conditions provided by many growers for farmworkers during a planting or harvesting season. The housing provided varies from farm to farm and ranges from adequate for temporary living to totally inadequate in other situations. Ramirez (1977) described the living conditions under which most migrants live as comparable to those in Third World countries:

> The housing he is provided by the farmers who employ him is grossly substandard, a one-room shack often serving as living quarters for nine people during a planting season. Facilities built over 40 years ago to house the "bracero" who came to work for a season without his family now house families which average two adults and five children.

Ramirez cites the predominance of housing units that have no indoor plumbing or electricity, the lack of sewage systems and fresh water supplies in the camps. Migrants sometimes have no choice but to either drink water from the fields that may be contaminated with insecticides and fertilizers and diarrhea-producing organisms, or to travel miles to find fresh drinking water. The President's Commission on Mental Health (February 1978) concluded "the health problems of migrants are not only compounded by the life-style and mobility of the farmworkers, but also by the unsafe and unsanitary conditions under which he lives and works."

Water

An example of the unhealthy working conditions is the frequent lack of potable drinking water. Dr. Ramon Sanchez, a physician in the Wenatchee (Washington) Health Clinic became concerned about the large number of patients with gastro-intestinal complaints. He originally dismissed this as something to be expected in a population recently migrating from Mexico and the Rio Grande Valley. Upon closer scrutiny, however, several things became apparent. Gastro-intestinal complaints were observed in all categories of migrants — recent migrants, seasonal and non-Mexican migrants, as well. He also found that large numbers of stool cultures were positive for intestinal parasites, including Ascaris, Hookworm, E. Histolytica, G. Lamblia, Trichuris and H. Nana. The rate of positive stool cultures was about 56 percent of all stools sampled for parasites.

These observations prompted Dr. Sanchez to conduct an investigation to see if he could find a common factor. His investigation led him to the conclusion that many of the patients had been drinking orchard irrigation water from spigots or lines laid out through various orchards. He found that orchard irrigation water usually comes as unfiltered, nontreated water directly pumped from the Wenatchee and Columbia Rivers. To verify this notion, he personally test sampled different water sources in the Wenatchee area. All six orchard irrigation water samples piped in from the Wenatchee River were highly contaminated with fecal contaminants. Dr. Sanchez verified his findings through comparison with another sampling study conducted by another physician and a department of public health analysis of the drinking water.

On the basis of the findings from the three independent samplings, Dr. Sanchez strongly suspects that the water supply available to many migrants in the Wenatchee Valley area is significantly contaminated with fecal coliform, enterics and possible parasites, so much so that water sources are probably responsible for much of the gastro-intestinal morbidity observed.

Dr. Sanchez attributes the drinking water problem to many causes, foremost of those being the failure of state and county health agencies to adequately acknowledge the problem and make a commitment to solving it. He identified additional causes of the problem to be:

1. Failure of orchardists to provide potable drinking water to laborers in the field.

2. Inadequate labeling or identification of nondrinkable water lines.

3. Inadequate education efforts directed to teach laborers to avoid irrigation water consumption.

4. Failure of public health agencies to adequately enforce water quality in labor camps (Sanchez, November 1978).

Work and Living Conditions

In addition to the potential health hazards from unsanitary working conditions, migrant farmwork is also dangerous to the health and livelihood of young children. The American Friends Service Committee (1971) has for some time pointed out the dangers inherent in farmwork for young children. Dr. Robert Tidwell (1979) recently obtained statistics on deaths and death rates for migrant children, provided by the Migrant Student Record Transfer System. The results presented in Table 1 cover a two-year period and include information from 35 states and Mexico.

The numbers presented in Table 1 should be viewed as very rough estimates and, at best, preliminary findings. Nevertheless, these preliminary death figures serve as indicators that many more migrant children die from accidents than any other cause. Also, the accident death rates increase considerably with age, due, possibly, to an increased number of youth working in the fields. Conversely, many more young children, ages 0 to 5, die from medical reasons than their older counterparts in the migrant population.

Table 1
Cause of Death by Age Group
Among Selected Sample of Migrant Children

Age Level	Number	Accidents	Medical	Cancer	Unknown
0-5	34	50.0%	29.4%	8.8%	11.7%
6-10	82	64.6	20.7	10.9	3.6
11-15	102	75.4	15.6	6.8	1.9
16+	69	81.0	10.0	5.7	2.8
Totals	287	70.7	17.4	8.0	3.8

(Explanation – Medical Deaths – Deaths due to cardiovascular surgery, kidney, meningitis and respiratory infection.)

Source: Dr. Robert Tidwell, MSRTS information provided February 1979.

Comparable figures, including similar age and cause classifications, for the general population of children are presently unavailable for comparison purposes. Should such information become available, it would be worthwhile to compare it to similar data on migrant children. Such a comparison might reveal whether a given cause of death among migrants is unusually high or not. For example, an analysis of the types of accidents that caused death among the migrant child population revealed that 44.3 percent of the children in all age groups died in automobile accidents. The second leading cause was drowning, 24.6 percent; followed by gunshot, 10.3 percent; burns, 5.4 percent; and farm accidents at 3.4 percent. Other causes listed (12 percent) ranged from electrocution to murder. Drowning was most prevalent among the 11 to 15 year population, and death from gunshot was most prevalent in the 16 and above population.

Besides the environmental conditions that contribute to the abysmal health status of migrants, there are additional barriers present that are attributable to the mobility of the family and the location of their work. The areas most frequently inhabited by migrants are rural and, therefore, subject to the problems inherent in a rural community. Among these problems are a shortage of health providers, lack of medical facilities and equipment, lack of health education, a shortage of bilingual and bicultural personnel able to provide direct services, and lack of transportation to health facilities.

Nutrition

A recent report released by the Florida Department of Citrus (1978) updated a 1973 survey of scientific literature dealing with the relationships between learning and hunger, undernutrition and malnutrition. One of the main conclusions advanced is that hungry children have been shown to exhibit behavioral changes that may limit their response to learning opportunities. The Florida study indicated that chronic undernutrition has also resulted in behavioral changes and impaired intellectual development. The report also noted that, to safeguard the health and well-being of the nation's children, school food service programs, such as the School Breakfast Program,were implemented to eliminate the hunger or undernutrition that could interfere with the learning process. Further, the Florida study found that many schools have also instituted nutrition education programs to give children the opportunity to learn the importance of the principles of good nutrition in their daily lives. The degree of impact of such programs on the health and nutrition of children of migrant farmworkers and fishers is unknown. What is known is that migrant children often come from socioeconomically disadvantaged areas, where there is the highest risk of suffering from possible malnutrition and hunger.

To what or whom are the above deplorable conditions attributable? Part of the answer may lie in the economic dilemma faced by American growers. On the one hand, many are faced with heavy land and equipment investments. On the other, many are confronted with demands of higher wages and operating costs with lower expected returns on their investments. It is not surprising then that grower attitudes relating to the health and general welfare of migrant workers are influenced substantially by economic considerations. That is, growers tend to be more directly involved and concerned about the health of their labor if they do the hiring themselves as opposed to hiring labor through a middleman or contractor. This was the principal finding reported by Johnson (1976) in a study conducted among Florida growers.

The purpose of Johnson's study was to evaluate the attitudes of farmers toward the health problems of their migrant labor. Specifically, the study sought to determine grower attitudes toward diseases of laborers, the use of available health

facilities by laborers, and the future health care needs of the laborer, each as perceived by his employer. To achieve this determination, a representative sample of growers (n=28) was selected through agricultural extension agents. Upon selection, the investigator then spent two months conducting open-ended interviews to glean information concerning several major areas of interest, e.g., nature of growers' operation, extent and nature of grower contact with health problems of laborers, the growers' own health status and growers' recommendations concerning health care delivery. Once the interviews were completed, the investigator then conducted a content analysis of the entire interview. A subjective assessment of the general attitude of the grower toward the health problems of labor was made. Attitude categories utilized were sympathy, empathy, indifference and hostility.

The results of the Johnson study indicated that, in terms of the subjective assessment of grower attitudes toward the health problems of their laborers, it was clear that, by far, the largest proportion of the sample (57.1 percent) was classified as being indifferent in attitude. Of the remaining categories, there were few cases unequivocally assignable to each category. That is, almost everyone interviewed expressed a degree of indifference; although, in some cases, strong undercurrents of sympathy (17.8 percent), empathy (14.2 percent) or hostility (10.7 percent) were judged to be tempering this basic indifference.

One of the conclusions reached by Johnson, upon analysis of his findings, was that the perceptions and attitudes of potato and cabbage growers toward the health problems of their labor are influenced by the hiring practices of the growers. Those growers who use the contractor system come into very little contact with the laborers, know very little about their lives, perceive few of their health problems and generally have feelings of indifference. Growers who continue to hire on an individual basis, however, have more knowledge of health problems and the daily lives of their workers. The author notes that, for the most part, this type of relationship between the grower and laborer is quite anachronistic.

Johnson concluded, as follows, concerning grower attitudes relating to migrant health:

> Recognition of specific health problems or "diseases" primarily involve those which affect the productivity of labor, or the condition of the laborer when he is on the job; knowledge of

health facilities is slight, and most growers only know about such facilities when they take workers off the job; and the attitudinal trend is for increasing indifference on the part of the growers as the contractor system expands, or as unionization of labor takes place.

The litany of problems, as can be noted in the preceding section, underlying the health state of interstate migrant workers is long. Yet, not only is effective health care delivery problematic for a mobile population, but rural populations in general, as evidenced by the efforts of several programs implemented during the past few years. A discussion of some of these programs is the topic of the next section.

Migrant Health Programs

Federal

Provision of health care to the migrant population is not a simple matter. It is complicated from the service delivery standpoint by the mobile life-style of the migrant family; and, from the program planning standpoint by red tape, varying regulations and qualification procedures at the different levels of government: federal, state and local. Health care services are provided through, or should be available to, migrant farmworkers and their children by the migrant health program and health care entitlement programs such as Medicaid under Title XIX, Title I (migrant) of the Elementary and Secondary Education Act (ESEA), and the Comprehensive Employment and Training Act (CETA) 303. These include health care services for children and youth enrolled in migrant education programs, as well as some health education services to the families of such children. By far, the largest of these efforts is the migrant health program.

Farmworker health improvement and maintenance are conducted through the migrant health program in accordance with the Migrant Health Act (Public Law 87-692), which was enacted in 1962 with an initial appropriation of $750,000. By 1977, funding had risen to $30 million. Funds are channeled through 10 regional offices of the Department of Health, Education and Welfare to provide ambulatory health services to migrant farmworkers in migrant health clinics. The program is administered by the Bureau of Community Health Services (BCHS), Health Services Administration of the Department of Health, Education and Welfare.

According to an unpublished Bureau of Community Health Services document (1977), the migrant health program was developed to provide access to health care services for migrant and seasonal farmworkers and their families. The law establishing the program *requires* the establishment of *centers* in high impact areas (areas in which 6,000 or more farmworkers reside) and establishment of *projects* in low impact areas (areas in which less than 6,000 farmworkers reside).

Currently, the provision of health services through the migrant health program is governed by Public Law 94-63, enacted July 29, 1975. This law is a complete rewrite of previous legislation dating back to 1962, with revisions in 1965 and 1970. This act authorizes the secretary of HEW to make grants to public and nonprofit private organizations to plan, develop and operate migrant health centers and projects, and establishes guidelines for the funding of such agencies. A migrant health center is defined in the act as "an entity which, either through its staff and supporting resources or through contracts with other public or private entities, provides primary health services, supplemental health services to support the primary services, referral to providers of supplemental care and payment, as appropriate and feasible, for the provision of such services as environmental health services, infectious and parasitic disease screening and control, accident prevention, and information on the availability and proper use of health services for migratory agricultural workers, seasonal agricultural workers and their family members."

The Bureau of Community Health Services indicates that migrant health centers/projects are established in close proximity to the work places of migrant and seasonal farmworkers to make comprehensive health services available to them and to help improve their environment. Also, the BCHS notes that a majority of these programs operate year-round and provide access to services for the total community. The programs are linked or integrated, according to BCHS, with hospital services, school health services, family planning services, mental health services, and nutrition and emergency food programs sponsored by local agencies (BCHS, 1977).

The BCHS supports 125 grantees who provide services to migrant and seasonal farmworkers and their dependents in

250 service sites in 25 states and Puerto Rico. The BCHS reports that the program served 499,000 individuals in fiscal 1977, at an average cost of $60 per person served. An average of 2.5 encounters are provided for individuals at a cost of $24 per encounter. Finally, BCHS reports that the per-capita allocation for health care for the target population of the migrant health program, made up of 700,000 migrants and 2,000,000 seasonal farmworkers and their dependents, is $11 (BCHS, 1977).

Viewed from another perspective, the President's Commission on Mental Health assessment of the migrant health program in 1977 found that the program served 490,000 clients in 95 projects, funded with an appropriation of $30 million — an average cost per client of approximately $60. Of these clients, 35 percent (175,000) were migrant farmworkers or their dependents, 20 percent (98,000) were seasonal farmworkers or their dependents and 45 percent (220,000) were others.

The President's commission also noted that the migrant health program constitutes, in effect, the only available health care for the great majority of farmworkers. Yet, according to the report, if total appropriations for 1977 are computed across the total population of approximately 5,000,000 farmworkers and dependents who are eligible for service, less than $6 per person was spent to meet their health care needs.

In the view of the President's commission panel on health, the meager appropriations available have, for the most part, been responsibly spent to provide emergency physical health care to farmworkers "although they in no way begin to provide comprehensive health care to this population." By its own estimate, according to the panel, the migrant health program serves approximately 25 percent of the target population. The National Association of Farmworkers Organization estimates that barely 10 percent of farmworkers are covered under the program.

The work of the President's commission on migrant health appears to be the most recent comprehensive analysis of health services for migrants. A number of observations, conclusions and alternative recommendations are contained in that report; yet, it is not known what the outcomes of these recommendations have been. One other area of

potential health services for migrants is alluded to in the report regarding health care entitlement programs such as Medicaid; however, not much is said, other than that they have been virtually inaccessible to the farmworker for a variety of reasons.

Flynn (1977) indicates that, over the past few years, there have been legislative changes that have had a big impact on the direction of the migrant health programs. In 1965, for example, Public Law 89-109 extended the program for three years and added necessary hospital care to the available services. In 1970, Public Law 91-209 again added three years to the life of the program; but, more significantly, broadened the coverage to include seasonal farmworkers and their families. The 1970 changes also included the requirement for direct consumer involvement in any project's board of directors. The law now reads that 51 percent or more of the board must be consumers. For many projects, this meant that, for the first time, recipients of health services, especially migrants and seasonal agricultural workers, could have an impact on the policies and regulations of migrant health centers. These, however, are settled-out migrants and, as such, are not facing the same problems as interstate migrants. While the establishment of consumer input through boards is important from one standpoint, i.e., involvement of settled-out migrants, the "true" interstate migrant is oftentimes left out of the process because of his mobility. Whether the interstate migrant's interests are effectively represented by settled-out migrants is open to question.

In 1975, the appropriation for the Migrant Health Act was increased by $5,000,000. However, that same amount was set aside, with other funds from several programs within the Bureau of Community Health Services, to establish the Rural Health Initiative (RHI). The Rural Health Initiative is an attempt by HEW to coordinate several categorical programs, including migrant health, and to develop health care systems for all people in a rural area, no matter who or what the health problems are. The Rural Health Initiative is geared to the population as a whole, rather than selected populations within that same geographical area.

The National Advisory Council on Migrant Health came into being as part of the law in 1975 that established the RHI. The council advises and makes recommendations to the secretary of HEW concerning the operation, selection and

funding of migrant health clinics. One concern of the council is that the Bureau of Community Health Services stop using migrant funds for other programs such as the RHI. The council passed a resolution to that effect in 1977 requesting that RHI be de-emphasized (Flynn, 1977).

Outside of the single reference by Flynn to the National Council on Migrant Health, no other references have been found in the literature to that body, and no one seems to be clear as to the philosophy or who has the leadership role and responsibility for migrant health in the nation outside of the Bureau of Community Health Services migrant health program.

More recently, in October 1978, Vice President Mondale announced that three departments would pool their resources in a joint effort to expand rural health services that could have direct benefits for the migrant population. This effort involving better targeting of existing monies was being undertaken by the Departments of Health, Education and Welfare; Agriculture; and Labor. The joint effort was seen as an example of the important gains that could be made by more effective interagency cooperation.

The basis for the joint effort, according to the Vice President, was "the need for decent, affordable and accessible health care, which is one of the most pressing unmet needs in rural America today." He noted that rural Americans suffer from higher rates of infant mortality, fatal injuries and chronic disease than nonrural Americans. Mondale also referred to his personal experiences in migrant labor camps in Florida and Texas, where he saw "the tragedy of young kids suffering from disease and from hearing and visual problems that can be corrected if medical care is available. . . ."

Mondale indicated that rural health problems will not be solved overnight, but they can be solved if people in the federal agencies, the medical profession, the states and rural communities begin to make a special effort. The initiative involves three main steps:

1. The Departments of Agriculture and Health, Education and Welfare will cooperate in financing the construction and renovation of 300 rural health care centers over the next four years. These centers will provide care for an estimated 1.3 million medically underserved rural Americans.

2. The Departments of Labor, and Health, Education and Welfare

will jointly undertake special steps to increase the supply of rural preventative and health support staff. Through the comprehensive employment and training program, migrant and seasonal farmworkers will be trained as medical paraprofessionals so that they can gain fulltime employment and, at the same time, help to solve the health needs of their own communities. Similarly, additional Job Corps trainees will be placed in local rural health care centers.

3. We will be consulting over the next several months with communities, medical schools and private groups to explore ways in which we can cooperate more closely in attracting and retraining health professionals in rural areas (Mondale, 1978).

One of the key ingredients that made the White House initiative possible was the execution of a memorandum of understanding between the Departments of Health, Education and Welfare, and Agriculture. This agreement, described as being so simple yet so important by Tresa H. Matthews, rural health specialist (January 1979), provides the basis for the interagency cooperation necessary to make the program work. The process for BCHS projects submitting Farmers Home Administration applications under the HEW/U.S. Department of Agriculture (USDA) joint agreement is presented in Appendix B.

Such an approach should be considered as a possible solution for many other areas where fragmentation characterizes the planning, development and delivery of services to migrant families. Some areas that immediately come to mind are Titles XIX and XX, Bureau of Community Health Services projects, Head Start and migrant education.

Titles XIX and XX of the Social Security Act

Although the Bureau of Community Health Services is the focal point for direct delivery of health care services to migrant workers; it would seem that states also bear some of the responsibility for these services through Titles XIX and XX. Title XX, the 1975 amendment to the Social Security Act (Public Law 93-647), provides for payments to states to offer a wide variety of social services programs. These programs may include day care, homemaker services, services to the handicapped, child and adult protective services, legal services, senior citizen programs, adoption services, and information and referral. Eligibility for these services under Title XX is defined as a family member whose monthly gross income falls below 80 percent of the median income of a family of four in the state, or the median income of four in

the 50 states and the District of Columbia. Based on its population, each state is allotted a share of $2.5 billion in federal funds under Title XX. These funds can be used to pay 75 percent of the costs of social services included on that state's annual social services plan. To obtain the federal money, the state must raise the other 25 percent through state appropriations or through donations from public or private agencies.

There are several important features of Title XX of relevance to interstate migrant workers and their families. Federal law places few restrictions on what states can do with their Title XX money. It does prohibit use of Title XX funds for major medical or subsistence costs, sets maximum limits on eligibility and requires certain administrative and record-keeping procedures. But within these broad guidelines, states are free to design their own programs according to what is wanted and needed within the state. States are free to define their own services, to determine who will receive them and to contract with service providers. Another important feature of Title XX is the requirement that states utilize an open planning process. This gives people a chance to find out what the state is doing with its social service dollars. Many states have used residency requirements to exclude migrants from access to services, yet one part of the planning process of direct relevance to residency is that each state that participates in the program should have a plan applicable to its programs for the provision of the services that:

> (E) provides that no durational residency or citizenship requirement will be imposed as a condition to participation in the program of the state for the provision of the services described . . . (Public Law 93-647, Title XX Grants to States for Services).

The language of the original act has been somewhat refined (Aid to Families with Dependent Children, 1978) and apparently offers states a large loophole on delivery of services to interstate migrant workers. Under a section entitled "Conditions for Approval of State Public Assistance Plans Under the Social Security Act," the guidelines note as follows:

> The state plan may not be approved if it includes:
> 1. Any residence requirement that excludes any person who is a resident of the State, defined by the Secretary of HEW as one who is living in the State voluntarily with the intention of making his home there and not for a temporary purpose. . . .

As can be noted, there is a substantial difference between what the law says about residency and the agency guidelines with respect to the issue. There is considerable difference thereby enabling states to sidestep interstate migrants if they so choose.

Title XX also calls for a high degree of program coordination under a section entitled "Services Program Planning." Section 2004, subsection H, describes one of the characteristics of the comprehensive annual services plan as coordination with other federal programs. The state must provide a description of how the provision of services under the program will be coordinated with the plan of the state approved under Part A of Title IV (Aid to Families with Dependent Children); the plan of the state developed under part B (Child Welfare Services) of that title; the supplemental security income program established by Title XVI; the plan of the state approved under Title XIX (Medical Assistance); and other programs for the provision of related human services within the state, including the steps taken to assure maximum feasible utilization of the services under these programs to meet the needs of the low income population.

Whether interstate migrant workers and their families are part of current state Title XX plans, what services are provided under these titles and how those services are coordinated are questions that must be explored as the task force pursues work in the health area.

Alternative Health Care Delivery Systems

In view of the fact that migrant families tend to be located primarily in rural areas, frequently isolated from medical facilities and on the move, new approaches must be developed in order to effectively deliver health services. Mobile health units have been used with varying degrees of success by BCHS projects in some parts of the country. A 1976 review of mobile health unit effectiveness noted that such units are most successful in delivering quality health care when they are backed up by comprehensive health service systems in permanent facilities, have good physician interest and community support. The report reviewing the BCHS-supported migrant projects that utilized mobile units concluded that:

> The effectiveness of mobile units is limited to highly specialized kinds of activity such as X-ray or dental services and to general

> health maintenance/preventive services such as screening, immunizations, examinations, health education, etc. The mobile unit must be small enough to be readily towed or easily maneuvered on the roads in the area where it is to be used. Equipment should be basic and simple to minimize breakdowns. . . . Mobile units should be used in situations where they supplement the services of a more comprehensive health service system and adequate backup services exist or can be provided (Promoting Community Health, 1976).

Even though the prospects of successful health care delivery using mobile health units appear to be dim on the basis of BCHS findings, many obstacles can be overcome, as evidenced by several successful projects during the past five years.

Some of the projects that have been identified include: the Washington State Summer Health Clinic, the Arkansas Regional Service Center Approach, New York State Health Vouchering System, East Coast Migrant Stream Approach, the California Vision Screening Program and the Arizona Migrant Child Accident Insurance Program. An indepth description of each of these programs is presented in Appendix C; however, there are several noteworthy features identifiable among the various approaches. These include:

1. Coordination and cooperation between the public and private sectors are important ingredients to effective program implementation.

2. Agency cooperation can help reduce program costs significantly.

3. A centralized regional approach for coordinating health services is an effective method of insuring targeting of health dollars and linking migrant families with service providers.

4. Involvement of the private and volunteer sector can facilitate program implementation and help to maximize health dollars.

5. Effective outreach is a critical factor in health service delivery to migrant families.

6. Health service programs that seek to serve interstate migrants should strive to provide rapid data and analysis so that migrants can be reached before they move.

7. It is important to chart migrant population samples to learn when the greatest number of families can be expected in an area.

8. The geographic distribution of migrant camps requires that service providers be highly mobile in order to reach large numbers of families.

As can be noted by the preceding suggestions, health care delivery to interstate migrant workers and their families is considerably different than traditional health care options available to most American families. One element of the health care system familiar to most Americans not yet spoken to is the topic of health insurance. For most American employees, health insurance is offered as a fringe benefit as part of the overall employment package. Although the costs of individual and family insurance programs are rising, many employer benefit plans pay for a portion of the health premiums. This enables employees to pay for insurance that they would otherwise be unable to afford. Individuals who seek health insurance outside of group plans oftentimes find the costs to be prohibitive, especially if the person is in the middle or lower income bracket.

What about insurance for the interstate migrant worker and his family? There is insufficient evidence to determine whether or not migrants participate in health insurance programs as they are commonly known. It can be hypothesized, however, that, because of their socioeconomic status and nature of employment, they probably do not. One exception to this is the Robert F. Kennedy Farm Workers Medical Plan instituted in California in 1969. The Kennedy plan provides health insurance to migrant farmworkers in California and Mexico under certain conditions. It is a benefit offered through the United Farmworkers in La Paz, California. Another insurance plan identified in the course of this investigation is the Arizona Migrant Child Accident Insurance Program described in Appendix C. At the federal level, the Bureau of Community Health Services has set aside $0.855 million for expansion of three entitlement Blue Cross/Blue Shield and prepaid projects that the program has pursued as a demonstration for a limited number of migrants (Manzano, 1979).

One other avenue of possible health care services for migrant workers discussed briefly under Titles XIX and XX is the role of states. To determine whether health services are readily available in a sample state, the Interstate Migrant Education Project sought the services of an attorney to explore this question. J. Peter Williams Jr., an attorney/educator who has contributed to task force work in other areas, was asked to investigate the area of migrant health service delivery and to respond to some specific questions, as well. His overall conclusion, after careful review of available documents and

interviews with administrators and other personnel in Texas, was "The status of health services to migrants is so poor that (in comparison) the delivery of education services actually begins to look magnificent." He also noted, after conducting his review, that in effect "There is *no* delivery of health services to any rural populations in the Southwest — Chicano or otherwise . . . " (February 1979).

It was instructive to review the findings of Williams in the area of health in Texas, which is one of the three large sending states of migrant farmworkers. As part of his work in exploring migrant health services, he dispatched a law clerk to collect information on the National Migrant Referral Project. The degree of difficulty in obtaining accurate information without being given the run-around when it comes to migrant matters is exemplified in the law clerk's utter frustration after contacting several individuals and being referred on to another source: "This whole experience had become a point of honor to me. As a Spanish-surnamed law student, I could not believe that this assignment could prove so frustrating or that I would get such a run-around from fellow Chicanos." (Ybarra, 1979. The complete text of Ybarra and Williams' findings is presented in Appendix D.)

Williams concluded his brief, yet thorough, review of migrant health services at the state level by suggesting that the ECS Interstate Migrant Education Task Force review the health recommendations contained in a special report on Texas migrant labor, prepared by the Good Neighbor Commission of Texas (1977). That report contains excellent recommendations in the health area (presented in Appendix E), and concludes that "In spite of the establishment of health programs specifically earmarked for migrant farmworkers, such as those funded under the federal Migrant Health Act, inadequate appropriations and the lack of programs which offer a full range of health services impede any real progress in improving the health status of the farmworker population. The implementation of a total health care system for farmworkers is long overdue."

Inadequate appropriations to satisfactorily provide health care services for the migrant population appear to be a major obstacle. As pointed out recently by the associate bureau director for migrant health in the Bureau of Community Health Services:

> Needless to say, substantial resources will have to be brought to bear on the migrant health problem, if it is to be resolved. Comprehensive care, including hospitalization, costs between $350 to $450 per person per year, including out-of-pocket expenses. Assuming there are 750,000 migrants and dependents, between $262.5 and $337.0 million would be needed to cover the needs of the migrant and his dependents (Manzano, 1979).

Manzano notes that part of the costs for migrant health are being funded by state and local governments, as well as by the migrant himself; but, he also notes that it is unlikely that much over $50 million is being provided to fund migrant health needs from all federal sources. Using the lower of the two estimates given above, $262.5 million, the $50 million represents barely 19 percent of the needed resources.

If seasonal farmworkers and dependents are included in these calculations, the dollar figures increase substantially. As Manzano indicates, "The required resources for two million seasonal farmworkers and dependents would be approximately $700 to $900 million. Taking all these amounts into account, clearly a substantial gap exists between available resources and estimated requirements. Until this funding issue is systematically addressed and resolved, the resulting unattended health problems of the migrant and seasonal farmworker will continue . . . " (Manzano, 1979).

Summary Findings

It was not the intent of this report to end on a note calling for more money to solve the glaring deficiencies evident in health care delivery to migrant workers. Rather, now that there is an awareness of the enormity of the problems, concerned individuals should seek to identify alternative solutions using available resources.

Whether additional funding would resolve many of the problems identified in health care delivery to migrants or not is debatable. The money has to come from somewhere and should it be federal programs, that usually translates into more deficit spending and higher taxes. Many are of the opinion that the squeeze for more government dollars has to stop somewhere. Perhaps one way of at least striking a balance in the grab for dollars in the health area is to maximize use of current resources. This could be achieved, in part, through careful reallocation of funds, establishing meaningful linkages among agencies, and through a reduction

of the bureaucracy and red tape evident in many programs and government.

To reiterate, some of the major findings of the Interstate Migrant Education Task Force are as follows:

- The health needs of migrants in all service areas, including preventive education, nutrition, dental, routine checkups, treatment and emergency medical care, are critical.

- There are many entities with specific mandates or who purport to serve migrant health needs. Yet, those needs continue to be unmet.

- Data, programs and related information suggesting provision of service to migrant children with special needs, such as handicapped children, are largely unavailable.

- A large percentage of the health problems identified among migrant families is attributable to unsanitary and unsafe working conditions.

- At the federal level, the meager health care delivered to migrants is, for the most part, provided by services through the migrant health program, although prospects for improvement appear brighter.

- Migrants are routinely excluded in most states from services available through various entitlement programs contained in Titles XIX and XX through a tangle of residency and annual income eligibility requirements.

- Agricultural farmwork benefits as an industry in that the health care of its workers is paid by the federal government as opposed to the industry itself.

- There is no clearcut leadership for development of sound policy relating to migrant health in the United States.

- Many alternative approaches that warrant further study and support have been initiated at the state and local levels.

The independent findings and recommendations developed by the task force are surprisingly consistent with many similar investigations identified either during the course of

this investigation or upon its conclusion. It now remains to be seen whether individuals in policy and decision-making positions can begin to more effectively take action in the many areas of identified need.

Task Force Position Statement and Recommendations

On the basis of these findings, it is the position of the Interstate Migrant Education Task Force that:

The migrant farmworker and his family are entitled to parity health, economic opportunity and educational access. Optimal health is important to educational achievement and overall development of all children and should, therefore, be equally emphasized for the migrant child. The task force urges that the following alternatives be considered for future action in the area of health services for migrant farmworkers and their children:

1. Appoint an oversight committee on migrant health. This committee would report annually on the status of migrant health to the U.S. House of Representatives Committee on Education and Labor.

2. Establish a national task force on migrant health to develop recommendations for the secretary of the Department of Health, Education and Welfare.

3. Continue to evaluate migrant health clinics periodically and prepare recommendations for modifications in services, funding procedures and program administration.

4. Encourage counties and states to establish the health needs of migrant farmworkers, fishers and loggers as a priority service population, particularly as those needs can be served through Titles XIX and XX.

5. The MSRTS health records of migrant children who reside in non-Title I project areas be made available to private physicians and migrant health clinics to promote continuity of services.

6. Migrant children be specifically listed in existing and any new health legislation.

7. Place a new emphasis on prevention in migrant health and provide resources to develop capacity to extend health care and carry out initiatives in this area.

8. Initiate a study in the areas of exceptional migrant children, including gifted, handicapped, abused and neglected, to determine what the needs are in these areas and to find out whether these needs are being met by federal, state and local programs.

9. Determine avenues whereby the agricultural and fishing industries can take a more active role in the health and welfare of migrant workers and their families.

10. Identify methods whereby national health organizations, such as the American Academy of Pediatrics and the American Medical Association, can, in conjunction with federal, state and local programs, e.g., USOE Title I Migrant, Head Start, Comprehensive Employment and Training Act, Farmers Home Administration, and Titles XIX and XX, foster joint planning for coordination purposes and thereby assist in resolving migrant health needs.

PART II

APPENDICES

APPENDIX A
Legal Basis for Exchange of Student Information

(Report of J. Peter Williams Jr., Attorney, Austin, Texas)

Can there be an effective data exchange between the states concerning migrant children and the educational programs provided them by the states of the task force?

Yes! There are some minor problems but the problems are subtle and certainly do not amount to proscriptions against such an exchange.

To develop a full explanation of this answer the writer examined all sections of:

1. The 1974 *Family Educational Rights and Privacy Act* hereafter referred to as FERPA, 20-U.S.C. 1232g.
2. Part 99 — *Privacy Rights of Parents and Students*, 45 Code of Federal Regulations, 99.1 et seq.
3. Re-examined applicable state statutes in the eight states of the task force (see *Exhibit A* attached).
4. Examined recent articles in law and law related journals which might point to relevant counsel for the task force.

State Statutes

Along with federal attempts to legislate information practices, states have also acted to protect individual privacy. State laws provide various types of protection for the confidentiality of records. Most states recognize the confidentiality of communications under the doctor-patient privilege. Several states have statutes relating to school records and credit reporting which complement the federal acts. Others have laws protecting the confidentiality of criminal history records and tax return information. Only a few state legislatures have enacted comprehensive acts dealing with state and local governmental data banks and informational practices.[1]

The State of the Law Prior to the Passage of the Buckley Amendment

Before passage of the Buckley Amendment, laws regarding school records varied widely among states. Twenty-four states provided for some form of parental or student access to school records. Of these 24, 15 conferred the right by statute, 3 by administrative regulation and 6 through administrative guideline. Only 5 states explicitly granted the right to contest, correct or expunge information in school files. Ten states expressly permitted release of students' files without parental consent to other than education agencies while 9 prohibited such release.[2]

Passage of FERPA in 1974

On November 19, 1974, the Family Educational Rights and Privacy Act became law. The purpose of the federal law, commonly known as the Buckley Amendment, is to protect the privacy of student records from unauthorized inspection. The law and the final federal rules cover access to student records maintained by certain education institutions and the release of such records.

The right of access by parents and the duty by education institutions to protect the student's privacy are directed *to*

[1] For a detailed listing, *see* COMPILATION OF STATE AND FEDERAL LAWS ON PRIVACY 5 (R. Smith ed. 1976) (hereinafter cited as COMPILATION). *See also* Lautsch, *A Digest of State Legislation Relating to Computer Technology*, 17 Jurimetrics J 39, 44-82 (1976); NATIONAL ASSOCIATION OF ATTORNEYS GENERAL, PRIVACY: PERSONAL DATA AND THE LAW (1976) for compilations of all forms of information practice laws.

[2] NATIONAL COMMITTEE FOR CITIZENS IN EDUCATION, CHILDREN, PARENTS AND SCHOOL RECORDS (1974). This book contains the results of a recent survey of all state laws and regulations.

the education records maintained by any education institution receiving federal funds. Education records are defined by the act to mean those records, files, documents and other materials which contain personally identifiable information directly related to a student and maintained by an education institution or a person acting for the institution. Because of the expanding range of media in which records can be recorded in this electronic age, the term "records" includes handwriting, printing, tapes, film, microfilm and *microfiches.* Future advanced methods of recording information will also be covered by the act. In determining whether a certain record, regardless of the media in which it is recorded, is covered by the act, the record custodian must first determine whether the record personally identifies the student. Any information contained in the record which would make it possible for someone to easily trace the identity of the student will bring the record within the scope of the law. Personally identifiable data would include the student's name, the names of the student's parents or siblings or any other family member; the address of the student or his family; the student's student number or social security number; and a detailed physical description of the student or his photograph.

The act provides that education institutions must obtain the prior written permission of the student's parents before the institution may release the educational records of the student in question.

However, the act makes it clear that where a student is seeking enrollment in another education institution, *the education records of the student may be transferred without prior parental consent.*

The custodian must make a reasonable effort to notify the parents of the transfer at their last known address, advise the parents of their right to challenge the content of the record and advise them of their right to receive a copy of the records transferred. This, of course, does *not mean* that *prior consent* of the parent was needed to effectuate a transfer; it merely means the parent is entitled to some reasonable effort at receiving his copy.

The Code of Federal Regulations should be quoted to further demonstrate the clarity of this point:

Sec. 99.30 reads as follows (in part):

§99.30 Prior consent for disclosure required.

(a)(1) An educational agency or institution shall obtain the written consent of the parent of a student or the eligible student before disclosing personally identifiable information fron the education records of a student other than directory information except as provided in §99.31

Sec. 99.31 reads as follows (in part):

§99.31 Prior consent for disclosure not required.

(a) An educational agency or institution may disclose personally identifiable information from the education records of a student without prior written consent of the parent of the student or the eligible student if the disclosure is —

(1) To other school officials, including teachers, within the educational institution or local educational agency who have been determined by the agency or institution to have legitimate educational interests;

(2) To officials of another school or school system in which the student seeks or intends to enroll, subject to the requirements set forth in §99.34.

The Position of MSRTS

The need for data privacy, as well as the right of students and parents to have access to student records, has been paramount in MSRTS since its beginning in 1969. Among the initial recommendations for record usage that were established by the states, was a copy of each student's record to be given to the student upon his withdrawal. *The position of MSRTS relative to FERPA is that MSRTS is only an administrative extension of the education agencies that provide scholastic and health services for migratory children; therefore, MSRTS is not obligated to directly honor parent or student requests for student data.* Requests for such data are to be made to each local school, which may subsequently request a student's record from the MSRTS Central Depository located in Little Rock. Likewise MSRTS should not have to obtain *prior parental consent* for the transmittal of data to a school enrolling a newly arrived migrant child.

The reader should consider that FERPA and migrant education are both founded on Public Law 93-380, enacted August 21, 1974. It is doubtful that General Counsel for the Department of HEW would ever rule that Congress *intended* for the two sections to be inconsistent in their administration. The same Congress that authorized the Secretary to

fund programs of migrant education and to "use statistics made available by the migrant student record transfer system" (20 U.S.C. 241c-2) did not *intend* to impede the operation of MSRTS by the language of FERPA (20 U.S.C. 1232g).

There have been suggestions to improve the statutory language. The Privacy Protection Study Commission has recommended amendments to the law including the following: Educational agencies and institutions would be required "to formulate, adopt and promulgate an affirmative policy" to implement the Act and to establish information practices to improve the accuracy of records. Initially, the Act was directed primarily at the security of records rather than their accuracy. *The definitions of "educational agency or institution" would be expanded for many purposes to encompass organizations which provide testing of data assembly services under contract to educational agencies or institutions.* Additionally, the definitions of the terms "educational records" and "student" would be expanded. Applicants for student status would have rights under the law if the recommendations are followed.[3]

The public continues to be concerned about data gathering and data dissemination.[4] Some state legislatures have enacted laws on education data. A subtle problem can be examined if we examine the statute of Arizona (a member state of the task force).

Sec. 15.152 of chapter 1.1, Rights of Parents and Guardians to Records, reads as follows:

> §15.152. Permissible use of pupil records.
>
> Pupil records are considered professional and confidential and shall be available under the following circumstances:
>
> (1) To the parents or guardian of the pupil, unless a parent's parental rights have been severed by a court.
>
> (2) To the professional staff of the school district in which the individual is a student.
>
> (3) In accordance with written instructions of a parent or guardian to transfer the records to another school, institution or agency.
>
> (4) To any state or federal agency as long as such records do not identify the student and upon the approval of the local school district board.
>
> (5) With respect to grade transcripts, to any other school or educational institution to which the student is attending or has applied for admittance.
>
> (6) To a pupil or person over the age of 18 whose records are maintained by the school.
>
> Added Laws 1974, Ch. 162, §1.

Subsection (5) above would seem to limit data that might be sent to the next school of a migrant child. Could health records be sent? Could curriculum or course of study be sent? Does the Arizona statute conflict with FERPA? Apparently the answer to this question was "yes." In April of 1978 as this memorandum was completed, the Arizona Legislature repealed 15.151 and enacted a new section of 15.151, parts A and B. See new statute attached as Exhibit B to this note.

If there is a conflict, FERPA regulations are designed to put the onus of change squarely on the state legislature. Regarding conflicts between FERPA and state or local law, the regulations read (in part):

> §99.61. Conflict with state or local law.
>
> An educational agency or institution which determines that it cannot comply with the requirements of section 438 of the act or of this part because a state or local law conflicts with the provisions of section 438 of the act or the regulations in this part shall so advise the designated under §99.60(b) within 45 days of any such determination, giving the text and legal citation of the conflicting law.

The state of Kansas recently enacted corrective legislation to remove the conflicts between its Open Records Law (K.S.A. 45-201 et seq.) and FERPA. The 1976 Kansas Legislature resolved the conflicts by passage of Senate Bill 624 effective July 1, 1976.

Perhaps the most functional piece of legislation in this connection is the 1977 California statute 54444 from Article III (Migrant Children) of California Reorganized Education Code.

Sec. 54444 reads (in part):

> In implementing the plan adopted by the State Board of Education, the Superintendent of Public Instruction is authorized to . . .
>
> (b) Enter into agreements or otherwise cooperate with other states or agencies of the state or the federal government in providing or coordinating services to migrant children including participation

[3]PRIVACY STUDY COMMISSION, Personal Privacy in an Informational Society (1977).

[4]Findings of a Louis Harris Aurvey, *published in* Privacy J. 1 (April 1977). Privacy was rated the most critical issue facing the data processing industry in a survey of 4,000 Data Processing Management Association members in late 1976. COMPUTERWORLD, Dec. 13, 1976, at 1.

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in or utilization of the Migrant Student Record Transfer System.

Section 54445 empowered the California State Board of Education to adopt rules and regulations necessary to implement the provisions of Article Three for Migrant Children.

Thus, the state of California has with the simple language of Sec. 54444 authorized *any kind* of interstate cooperation and the usage of MSRTS.

Exhibit A is a current statement of the statutes concerning privacy of data and the exchange of educational data.

EXHIBIT A

This section, as depicted in this graph, sets forth the available state statutes on privacy of data and statutes pertaining to the exchange of data by governmental bodies.

State	Statute on Privacy of Data	Statute on Exchange of Data by Governmental Bodies
Arizona	§ 15-151 *et seq.*	§ 15-152.3 § 15-152.4
Arkansas	No applicable statute found	No applicable statute found
California	§ 49073 *et seq.*	§ 49076 § 16165 *et seq.*
Florida	§ 232.23	§ 232.23
Michigan	No applicable statute	No applicable statute
New York	No applicable statute	No applicable statute
Texas	No applicable statute	No applicable statute
Washington	No applicable statute	No applicable statute

EXHIBIT B

§ 15-151. Educational records; injunction; special action

A. The right to inspect and review educational records and the release or access to such records, other information or instructional materials is governed by federal law in the Family Educational Rights and Privacy Act, Title 20, United States Code, § 1232g and § 1232h, and federal regulations issued pursuant to such act.

B. In addition to the enforcement procedures provided in such act the superior court of this state may grant injunctive or special action relief of any educational agency or institution or officer or employee of such agency or institution fails to comply with such act regardless whether such agency or institution is the recipient of any federal funds subject to termination pursuant to such act or whether administrative remedies through any federal agency have been exhausted. Added Laws 1978, Ch. 7, § 2, effective April 6, 1978.

APPENDIX B
Process for BCHS Projects Submitting FmHA Applications Under the DHEW/USDA Joint Agreement

The Bureau of Community Health Services (BCHS) ongoing Community Health Centers (CHCs), Migrant Health (MH) projects, Health Underserved Rural Area (HURA) service projects, and new projects applying for grant applications under Section 330 or Section 329 of the Public Health Service Act in medically underserved rural areas having 10,000 or less population are eligible to make application to the Farmers Home Administration (FmHA) for a Community Facility Loan.

The process is as follows:

1. BCHS guidance explaining the application process sent to Regional Offices;

2. Regional Offices sent letters to all eligible projects in their Region (CHCs, MH, HURA service projects, including planning and development grants.) Regional Offices inform new potential grantees and encourages them to apply concurrently to FmHA as appropriate;

3. Tentative lists of projects identified by Regional Offices as having facility needs submitted to the DHEW Central Office (BCHS). BCHS reviews the list and provides tentative approval for projects to make application to FmHA. BCHS provides the list to FmHA National Office. DHEW Regional Offices send a copy of the list to FmHA District Offices;

4. DHEW Regional Offices and FmHA State Offices to follow-up projects on list to encourage and assist them in applying for FmHA loans. Technical assistance (TA) is provided by FmHA State and District Offices as well as DHEW Regional Offices and TA contractors.

5. Projects contact the nearest FmHA District Office in their State for Preapplication forms (AD-621), indicating that they plan to apply under the DHEW/USDA Joint Agreement;

6. Projects submit Preapplication form (AD-621) to FmHA District Office and to the DHEW Regional Office. Copies of each Preapplication form are provided to the FmHA National Office and DHEW Central Office (BCHS) by the appropriate State and Regional Office staff;

7. Projects send a copy of the Preapplication form to the Health Systems Agency, A-95 Agency, State Health Planning Development Agency, and/or Section 1122 Agency as appropriate;

8. FmHA District Office and DHEW Regional Offices consult with each other to facilitate Preapplication activities of projects;

9. Applicant receives "Notice of Preapplication Review" (Form AD-622) from FmHA. Review is completed within 45 days of submission of Preapplication;

10. FmHA District Supervisor arranges for a meeting with a successful applicant to provide copies of appropriate forms appendices, furnish guidance for orderly processing, initiate a checklist to establish a timetable for completion of necessary items required by the applicant and invites DHEW Regional Office to participate;

11. Applicants are responsible for obtaining architectural or engineering services necessary in the planning, designing, bidding, and constructing of their facility;

12. Regional Offices review applications (Form AD-621), verify that the data is consistent with the grant application, recommends approval of the project, and provides data regarding the dollar level of grant support for the project and the National Health Service Corps (NHSC) manpower committed to the project to the DHEW Central Office (BCHS) with a similar letter to the FmHA State Office. BCHS provides the FmHA National Office information on those projects recommended for approval by the DHEW Regional Office and concurred in by the DHEW Central Office (BCHS);

13. Applications are reviewed by the FmHA District Office in consultation with the DHEW Regional Office.

14. Loans are approved by the FmHA State Office. Funding for loans is made available through the FmHA National Office. Lists of funded loans are made available from the FmHA National Office to the DHEW Central Office (BCHS);

15. Copies of the Notice of Loan

Approval together with the funding level will be forwarded to the applicant by the FmHA State Office.

16. *Disapproval:* All projects which are not approved (Preapplication, AD-621/Application, AD-624) should be reported to the DHEW Central Office (BCHS) and to the FmHA National Office by the respective Regional or District Office. Each Regional or District Office should indicate the reason(s) for disapproval. Disapprovals will need concurrence by the DHEW Central Office.

Program Guidance Material for Working Relationship Between the Community Faility Loan Program (CFLP), Farmers Home Administration (FmHA), United States Department of Agriculture (USDA), and the Bureau of Community Health Services (BCHS), Health Services Administration (HSA), Department of Health, Education, and Welfare (DHEW)

Recent efforts of the Federal Government as expressed in both health services delivery and facility planning legislation have been directed toward increasing accessibility to ambulatory health care. A facility construction loan program is administered by the Community Facility Loan Program, Farmers Home Administration, U.S. Department of Agriculture, which is authorized to make loans for essential community facilities. The Health Services Administration, through BCHS' capacity building efforts, supports the development of systems of health care linked to other health care resources, through providing funds to cover start-up and operating expenses of approved health care projects.

In order to coordinate these two programs, the DHEW and USDA have developed a memorandum of understanding, the purpose of which is to more readily make available needed health care facilities to populations in medically underserved rural areas. For this activity FmHA has agreed to set aside up to $25 million for fiscal year 1979 for funding Community Health Centers (CHCs), Health Underserved Rural Area (HURA) service projects, and Migrant Health (MH) projects which are eligible for FmHA loans. FmHA can make loans to BCHS projects (CHCs, HURA, and MH) for up to 100 percent of project costs of construction and renovation (including equipment) at 5 percent interest, up to a maximum term of 40 years. DHEW has agreed to assure the placement of medical manpower at project sites and to provide operating expenses as needed to the maximum extent funding allows during the life of the community facility loan. FmHA loans can be repaid either through the use of grant dollars and/or grant generated income. The following material will set forth the process and requirements which are necessary to that activity.

Eligibility

The Bureau of Community Health Services CHCs, HURA service projects, and MH projects in medically underserved rural areas having 10,000 or less population are eligible to make application to FmHA for a community facility loan.

Communities with neither a health facility nor a primary care service component may jointly and concurrently apply to FmHA and DHEW. However, the FmHA will not approve a loan application until it has assurance from DHEW that the project has been approved to receive an operating grant.

Funding Level

Funds are being made available by FmHA to enable eligible CHCs, HURA service projects, and MH projects of BCHS to meet the immediate need for health care facilities. Therefore, these applicants will be given priority recommendations for funding. FmHA will accept applications at any time during the fiscal year. The formal written agreement (Attachment A) indicates the elements that have been agreed to by both parties.

Application and Review

Eligible CHCs, HURA service projects, and MH projects, according to the guidance material, are encouraged to obtain and submit preapplication forms for a community facility loan from the FmHA District Office by direct contact with that office. A copy of the DHEW notice of grant award should accompany the preapplication form. The applicant should indicate that it is applying under the joint USDA/DHEW agreement.

The applicant should submit the Preapplication Form for review by the FmHA District Office, DHEW Regional Office, HSA, State Health Planning Development Agency (SHPDA) and/or Section 1122 Agency, and the State A-95 Agency. A Notice of Preapplication Review Action is prepared by the District Office within 45 days from the receipt of the

application. The Notice of Preapplication Review Action will state whether the applicant should proceed further with a formal application or whether the application was not favorable. The FmHA District Supervisor will arrange for a conference with a successful applicant to provide copies of appropriate forms and appendices, furnish guidance for orderly application processing, and initiate a processing checklist to establish a timetable for completion of necessary items.

Applicants are responsible for obtaining the engineering or architectural services necessary in the planning, designing, bidding, contracting, and construction of their facility. Technical assistance in these areas can be obtained from BCHS technical assistance contractors in each DHEW Region. This assistance should be requested from the Regional Technical Assistance Coordinator in the Division of Health Services Delivery. The BCHS technical assistance contractors, however, should not be used as a substitute for the complete construction services that are generally provided through an architectural contract.

Applicants are responsible for meeting FmHA facility design and construction requirements. Facilities are also to be designed and constructed in accordance with the requirements of State and local agencies having jurisdiction in such matters. Applicable standards set forth in the National Fire Protection Association's Life Safety Code (NFPA 101) must be met. Such facilities must also comply with Section 504 of the Rehabilitation Act of 1973 (Nondiscrimination on Basis of Handicap). DHEW will accept responsibility for Title VI (Civil Rights Act of 1964) and conduct compliance reviews of grantees offering health services.

Applicants will be responsible for obtaining review of the appropriate State agencies (HSA, SHPDA and/or Section 1122 agency or the State A-95 Agency) certifying that the proposed health care facility is consistent with the health systems plan and State medical facilities plan.

Any exceptions to the above must have prior FmHA National Office concurrence.

The Regional Offices will be asked to review the FmHA application under this joint USDA/DHEW agreement and to verify the approved budget of the Community Health Center, HURA service project, or Migrant Health project grant application in a letter signed by the Regional Health Administrator directed to the FmHA State Office. This letter will provide the dollar level of grant support as well as the NHSC manpower being committed to the project.

Applications will be reviewed by the FmHA State Office in consultation with the DHEW Regional Office. Successful applicants will be funded directly from funds made available from the FmHA National Office. Copies of the Notice of Loan Approval together with the funding level will be forwarded to the applicant by the FmHA District Office.

Memorandum of Understanding Between U.S. Department of Health, Education and Welfare and U.S. Department of Agriculture Regarding Rural Health Facilities

Introduction

The immediate and pressing need for health care services in many rural communities is well documented. However, resources to help meet this need are limited. Therefore, it is extremely important to coordinate Federal programs, which have an impact on rural health care, in order to help rural areas with the most critical health care service problems.

Purpose

The purpose of this Memorandum of Understanding is to coordinate two such Federal programs; HEW's Health Services Administration's (HSA) Community and Migrant Health Center Programs with USDA's Farmers Home Administration's (FmHA) Community Facility Loan Program (CFLP).

Community and Migrant Health Center Programs provide comprehensive primary health care to residents of medically underserved areas. The CFLP is designed to lend money to public bodies, nonprofit corporations, and federally

recognized Indian tribes in rural communities of 10,000 or fewer people. The loan can be used to construct, enlarge, extend, acquire, or otherwise improve essential community facilities, such as medical and health care facilities.

HEW grants cover only operating expenses of rural health care projects and do not assist a community in the construction of clinic facilities. FmHA, on the other hand, can make loans for constructing, enlarging, extending or other improving, and equipping of community nonprofit health facilities.

These two programs can be directed toward the same rural medically underserved areas in order to have the strongest impact in helping to meet the health care needs of these populations. Without this agreement, many of the rural medically underserved areas may not qualify to borrow money for facilities from FmHA, particularly for primary health care facilities. However, with this agreement FmHA will receive the assurance that HEW will provide the clinics with service funds on an ongoing basis which will in turn provide the working capital and cash flow needed by the clinics to repay their facilities loans. Services under this agreement can be available in rural medically underserved areas in all States.

Authorities

The authorities for operation of Community and Migrant Health Center Programs of HSA are Sections 330 and 319 of the Public Health Service Act.

The authority for FmHA, CFLP, is Section 306(a) of the Consolidated Farm and Rural Development Act.

Agreement

USDA and HEW agree as follows:

USDA

FmHA agrees to annually set aside a portion of the Community Facilities funds for Community and Migrant Health Center Program grantees who apply and are eligible for Community Facility loans. The first annual allocation will be up to $25 million. The allocation will be reviewed quarterly to determine if an adjustment is needed.

FmHA agrees to develop application guidance material and technical assistance capability to enable HEW projects to plan, develop and submit applications for Community Facility loans as provided under this agreement.

HEW

HEW agrees to designate the counties and projects from which construction and equipment applications will be prepared and submitted. HEW will prepare an estimate of the number and dollar value of Community Facility loan applications prior to the beginning of each fiscal year and will update it quarterly.

In addition, HEW will submit to FmHA a list of projected expenditures for constructing, enlarging, extending or otherwise improving and equipping of primary health care facilities for fiscal years 1979 through 1983. Revised estimates shall be submitted annually.

HEW agrees to provide FmHA a copy of the project application describing the following project elements:

- need for facility
- existing facilities
- proposed facilities
- people to be served
- providers needed
- facility cost estimate
- annual operating budget
- maps and sketches
- identification (name special health program area)
- conclusion and recommendations

HEW agrees to instruct its grantees to coordinate with transportation networks in their communities.

HEW agrees to assure the provision of medical manpower needed at project sites from the National Health Service Corps or other HEW grant supported medical manpower programs, to the maximum extent funding allows.

HEW agrees to provide projects with operating grants as needed during the life of the community facilities loan, to the maximum extent funding allows.

HEW agrees to furnish FmHA with a periodically updated list of rural medically underserved areas designated for targeting resources in Public Health Service programs which FmHA will forward to its State Directors.

Both

FmHA and HEW agree to develop an application review process which permits FmHA State Directors and HEW Regional Health Administrators joint review, with concurrent review by the national offices of the respective agencies. In addition, both agencies will coordinate the application process with the State offices designated by the Governors to coordinate Federal rural development efforts.

HEW and FmHA agree to develop, publicize, distribute, and explain to their national and field staffs and respective program constituencies the required procedures for submitting facility applications under the joint HEW-FmHA program.

HEW and FmHA national office representatives agree to meet on a quarterly basis to review program progress, resolve operational or procedural problems, and plan necessary modifications or redirection of the program.

Period of Agreement

This Memorandum of Understanding will cover the time period of fiscal year 1979 through the end of fiscal year 1983.

Modification/Cancellation Provision

Request for modifications and amendments to the Memorandum of Understanding may be initiated by either party. Such modifications or amendments will only be effective upon mutual agreement by both parties. Under no condition will either party be allowed unilateral power to modify, veto or amend any component thereof.

Effective Date

This Memorandum of Understanding shall become effective immediately on the date it is signed by the Secretaries of USDA and HEW.

Bob Bergland
Secretary of Agriculture
Oct. 2, 1978

Joseph A. Califano Jr.
Secretary of Health, Education and Welfare
Sept. 29, 1978

APPENDIX C
Alternative Health Care Delivery Systems

Washington State Summer Health Clinic

The Washington summer health clinic is an example of how the work of many dedicated individuals and cooperating agencies can be utilized to serve migrant children in low density and remote parts of a state.

The project was funded under the Elementary and Secondary Education Act, Title I migrant education (Public Law 93-380) at a total cost of $11,602. It was conducted in six Yakima Valley, Washington communities during July and August of 1978. Eight-hundred-twenty-five children received a complete physical evaluation. Six-hundred-twenty-nine of the 825 children received a physical evaluation by a pediatrician. The combined cost figures for the total service was $19.56 per child. The costs per child are notable, particularly when they are compared to resident costs in a private physician's office and the mobile nature of the client. Plus, the figure of $19.56 was somewhat inflated by the consultant costs for planning, evaluation and training, which amounted to approximately $4 per child. This additional cost was offset somewhat by the limited amount of travel and per diem costs required by centralizing the pilot project in the lower Yakima Valley.

The summer clinic is noteworthy, however, not only from the cost-effectiveness and caliber of health services viewpoints, but it is also a prime example of interagency cooperation within a state. The services were funded under the state migrant education program, which provided a staff of nurses, physicians and outreach workers on a mobile van that moved to locations where migrant families were in residence. The services were linked to existing health services of local agencies, schools, child development centers and Head Start programs. This linkage provided screenings, examinations, treatment and immediate referrals for migrant children ages infant to 17 years. Cooperating agencies included the State Department of Social and Health Services, Yakima Farmworkers Clinic of Wapato, the Yakima County Health Department, the Sunnyside School District and the Yakima Valley Medical Society.

The Washington summer clinic and similar nontraditional approaches to health care delivery warrant much more attention by decision makers than has been given in the past. These endeavors are important not only from the cost-effectiveness standpoint; but, more importantly, from the human standpoint where much needless suffering can be prevented. Among the significant findings, the summer clinic found that:

- Although many people only think of the migrant child and his illnesses, they fail to realize that this child, through inadequate immunization and treatment, harbors illnesses that are a threat to the community.
- The incidence of positive tuberculin tests in the migrant child is many times that of the nonmigrant.
- It was estimated that 80 percent (660) of the children demonstrated some degree of nutritional anemia and, of that number, 115 required supplemental iron.
- Such physical conditions as phimosis, poor dentition, etc., were so common as not to be listed on evaluation charts.
- Upper respiratory infections, otitis media, skin diseases, etc., were so significant that it was concluded that one of the first priorities of a repeat program would be on the development of a preventive education program aimed at both home and school to develop an awareness within the family unit.
- Thirteen percent of the children required some type of immediate therapy, and five of these children were so severe that they were referred to the Children's Orthopedic Hospital in Seattle.
- Forty-two children were referred to the local farmworkers clinic or to physicians in the area.
- There were 492 immunizations given by the clinic registered nurse (Migrant Summer Health Clinic Project, 1978).

It is interesting to note that the overall percentage of significant health problems reported in the summer clinic (13 per-

cent) compares favorably with that found in the California study for children ages 3.0 to 3.5 years reported earlier. The overall rate of significant health problems reported in the 1971 to 1975 California study was 15 percent for preschool age boys and 13 percent for preschool age girls.

Arkansas Regional Service Center Approach

Another practical approach to delivery of health services is the regional service center system, which has proved to be very effective in Arkansas. The health service dollar for migrant children in Arkansas is maximized through a regional service center approach that enables migrant families to go to a physician of their choice. A specified amount of Title I migrant education monies provides the basic operating budget for the center. These monies are not given to local education agency (LEA) budgets; rather, they are controlled and expended through the service center budget. This procedure helps to: (1) avoid lack of interest in providing health services for migrant children in some areas, (2) avoid conflicts among agencies and (3) guarantee a fair distribution of available funds in providing health services for migrant children in all school districts.

The service center allocation is used to provide and pay for health services for migrant children in the region. This pool of money is then distributed to schools on a per-pupil formula based on the number of identified and enrolled migrant children in the school district the previous year. Each school superintendent is notified in August of the budget allocation for that district for health services for migrant children enrolled in the district during the year.

There are several key features in the Arkansas regional approach that enable migrant families to access the health delivery system. One aspect is the emergency fund that is maintained by the service center. This fund is established through a percentage set aside of the overall center allocation. This fund is used for emergency situations that arise in any school district during the year.

Another feature of the Arkansas approach is the overall coordinating function of the service center. The center employs two nurses. Each nurse is assigned to work with a group of schools in the region. The nurses work with the same schools throughout the year, which helps to maintain continuity of services. The nurses visit the schools on a regular basis and conduct mini-physicals on all identified and enrolled migrant children. Children with suspected health problems are referred to the appropriate health provider, e.g., dentist or physician. The health provider submits an estimate of the cost of proposed health services to the center. The health records clerk, who is also an employee of the center, in cooperation with the nurse, reviews proposed health service estimates submitted by providers and issues purchase orders for services. The clerk is also responsible for maintaining all referral records and conveying health records to the Migrant Student Record Transfer System in Little Rock. Children's health records are updated by the records clerk through the MSRTS on a weekly basis.

The service center uses four forms in order to conduct the transactions necessary to provide health services. These forms are:

The Referral Form, which is completed by the nurse and regional director. The Referral Form is given to the parent and authorizes the parent to take the child to a physician of his choice.

The Professional Services Purchase Order is sent to the health provider after the physician has completed his portion of the Referral Form and submitted an estimate.

The Prescription Authorization Form is completed by the physician, nurse and regional director, and enables migrant parents to obtain prescriptions at no cost. The pharmacist bills the service center.

A Memorandum is sent to health providers who fail to complete and return the white authorization form provided by the center. The Memorandum reminds providers that payment for services cannot be processed until the authorization form for a given patient is completed.

The Arkansas regional approach, as described by Lubker (January 1979), bypasses many of the typical problems encountered in delivery of health services to migrant children. Two elements seem to contribute substantially to its success.

The first is the Title I migrant education state director's accuracy in projecting migrant student counts and allocating money on a per-pupil basis to state school districts for health services. The second important element is that the health allocation is provided to districts as an over-and-above item in the local education agency budget. Health money is allocated as a separate item, not at the expense of any other program; hence, school districts have little room to complain about health displacing materials or any other budgeted items.

New York State Health Vouchering System

Another approach aimed at insuring effective health services delivery has been described by Richard Bove (1979). In the New York approach, migrant families receive health education and services through one outreach project located at Cornell University. The Bureau of Migrant Education (BME) funds Cornell to validate requests from and release funding to migrant projects in New York state. The process involves payments for family health education programs in communities and clinics, and involves payments for medical services to eligible migrant children as a supportive service to involvement in an education program.

The process for the vouchering program for services to migrant children includes the following:

1. Cornell writes a grant to the BME anticipating funding requests for a given year or part of a year.
2. All migrant funded programs are instructed concerning the procedure for assessing funding.
3. The procedure includes both telephoning requests and completing a form that indicates that funding is not available from some other source.
4. The telephone call insures an immediate response to the need of the child, and the signoff form avoids unnecessary and duplicative expenditures.
5. The signoff form is verified by a field staff person from Cornell and a staff person from the BME. Both are familiar with funding patterns for health services in communities of the state.
6. Physicians and other providers submit their bills either to the local migrant education project or to Cornell University. In either instance, once the bills have been cross-referenced to the request for funding and to the relevant signoff form, Cornell releases the payments.
7. Any questionable requests are referred to the BME for decision (Bove, January 1979).

Through this procedure, the BME can meet the health needs of children, assure a fair determination concerning the need for funding, and centralize all administration, supervision and procedures for meeting health needs of children.

East Coast Migrant Stream Approach

The East Coast migrant health project attempted to insure effective delivery of available resources to migrant families through an extensive volunteer and outreach system in each community where migrants reside. According to Abhold (1977), the project was initiated in three states, four counties and four Congressional districts. In 1977, it was serving eight states, 38 counties having the highest migrant and seasonal worker impact, and 16 Congressional districts. Additionally, since 1975, it had opened 15 comprehensive health planning regions for which miniproposals are written each year in addition to the composite proposal.

Staff members from the project performed many functions, such as linking health providers with migrants, advocacy and initiating needed services. As an example, staff members did advance work with health providers, who were then able to supplement existing services through outreach work. The idea was to bridge the gap between the provider and the migrant. This was done through referrals to agencies already funded for services or directly in clinics where health services were given. Staff members were often called upon to follow up difficult cases who needed special medical attention or social services. Many volunteers from different sectors assisted in the effort. As noted by Abhold, 60 women from religious organizations in 30 communities, 24 laywomen and 15 laymen, including nursing specialists, health educators, social workers and family health workers, volunteered to help farmworkers through the project.

In addition, staff members coordinated services provided by other funded projects, agencies and organizations to avoid duplication and resulting waste of energy and money. In this role, the project supplied both short-term relief

and long-term planning for resolution of some medical problems.

The results of the project, as reported by Abhold, were impressive. Where once no medical service was available within 25 miles for a population of 3,000 to 12,000 migrant farmworkers, the project was able to establish a permanent health clinic that recorded 1,000 users monthly. The program offered comprehensive primary health care, strengthened by access to secondary and tertiary health care within a reasonable distance, through the outreach function of the volunteers.

Many similar successes are reported by Abhold (October 1977), who concluded that:

> . . . While developing a comprehensive health center with the enviable availability of a complete range of services is praiseworthy, it is another thing to make these accessible and acceptable to all the people within that catchment area. Persons can live in the area who have neither the knowledge nor the means to receive very necessary medical care because it is out of reach physically and economically. Accountable stewardship of accumulated resources requires an outreach effort by those who administer them. . . .

The present status of the East Coast migrant stream approach is not known; however, Abhold's description of previous efforts demonstrates the importance of advance work, volunteers and outreach functions in health care delivery to the interstate migrant worker and his family. The significant role that outreach must play in delivering services to migrant families is also evidenced in provision of vision screening services available in California for the past several years.

California Vision Screening Program

Since 1973, the state of California has operated an "on the run" vision care program that has served thousands of migrant children. As reported in an article by Miller (1976), the vision screening program was initiated by Dr. Lorance W. Harwood to answer the following questions:

1. How can the health care community, which has traditionally oriented its services toward geographically stable populations, meet the needs of migrant families?
2. What steps can be taken to reduce the financial burden of good health services?
3. What combination of local, state and federal resources is available to meet the needs of migrant families?

To answer those questions, Dr. Harwood and Dr. Marshall Stadt designed a pilot project that provided vision screening for more than 8,000 migrant children in northern California in a two-year period. The basic operational plan of the program was to screen all children under age 6 initially, with older children accepted on a per-opportunity basis. The camps were scheduled for preliminary diagnostic screening on the dates in which their populations would be greatest. Optometric care was rendered in the camp, with diagnosis for lenses being done on the same day or the day following the preliminary diagnostic survey. Optometric prescriptions were ordered and delivered in the shortest time possible, while those requiring medical care were referred immediately to the nearest cooperating county hospital or physician. Preschool children were given examinations at day care centers, and older children were seen in regional education centers provided at public schools in neighboring towns.

A series of tests known as the Modified Clinical Technique (MCT) were used to locate those children with ocular problems. Children with problems in the MCT were then given a complete vision examination to fully describe the difficulty and determine corrective action.

In the first two years (1973 and 1974), approximately 8,900 children were seen in northern California at a cost estimate of $6 per child for the entire range of services provided in the program. The screening revealed that nearly 11 percent of the preschoolers had ocular problems that required further evaluation. Results also indicated that the number of children with ocular problems increased with age. The program found that, by the time the children are in the fourth grade, nearly 20 percent would probably need care.

The vision screening program initiated in California has been highly successful and has been replicated in many states. Miller notes that it offers, as one aspect of better health planning, the opportunity to improve the lives of America's migrant children. In terms of unique problems that must be considered when planning for migrant health programs, Dr. Harwood identified three major concerns: First, any vision care program has to provide rapid data and analysis so that

migrants can be reached before they move from the target area. Second, to reach the greatest number of children, it is necessary to chart migrant population samples to learn when the greatest number of families could be expected in an area. Finally, the geographic distribution of the migrant camps requires that optometrists be highly mobile in order to reach large numbers of children.

Arizona Migrant Child Accident Insurance Program

The Arizona Accident Insurance Program offers coverage to migrant children who experience accidental injuries, including those from interscholastic sports activity. The program excludes coverage of accidents sustained as a result of riding in a car or on a motorcycle, unless the vehicle was at the time being used for transportation to or from school or from a school activity, such as a field trip. The Arizona Program is described in a brochure written in English and Spanish. The brochure presents some of the highlights of the program for purposes of communicating with migrant parents. Sections of the program, as presented in the brochure, are presented below.

Arizona Migrant Child Accident Insurance Program

1. To qualify for Migrant Program Insurance, a child must move across school district boundaries in order that a member of his immediate family might secure temporary or seasonal work in agriculture, fisheries or related industries. A child whose family has ceased to migrate remains eligible for the insurance for five years, as long as he is annually enrolled in the MSRTS.
2. Upon enrolling your child in a school having the MSRTS, insist he or she be placed in the MSRTS immediately. The insurance does not become effective until the child's enrollment has been received at an MSRTS terminal, regardless how long he or she has been in school.
3. Children age 0 to 4 are eligible for the MSRTS. They are covered by Migrant Program Insurance if they attend a Title I Migrant preschool program.
4. Even though you may withdraw your child from school or approved day care facility, he or she will continue to be covered by the insurance until the next September 30, unless your family moves to another state.
5. If your child is injured, contact your school district office, migrant home visitor, or if your child is not currently enrolled in school, the Migrant Child Education Office, 1535 W. Jefferson, Phoenix, Arizona 85007, phone 255-5138. Someone will help you to fill out a claim form for you to take to the doctor or hospital for signatures. You are responsible for sending the completed form to the insurance company. A claim must be filed within 90 days of the injury. Additional medical bills for the same injury do not require a second claim form and may be sent directly to the insurance company. Bills that are not covered by the insurance will be returned to you.
6. Any questions you have about a particular claim that the school can't answer should be directed to the migrant insurance adjuster at Great Republic Life Insurance Company, 8841 North 7th Street, Phoenix, Arizona 85020 (602) 997-7441.
7. If you enroll your child in a school district not implementing the MSRTS, insist the school district look into the possibility of becoming part of the MSRTS by contacting the officer of the State Supervisor of MSRTS, 1535 West Jefferson, Phoenix, Arizona 85007, (602) 255-5138.

Questions About Migrant Child Accident Insurance Program

Q: Does the accident insurance cover a tonsillectomy or other surgery?
A: No. Only when the surgery is due to an accident.

Q: Is a migrant student covered for accidents while committing a crime? What about alcohol, drugs or fights?
A: No. If, for example, a student cuts his hand while breaking through a store window, he is not covered. If the student is accidentally injured while under the influence of alcohol or drugs, he is not covered. A student is not covered for injuries received from a fight.

Q: If a child is injured by a gunshot wound, is he covered?
A: Yes. As long as the injury is caused from an accident, for example, while hunting. A gunshot wound from a fight is not covered.

Q: My child was injured in another state while we were enroute to Arizona to work. Is he covered?
A: No. Only a few states provide insurance for migrant students even though all states implement the MSRTS and other migrant programs. The Migrant Program Insurance provided by

Arizona covers only those accidental injuries which happen while a student resides here.

Q: What is included in the term dismemberment?
A: Loss of both hands, loss of both feet, loss of sight in both eyes or any combination thereof is covered for $10,000. Loss of one hand, loss of one foot or loss of sight in one eye is covered for $1,000. The loss must result within 90 days of the injury.

Q: Does the parent receive a copy of the insurance policy?
A: No. The school has the policy.

Q: What if my child is injured during the summer and there is no one at the school to help me file a claim?
A: You will have to do it yourself. Claim forms are available from Great Republic Life Insurance Company, whose address is listed on the back of this booklet. Claim forms and assistance are available from the MSRTS office, whose address is also listed on the back of the booklet.

Program Contacts

Program	Contact
Washington State Summer Health Clinic	Mr. Raul de la Rosa Supervisor of Migrant Education Division of Special Programs and Services Office of the Superintendent of Public Instruction Old Capitol Building, Room 310 Olympia, Washington 98504 (206) 753-3220
Arkansas Regional Service Center	Mr. Herman L. Lubker Superintendent Bald Knob School District P.O. Box 320 Bald Knob, Arkansas 72010 (501) 724-3361
New York State Health Vouchering System	Mr. Richard A. Bove Chief Bureau of Migrant Education State Education Department EBA, Room 883 Albany, New York 12224 (518) 474-6109
Arizona Migrant Child Accident Insurance Program	Dr. J. O. Maynes Jr. Director Migrant Child Education Department of Education 1535 West Jefferson Phoenix, Arizona 85007 (602) 255-5138

APPENDIX D
Health Care Delivery in Texas

Report from Xavier Ybarra:

I commenced my investigation concerning data on availability of migrant health services on February 1, 1978, by going to the Governor's Office of Migrant Affairs (GOMA) at 411 West 13th Street, 8th Floor.

They had no information, directed me to National Migrant Referral Project, 454-4523. This receptionist told me they had no information, but she directed me to Juarez Lincoln.

The secretary at Juarez Lincoln stated that they had no ongoing information. They may have some information, but it is packed in boxes and they do not have the manpower to look for it. She suggested I try the Austin ISD.

I talked with Kathleen Bryan, a nurse with the school district's migrant program. She told me that she had no literature on the subject, but she did inform me that the program is part of Title I. If a school district is interested, it must go through the Texas Educational Agency for approval. Her job is mainly a screening program. Any further medical attention is provided through other agencies or the child's own physician. Bryan told me to contact Dan Cardenas with the National Migrant Referral Project.

I tried to contact Cardenas, but he was in a meeting for most of the afternoon. I continued my efforts to get through to Cardenas for a full week. I finally got through to him on February 7 and he was (then) most helpful.

This whole experience had become a point of honor to me. As a Spanish-surnamed law student, I could not believe that this assignment could prove so frustrating or that I would get such a run-around from fellow Chicanos.

Responses of J. Peter Williams Jr. to specific questions.

1. How is migrant health data transmitted?
   A paper written on the topic, *The Health of Migrant Americans in the South* would have you believe it is transmitted in the Migrant Student Record Transfer System. The nurse at Austin Independent School District says "not so." She claimed, like St. Edward's University, that Austin ISD did all that workup "from scratch." Nothing in the Code of Federal Regulations would *require* schools to send medical data.

2. How do migrant health services exchange data?
   The National Migrant Health Referral System Project Prospectus for 1978-79, supported by the HEW migrant health office and assisted by a special task force, redesigned the referral system. The project prospectus describes some of the major elements of the system, including the personal health card, a new referral card, a health services directory and migrant telephone service. All these plans could have been initiated in the late 1950s. There is evidence here that virtually no effective transmittal has occurred in the past.

3. Does anyone in Texas Education Agency (TEA) know how many migrant children are in special education?
   Three top officials (two in the division of special education and migrant education) professed not to know if any data existed on this question.

4. If a migrant child is in special education, does his individual education plan (IEP) go with him?
   A top level official in special education said that no student's IEP's were going into the MSRTS. Their course of studies, grades, age, sex, etc., were the only data transmitted. There is no national IEP format as yet.

5. Is there any data as to child abuse and neglect in the select groups known as migrant children?

We have no one who even knows where to look for that data. Regular reports of child abuse at the Department of Social Welfare (now called Department of Human Services) do not indicate that a child is a migrant child.

APPENDIX E

Texas Migrant Labor: A Special Report Submitted to the Governor and Legislature, 1977

Health Recommendations

I. Safety and Health Practices

A. The Occupational Safety and Health Administration (OSHA) within the Department of Labor should strenuously enforce agricultural safety and health standards.

B. The Occupational Safety and Health Administration should work with the Environmental Protection Agency to protect farmworkers from the dangers of pesticides through the development of a reporting system on the number of injuries suffered due to pesticides exposure, and through the requirement of reentry standards (i.e., the time period needed after a pesticide has been used until it is safe to pick the crop).

C. The Inter-Agency Task Force on Migrant Labor should form a working group to initiate the development of a Texas sanitation law similar to the federal OSHA law.

D. A state conference on migrant farmworker health care should be held on an annual basis and its proceedings should be widely disseminated among health care providers, appropriate state/federal agency administrators and legislators.

E. The Texas Water Development Board and the Texas Water Quality Board should assess water supply and sewage disposal needs in the "colonias" of the Rio Grande Valley and assist in providing access to a safe water supply and an adequate sewage treatment system.

II. Health Manpower

F. The Legislature and state supported universities should take necessary actions to increase the utilization of mid-level health practitioners to meet the health needs in health manpower shortage areas.

G. The Legislature should appropriate $1.2 million for the 1978-79 biennium to the State Rural Medical Education Board for loans to medical students agreeing to practice in rural areas.

H. The Texas Education Agency and the Texas College and University System Coordinating Board should explore the utilization of the California Medi-Corps concept as a means of providing new career opportunities for migrant youth and in increasing the number of health-related personnel who are sensitive to the needs of the farmworker family.

III. Health Care Systems

I. The Department of Health, Education and Welfare, and the Department of Labor should consider and pilot various health care approaches for migrant farmworkers, such as the Laredo "fee for service plan" and the "prepaid plan" utilized by Su Clinica Familiar.

J. Increased appropriations should be requested for funding migrant health clinics by the Department of Health, Education and Welfare.

K. The National Migrant Health Referral Project should request the necessary funds and take appropriate actions to have all migrant health providers utilize and participate in their program.

L. The Good Neighbor Commission and other state agencies should initiate more effective communication and coordination with Mexico on mutual health-related issues such as health insurance, communicable disease control and professional exchange of information.

M. A federal task force, chaired by the Department of Health, Education and Welfare, should develop and implement a national farmworker-health policy.

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Doris D. Ray, Teacher, West Valley High School, Alaska
Wayne Teague, Superintendent of Public Instruction, Alabama
Barbara S. Thompson, Superintendent of Public Instruction, Wisconsin
Charles W. Turnbull, Commissioner of Education, Virgin Islands
Charles D. Wagoner, D.D.S., Member, State Board of Education, West Virginia
George B. Weathersby, Commissioner for Higher Education, Indiana
Harris J. Wollman, Secretary of Education and Cultural Affairs, South Dakota

Education Commission of the States

The Education Commission of the States is a nonprofit organization formed by interstate compact in 1966. Forty-seven states, American Samoa, Puerto Rico and the Virgin Islands are now members. Its goal is to further a working relationship among governors, state legislators and educators for the improvement of education. This report is an outcome of one of many commission undertakings at all levels of education. The commission offices are located at Suite 300, 1860 Lincoln Street, Denver, Colorado 80295.

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