A symposium will be held next month (April) in New York City dedicated to educating people in health careers. Through the Regional Medical Program, planning for health careers now involves all seven universities and the community colleges of the five boroughs.

It would indeed be an unthinkable waste of public planning funds as well as a severe setback to a new spirit of cooperation that has developed among the many separate and independent professional and institutional components of the health enterprise not to extend this legislation—a program with so much promise, which is so widely accepted and on behalf of which so many public spirited professional and non-professional people have made substantial contributions of their time, needs continuing Federal support.

MIGRANT HEALTH PROGRAM

The Migratory Workers provisions of H.R. 15758 would extend the six-year old Migrant Health Program for another two years. The plight of the migrant farm worker in this country has been widely publicized in recent years, but the publicity in no way cushions the shock that must be felt by every thinking American upon being reminded that people living in this country today, working amidst plenty, must endure such squalor. The average annual income of the migrant farm worker in 1965 was $1,400. While the average annual expenditure for personal health care is more than $200 for all Americans, the figure is only $12 per year for the migrant, including $7.20 in Federal funds and $4.80 from other sources.

At present only an estimated one-third of the total migrant population has access to Migrant Health Act project services. During the 1967 fiscal year, one-fourth of the Nation's migrants had access to project services for a brief period only. This means that of the one million men, women and children, who travel the migrant stream, only about 350,000 have access to Migrant Health Act project services.

By August 1, 1967, 115 public or private nonprofit community organizations were using migrant health grants to help them provide medical, nursing, hospital, health education and sanitation services to their seasonal migrants; but, three-fifths of the counties identified as migrant home-base or work areas are still untouched and service coverage remains weak in many of the areas where projects are now receiving grant assistance.

One or more migrant health projects operate in 36 states and Puerto Rico. Each project serves migrants in from one to 20 countries. Community-based projects offer personal health care to migrants in about two-fifths (270) of the 726 counties thus far identified as migrant work or home-base areas. They offer sanitation services in most of these and an additional 142 counties. About 40 home-base counties, reporting an estimated outmigration of 200,000 persons, are included in migrant health project areas in southern Florida, Texas, New Mexico, Arizona, southern California and the bootheel of Missouri. Continuity of care becomes more possible as project services are provided at strategic points along major migration routes. Personal health records carried by the migrants facilitate continuity and help to avoid duplication or gaps in services. Project reports indicate that from 10 to 90 percent of the migrants contacted present a personal health record upon request. A few state-level projects provide sanitation, nursing or other services throughout the state wherever a major migrant influx exists. This is most likely to be true in the case of sanitation services.

For continuity of care and protection, migrants need access to health services in every county where they live and work temporarily. Because geographic coverage by project services is still far from complete, a total of 750,000 migrants had no access to personal health care provided through projects in 1966. The remainder had ready access to personal health services for only part of the year.

Only one out of three counties with migrants offered grant-assisted personal health care geared to the special needs of migrants during 1966. Only six out of ten counties offered protection of their living and working environment through sanitation services with grant assistance. Lack of continuity of health care will remain a problem as long as many communities have no place to which a migrant can turn and expect to find needed health care. Recently, in one of the wealthiest states in the nation, a migrant with an emergency illness was refused care by 4 hospitals because he could not assure payment of the bill. At the fifth hospital where he obtained attention, doctors said that the patient would have died if he had had to shop around for hospital treatment for another two hours.