Migrant farmworkers are not commuters. They travel so far from their homes that they must establish a temporary residence in one or more other locations during each crop season. On the average, the people live and work in two or three locations annually. They may move several times from farm to farm or camp to camp at each location. At each of his temporary homes the migrant needs access to health services and a safe home and work environment; but his home base and work communities are typically rural, isolated, lacking in both economic resources and health resources. As a result the typical migrant home is small, overcrowded, and of substandard construction. It often lacks facilities for food storage and preparation. It often lacks adequate and safe water supply for drinking, dishwashing, bathing, and laundry. The area too often lacks adequate sewage and waste disposal facilities which attracts insects and rodents. There are no recreational areas or facilities. The typical places where they work are exposed to heat, cold, wind, dust, chemicals and mechanical hazards. They lack safe and accessible water for drinking or washing and they lack adequate toilet facilities. On some farms there are no facilities at all. All of us have a stake in the continuation and extension of this program.

The migrant's road to health care is beset with obstacles—as the side of the migrant is poverty, lack of health knowledge, isolation, fear of non-acceptance by the community. On the side of the community are legal restrictions against serving nonresidents, legal exclusion from protective legislation, health planning priorities that exclude migrants, inadequate health manpower, inadequate financial resources, problems of serving a mobile group and resistance to minority groups. Many of the communities where migrants live and work temporarily are themselves considered poverty areas.

Little wonder then that the accident mortality rate for migrants is 1964 was nearly three times the U.S. rate. It was 6 percent greater than the U.S. rate 30 years ago. Migrants' 1964 mortality from tuberculosis and other infectious diseases was 2½ times the national rate, approximately the national average of over a decade ago. Their mortality from influenza and pneumonia was more than twice the national rate and slightly in excess of the U.S. rate for 1940.

The infant mortality rate reflects like an index the results of our nation's apathy toward these workers. In 1964 the infant mortality rate among migrants was at the level of the country as a whole for 1949. The maternal mortality rate is 1964 was the same as the national level of a decade ago.

Of the more than one million migrants, including workers and their dependents, 650,000 still live and work outside the areas served by existing migrant health projects. By conservative estimates, this group includes:

1. Over 6,500 persons with diabetes who are without adequate medical care.
2. Over 5,000 migrants with tuberculosis who are traveling and working with their disease undetected and untreated.
3. Over 3,000 children under the age of 18 who have suffered cardiac damage as a result of rheumatic fever. These children are not likely to receive treatment for prevention of reinfection and further cardiac damage. Such treatment in ordinarily available to most nonmigrant children in their communities.
4. Approximately 9,800 children have untreated firm deficiency anemia. This increases their susceptibility for childhood infection and interferes with their normal growth and development.
5. Over 250 infants who will die in the first year of life as a result of congenital malformation or disease. Early, adequate medical care will not be available for these infants.
6. Over 16,000 expectant mothers who will find it difficult to obtain prenatal care. Infant and material mortality rates can be expected to be significantly higher under such conditions.
7. Between 20,000 to 30,000 individuals who have enteric parasitic infestations—resulting in most cases from poor sanitation. Such a problem is almost nonexistent in the general public.

Before the passage of the Migrant Health Care Act in 1962 the migrant farmworker had virtually no medical care available to him and to his family. Only in grave emergencies did he get care, and even then he was frequently denied the needed medical services. Much progress has been made since 1962 but there is still a long way to go before the migrant farmworker and his family will have available even the barest minimum of medical services.

Certain facts are highlighted which show progress is being made, but there is also evidence that the progress is too slow, and only a small segment of the migrant population is the beneficiary of the migrant health program.