HEALTH CLINICS FOR MIGRATORY FARMWORKERS

HEARING

BEFORE A

SUBCOMMITTEE OF THE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE HOUSE OF REPRESENTATIVES

EIGHTY-SEVENTH CONGRESS

SECOND SESSION

ON

S. 1130

AN ACT TO AMEND TITLE III OF THE PUBLIC HEALTH SERVICE ACT TO AUTHORIZE GRANTS FOR FAMILY CLINICS FOR DOMESTIC AGRICULTURAL MIGRATORY WORKERS, AND FOR OTHER PURPOSES

H.R. 5285, H.R. 5849, H.R. 6114, H.R. 6480, and H.R. 7088

BILLS TO AMEND TITLE III OF THE PUBLIC HEALTH SERVICE ACT TO AUTHORIZE GRANTS FOR IMPROVING DOMESTIC AGRICULTURAL MIGRATORY WORKERS' HEALTH SERVICES AND CONDITIONS

H.R. 8882

A BILL TO AMEND TITLE III OF THE PUBLIC HEALTH SERVICE ACT TO AUTHORIZE GRANTS FOR FAMILY CLINICS FOR DOMESTIC AGRICULTURAL MIGRATORY WORKERS, AND FOR OTHER PURPOSES

FEBRUARY 15, 1962

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Committee on Interstate and Foreign Commerce

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HEALTH CLINICS FOR MIGRATORY FARMWORKERS

THURSDAY, FEBRUARY 15, 1962

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH AND SAFETY,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:10 a.m., in room 1334, New House Office Building, Hon. Kenneth A. Roberts (chairman of the subcommittee) presiding.

The CHAIRMAN. The subcommittee will please be in order.

The subcommittee has before it today S. 1130, a bill to provide Federal grants to communities to assist in the provision of health services and medical care to domestic agricultural migrant workers and to their families. This bill has been passed by the Senate and referred to this subcommittee for consideration.

We have also before the committee several bills which deal with the same subject: H.R. 5285, by Mr. Zelenko; H.R. 5849, by Mr. Fulton; H.R. 6114, by Mr. Kowalski; H.R. 6480, by Mr. Farbstein; H.R. 7088, by Mr. Cohelan; and H.R. 8882, by Mr. Ryan. Copies of these bills and agency reports will be inserted at this point in the record.

(The bills mentioned plus agency reports are as follows:)

[S. 1130, 87th Cong., 1st sess.]

AN ACT To amend title III of the Public Health Service Act to authorize grants for family clinics for domestic agricultural migratory workers, and for other purposes

Be it enacted by the Senate and House of Representative of the United States of America in Congress assembled, That title III of the Public Health Service Act (42 U.S.C., chapter 6A, subchapter II) is amended by inserting at the end of part A thereof the following new section:

"GRANTS FOR FAMILY HEALTH SERVICE CLINICS FOR DOMESTIC AGRICULTURAL MIGRATORY WORKERS

"SEC. 310. (a) There are hereby authorized to be appropriated for the fiscal year ending June 30, 1962, and for each fiscal year thereafter, such sums, not to exceed $3,000,000 for any year, as may be necessary to enable the Surgeon General (1) to make grants to public or other nonprofit agencies, institutions, and organizations for paying part of the cost of (i) establishing and operating family health service clinics for domestic agricultural migratory workers and their families, including training persons to provide services in the establishing and operation of such clinics, and (ii) special projects to improve health services for and the health conditions of domestic agricultural migratory workers and their families, including training persons to provide health services for or otherwise improve the health conditions of such migratory workers and their families, and (2) to encourage and cooperate in intrastate or interstate programs, for the purpose of improving health servies for or otherwise improving

the health conditions of domestic agricultural migratory workers and their families.

"(b) The Surgeon General is authorized to appoint an expert advisory committee to advise him in connection with the administration of this section, including the development of program policies and the review of grant applications."

Passed the Senate August 25, 1961.

Attest: FELTON M. JOHNSTON,
Secretary.

[H.R. 5285, 87th Cong., 1st sess.]

A BILL To amend title III of the Public Health Service Act to authorize grants for improving domestic agricultural migratory workers' health services and conditions

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That title III of the Public Health Service Act (42 U.S.C., chapter 6A, subchapter II) is amended by inserting at the end of part A thereof the following new section:

"GRANTS FOR IMPROVING DOMESTIC AGRICULTURAL MIGRATORY WORKERS' HEALTH SERVICES AND CONDITIONS

"SEC. 310. (a) There are hereby authorized to be appropriated for the fiscal year ending June 30, 1962, and for each fiscal year thereafter, such sums, not to exceed $3,000,000 for any year, as may be necessary to enable the Surgeon General (1) to make grants to public or other nonprofit agencies, institutions, and organizations for paying part of the cost of special projects to improve health services for and the health conditions of domestic agricultural migratory workers and their families, including training persons to provide health services for or otherwise improve the health conditions of such migratory workers and their families, and (2) to conduct studies, investigations, and demonstrations, to train Federal or other personnel for providing such services or otherwise improving such conditions, and to encourage and cooperate in intrastate or interstate programs, for the purpose of improving health services for or otherwise improving the health conditions of domestic agricultural migratory workers and their families.

"(b) The Surgeon General is authorized to appoint an expert advisory committee to advise him in connection with the administration of this section, including the development of program policies and the review of grant applications."

[H.R. 5849, 87th Cong., 1st sess.]

A BILL To amend title III of the Public Health Service Act to authorize grants for improving domestic agricultural migratory workers' health services and conditions

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That title III of the Public Health Service Act (42 U.S.C., chapter 6A, subchapter II), is amended by inserting at the end of part A thereof the following new section:

"GRANTS FOR IMPROVING DOMESTIC AGRICULTURAL MIGRATORY WORKERS' HEALTH SERVICES AND CONDITIONS

"SEC. 310. (a) There are hereby authorized to be appropriated for the fiscal year ending June 30, 1962, and for each fiscal year thereafter, such sums, not to exceed $3,000,000 for any year, as may be necessary to enable the Surgeon General (1) to make grants to public or other nonprofit agencies, institutions, and organizations for paying part of the cost of special projects to improve health services for and the health conditions of domestic agricultural migratory workers and their families, including training persons to provide health services for or otherwise improve the health conditions of such migatory workers and their train Federal or other personnel for providing such services or otherwise improving such conditions, and to encourage and cooperate in intrastate or interstate programs, for the purpose of improving health services for or otherwise

improving the health conditions of domestic agricultural migratory workers and their families.

"(b) The Surgeon General is authorized to appoint an expert advisory committee to advise him in connection with the administration of this section, including the development of program policies and the review of grant applications."

[H.R. 6114, 87th Cong., 1st sess.]

A BILL To amend title III of the Public Health Service Act to authorize grants for improving domestic agricultural migratory workers' health services and conditions

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That title III of the Public Health Service Act (42 U.S.C., chapter 6A, subchapter II) is amended by inserting at the end of part A thereof the following new section:

"GRANTS FOR IMPROVING DOMESTIC AGRICULTURAL MIGRATORY WORKERS' HEALTH SERVICES AND CONDITIONS

"SEC. 310. (a) There are herby authorized to be appropriated for the fiscal year ending June 30, 1962, and for each fiscal year thereafter, such sums, not to exceed $3,000,000 for any year, as may be necessary to enable the Surgeon General (1) to make grants to public or other nonprofit agencies, institutions, and organizations for paying part of the cost of special projects to improve health services for and the health conditions of domestic agricultural migratory workers and their families, including training persons to provide health services for or otherwise improve the health conditions of such migratory workers and their families, and (2) to conduct studies, investigations, and demonstrations, to train Federal or other personnel for providing such services or otherwise improving such conditions, and to encourage and cooperate in intrastate or interstate programs for the purpose of improving health services for or otherwise improving the health conditions of domestic agricultural migratory workers and their families.

"(b) The Surgeon General is authorized to appoint an expert advisory committee to advise him in connection with the administration of this section, including the development of program policies and the review of grant applications."

[H.R. 6480, 87th Cong., 1st sess.]

A BILL To amend title III of the Public Health Service Act to authorize grants for improving domestic agricultural migratory workers' health services and conditions

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That title III of the Public Health Service Act (42 U.S.C., chapter 6A, subchapter II) is amended by inserting at the end of part A thereof the following new section:

"GRANTS FOR IMPROVING DOMESTIC AGRICULTURAL MIGRATORY WORKERS' HEALTH SERVICES AND CONDITIONS

"SEC. 310. (a) There are hereby authorized to be appropriated for the fiscal year ending June 30, 1962, and for each fiscal year thereafter, such sums, not to exceed $3,000,000 for any year, as may be necessary to enable the Surgeon General (1) to make grants to public or other nonprofit agencies, institutions, and organizations for paying part of the cost of special projects to improve health services for and the health conditions of domestic agricultural migratory workers and their families, including training persons to provide health services for or otherwise improve the health conditions of such migratory workers and their families, and (2) to conduct studies, investigations, and demonstrations, to train Federal or other personnel for providing such services or otherwise improving such conditions, and to encourage and cooperate in intratstate or interstate programs, for the purpose of improving health services for or otherwise improv-

ing the health conditions of domestic agricultural migratory workers and their families.

"(b) The Surgeon General is authorized to appoint an expert advisory committee to advise him in connection with the administration of this section, including the development of program policies and the review of grant applications."

[H.R. 7088, 87th Cong., 1st sess.]

A BILL To amend title III of the Public Health Service Act to authorize grants for improving domestic agricultural migratory workers' health services and conditions

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That title III of the Public Health Service Act (42 U.S.C., chapter 6A, subchapter II) is amended by inserting at the end of part A thereof the following new section:

"GRANTS FOR IMPROVING DOMESTIC AGRICULTURAL MIGRATORY WORKERS' HEALTH SERVICES AND CONDITIONS

"SEC. 310 (a) There are hereby authorized to be appropriated for the fiscal year ending June 30, 1962, and for each fiscal year thereafter, such sums, not to exceed $3,000,000 for any year, as may be necessary to enable the Surgeon General (1) to make grants to public or other nonprofit agencies, institutions, and organizations for paying part of the cost of special projects to improve health services for and the health conditions of domestic agricultural migratory workers and their families, including training persons to provide health services for or otherwise improve the health conditions of such migratory workers and their families, and (2) to conduct studies, investigations, and demonstrations, to train Federal or other personnel for providing such services or otherwise improving such conditions, and to encourage and cooperate in intrastate or interstate programs, for the purpose of improving health services for or otherwise improving the health conditions of domestic agricultural migratory workers and their families.

"(b) The Surgeon General is authorized to appoint an expert advisory committee to advise him in connection with the administration of this section, including the development of program policies and the review of grant applications."

[H.R. 8882, 87th Cong., 1st sess.]

A BILL To amend title III of the Public Health Service Act to authorize grants for family clinics for domestic agricultural migratory workers, and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That title III of the Public Health Service Act (42 U.S.C., chapter 6A, subchapter II) is amended by inserting at the end of part A thereof the following new section:

"GRANTS FOR FAMILY HEALTH SERVICE CLINICS FOR DOMESTIC AGRICULTURAL MIGRATORY WORKERS

"SEC. 310. (a) There are hereby authorized to be appropriated for the fiscal year ending June 30, 1962, and for each fiscal year thereafter, such sums, not to exceed $3,000,000 for any year, as may be necessary to enable the Surgeon General (1) to make grants to public or other nonprofit agencies, institutions, and organizations for paying part of the cost of (i) establishing and operating family health service clinics for domestic agricultural migratory workers and their families, including training persons to provide services in the establishing and operation of such clinics, and (ii) special projects to improve health services for and the health conditions of domestic agricultural migratory workers and their families, including training persons to provide health services for or otherwise improve the health conditions of such migratory workers and their families, and (2) to encourage and cooperate in intrastate or interstate programs, for the

purpose of improving health services for or otherwise improving the health conditions of domestic agricultural migratory workers and their families.

"(b) The Surgeon General is authorized to appoint an expert advisory committee to advise him in connection with the administration of this section, including the development of program policies and the review of grant applications."

DEPARTMENT OF AGRICULTURE,
Washington, D.C., February 19, 1962.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives.

DEAR MR. HARRIS: This is in response to your request of September 11, 1961, for a report on S. 1130, an act to amend title III of the Public Health Service Act to authorize grants for family clinics for domestic agricultural migratory workers, and for other purposes.

In view of the acute need in many areas for health services for migratory workers and our information that the Department of Health, Education, and Welfare believes this is a workable act, this Department recommends its passage.

The Bureau of the Budget advises that there is no objection to the presentation of this report from the standpoint of the administration's program.

Sincerely yours,

ORVILLE L. FREEMAN, *Secretary.*

U.S. DEPARTMENT OF LABOR,
OFFICE OF THE SECRETARY,
Washington, September 22, 1961.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.

DEAR CONGRESSMAN HARRIS: This is with further reference to your request for our comments on S. 1130, an act and H.R. 8882, a bill to amend title III of the Public Health Service Act to authorize grants for family clinics for domestic agricultural migratory workers, and for other purposes.

These measures would carry out the same purposes as H.R. 5285, upon which we reported to the committee on June 21, 1961. We would appreciate, therefore, your consideration of our report on that bill as stating our views on S. 1130 and H.R. 8882.

The Bureau of the Budget advises that there is no objection to the presentation of this report from the standpoint of the administration's program.

Yours sincerely,

W. WILLARD WIRTZ,
Acting Secretary of Labor.

EXECUTIVE OFFICE OF THE PRESIDENT,
BUREAU OF THE BUDGET,
Washington, D.C., February 15, 1962.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This is in reply to your letters of August 28 and September 11, 1961, requesting the views of the Bureau of the Budget on H.R. 8882 and S. 1130, identical bills, to amend title III of the Public Health Service Act to authorize grants for family clinics for domestic agricultural migratory workers, and for other purposes.

The Secretaries of Health, Education, and Welfare, and Agriculture have explained the reasons for this administration's support of the objectives of this legislation. We concur in their views.

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Enactment of this legislation would be consistent with the administration's objectives.

Sincerely yours,

PHILLIP S. HUGHES,
Assistant Director for Legislative Reference.

DEPARTMENT OF AGRICULTURE,
Washington, D.C., June 6, 1961.

HON. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives.

DEAR CONGRESSMAN HARRIS: This is in response to your request of March 7, 1961, for a report on H.R. 5285, a bill to amend title III of the Public Health Service Act to authorize grants for improving domestic agricultural migratory workers' health services and conditions.

In view of the obvious need in many areas for better medical care for domestic agricultural workers and the favorable testimony of the Department of Health, Education, and Welfare on its Senate counterpart, S. 1130, we recommend passage of this bill.

The Bureau of the Budget advises that there is no objection to the presentation of this report from the standpoint of the administration's program.

Sincerely yours,

ORVILLE L. FREEMAN, *Secretary.*

EXECUTIVE OFFICE OF THE PRESIDENT,
BUREAU OF THE BUDGET,
Washington, D.C., June 3, 1961.

HON. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives,
Washington, D.C.

MY DEAR MR. CHAIRMAN: This is in reply to your letter of March 17, 1961, requesting the views of the Bureau of the Budget on H.R. 5285, a bill to amend title III of the Public Health Service Act to authorize grants for improving domestic agricultural migratory workers' health services and conditions.

The bill authorizes appropriations of not to exceed $3 million annually for grants to public and nonprofit agencies to pay a portion of the costs of special projects to improve the health services for and the health conditions of migratory workers and their families. The bill also authorizes the Public Health Service to use a portion of the funds for studies, investigations, and demonstrations relating to this subject. Finally, the bill authorizes the Surgeon General to appoint an advisory committee to advise on the development of program policies and the review of grant applications.

The Secretary of Health, Education, and Welfare has testified on an identical version of this bill (S. 1130) before the Senate Labor and Public Welfare Committee and has detailed the reasons for this administration's support of the objectives of the bill. We concur in the Secretary's views.

Enactment of this legislation would be consistent with the administration's objectives.

Sincerely yours,

PHILLIP S. HUGHES,
Assistant Director for Legislative Reference.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
May 10, 1961.

HON. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This letter is in response to your request of March 6, 1961, for a report on H.R. 5285, a bill to amend title III of the Public Health

Service Act to authorize grants for improving domestic agricultural migratory workers' health services and conditions.

The bill would amend part A of title III of the Public Health Service Act by adding a new section entitled "Grants for Improving Domestic Agricultural Workers' Health Services and Conditions." Under this new section, Congress would be authorized to appropriate not to exceed $3 million each year to enable the Surgeon General (1) to make grants to public or other nonprofit agencies, institutions, and organizations for paying part of the cost of special projects to improve health services for and the health conditions of domestic agricultural migratory workers and their families, including training persons for this purpose, and (2) to conduct studies, investigations, and demonstrations, to train Federal or other personnel for providing such services or otherwise improving such conditions, and to encourage and cooperate in intrastate or interstate programs, for the purpose of improving health services for or otherwise improving the health conditions of domestic agricultural migratory workers and their families. The bill also authorizes the Surgeon General to appoint an expert advisory committee to advise him in the administration of this program, including the development of program policies and the review of grant applications.

Domestic agricultural migrants and their families comprise a population of almost 1 million persons—a population as large as that of any 1 of 15 States—who live and work for varying periods of time each year in about 1,000 counties. The major impact falls in 31 States, but nearly all States are affected in some degree.

Migrant agricultural workers are among the most underprivileged citizens of the United States from the standpoint of their health conditions and their opportunities to receive health services. Their living, working, and travel conditions are generally substandard and result in serious illness and accident hazards to all members of their families. Their income is uncertain, irregular, and seldom sufficient to enable them to pay for needed health care. Their work requires frequent movement from place to place over extended periods of time. Their generally low level of education is reflected in their inadequate knowledge of good health practices.

Despite the scope and intensity of their health problems, domestic agricultural migrants have only meager and scattered health services available to them. Local communities and States vary widely in their assumption of responsibility for the health of migrants. Even when communities take responsibility, their services are almost universally inadequate. In addition, continuity of service is seldom available as migrants move from one county or State to another.

The seriousness of the health conditions of this group, the inadequacy of health services available to them, and the interstate nature of the migrant health problem clearly require national action. Leadership and financial assistance by the Federal Government are necessary to assist in making available the health services which these citizens of the United States need.

H.R. 5285 would provide legislative authorization for the necessary leadership and financial assistance. Through a combination of special project grants and direct Public Health Service operations, it will be possible to assist States and communities to:

(1) Provide prompt and adequate medical and hospital care for migrant workers and their families.

(2) Extend public health nursing services to migrant workers and their families.

(3) Establish family-type outpatient services for preventive and curative care.

(4) Provide health education materials and instruction.

(5) Upgrade housing and sanitation conditions in camps, at work locations, and at rest stops.

(6) Promote interagency, intrastate, and interstate planning to insure continuity of health services as families move from place to place.

The special health interests and skills of the Children's Bureau and the Office of Vocational Rehabilitation would be used in the review of grant applications to insure that the program serves to complement rather than duplicate the current operations of these agencies.

We would therefore recommend that H.R. 5285 be enacted. There is enclosed herewith, in accordance with Public Law 801, 84th Congress (5 U.S.C. 642a), an estimate of additional cost that enactment of the bill would entail.

We are advised by the Bureau of the Budget that there is no objection to the presentation of this report from the standpoint of the administration's program.

Sincerely yours,

ABRAHAM RIBICOFF, *Secretary.*

Program: Grants for improving domestic agricultural migratory workers' health services and conditions (H.R. 5285), estimate of additional cost, 1962–66

APRIL 21, 1961.

Item	1962	1963	1964	1965	1966
Appropriation requirements:					
Project grants for improving domestic agricultural migratory workers' health services and conditions	$2,500,000	$2,500,000	$2,500,000	$2,500,000	$2,500,000
Direct operations	500,000	500,000	500,000	500,000	500,000
Total requirements	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000
Expenditures:					
Project grants for improving domestic agricultural migratory workers' health services and conditions	850,000	2,730,000	2,500,000	2,500,000	2,500,000
Direct operations	425,000	525,000	500,000	500,000	500,000
Total expenditures	1,275,000	3,255,000	3,000,000	3,000,000	3,000,000
Man-years of employment	51	57	57	57	57

DEPARTMENT OF LABOR,
OFFICE OF THE SECRETARY,
Washington, June 21, 1961.

HON. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.

DEAR CONGRESSMAN HARRIS: This is in further reply to your request for our views on H.R. 5285, a bill "To amend title III of the Public Health Service Act to authorize grants for improving domestic agricultural migratory workers' health services and conditions."

The Department of Health, Education, and Welfare, which would have the responsibility for administering this bill, has presented detailed views with respect thereto. However, I should like to add my support, as Secretary of Labor, to the general nature of this legislation while deferring to the Department of Health, Education, and Welfare on its details.

Numerous studies and recommendations point up the urgent need for the adoption of a Federal grant-in-aid program to develop and improve the health services and conditions of domestic migratory agricultural workers and their families. In 1946 the Federal Interagency Committee on Migrant Labor recommended that a well-operated health services program for migrants be provided and that Federal grants-in-aid be made to State health departments to assist them in the development of such services. The committee set forth in some detail suggested standards for a health-service program for migrant workers, including progams for the control of communicable disease, tuberculosis, venereal disease, maternal and child health, medical care consisting of doctors' and nurses' clinics.

At its annual conference in 1959, the Association of State and Territorial Health Officers, which includes the heads of the official State health agencies in each of the 50 States, District of Columbia, Puerto Rico, Guam, and the Virgin Islands, recommended increased funds for migrant health services of both the Public Health Service and the Children's Bureau, as well as an increase in Federal grant-in-aid funds to stimulate the development, improvement, and expansion of services to meet the migratory labor problem. Continued and strengthened emphasis and encouragement of action to assure the provision of needed health services to migrant families was also recommended by the President's Committee on Migratory Labor in its 1960 report to the President.

The Bureau of the Budget advises that there is no objection to the presentation of this report from the standpoint of the administration's program.

Yours sincerely,

ARTHUR J. GOLDBERG, *Secretary of Labor.*

COMPTROLLER GENERAL OF THE UNITED STATES,
Washington, D.C., May 17, 1961.

Hon. OREN HARRIS,
House of Representatives.
Chairman, Committee on Interstate and Foreign Commerce,

DEAR MR. CHAIRMAN: Your letter of April 15, 1961, acknowledged April 17, requests our comments on H.R. 5849, a bill to amend title III of the Public Health Service Act to authorize grants for improving domestic agricultural migratory workers' health services and conditions.

We have no information as to the desirability of the proposed legislation and no recommendations are made as to its merits. However, we wish to comment on certain aspects of the bill.

Section 310(b) would authorize the appointment of an expert advisory committee by the Surgeon General to advise him in connection with the administration of the program. However, there is no provision for compensation for services or reimbursement for travel expenses of the members of the committee. If such compensation and reimbursement is intended, the bill should specifically provide therefor. You may want to add language similar to the following to section 310(b):

"Members of such committee who are not otherwise in the employ of the United States, while attending meetings of the committee or otherwise serving at the request of the Surgeon General, shall be entitled to receive compensation at a rate to be fixed by the Secretary of Health, Education, and Welfare, but not exceeding $____ per diem, including travel time, and while away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by law (5 U.S.C. 73b–2) for persons in the Government services employed intermittently."

H.R. 5849 would provide an additional grant program to be administered by the Public Health Service. No provision is made in the bill nor in legislation applicable to other grant programs now authorized by the Public Health Service Act, as amended, to require a grantee to keep adequate cost records of the projects to which the Federal Government makes financial contributions, or specifically authorizing the Surgeon General or the Comptroller General access to the grantee's records for purposes of audit and examination. In view of the increase in grant programs over the last several years we feel that in order to determine whether grant funds have been expended for the purpose for which the grant was made the grantee should be required by law to keep records which would fully disclose the disposition of such funds. We also feel that the agency as well as the General Accounting Office should be permitted to have access to the grantee's records for the purpose of audit and examination. We therefore suggest that consideration be given to amending the bill to include such requirements with respect to the proposed new program, or preferably to an amendment of the Public Health Service Act to cover all grant programs therein authorized. The latter could be accomplished by the following language:

"RECORDS AND AUDIT

"(a) Each recipient of assistance under this Act shall keep such records as the Surgeon General shall prescribe, including records which fully disclose the amount and disposition by such recipient of the proceeds of such grants, the total cost of the project or undertaking in connection with which such funds are given or used, and the amount of that portion of the cost of the project or undertaking supplied by other sources, and such other records as will facilitate an effective audit.

"(b) The Secretary of Health, Education, and Welfare and the Comptroller General of the United States or any of their duly authorized representatives shall have access for the purpose of audit and examination to any books, documents, papers, and records of the recipients that are pertinent to the grants received under this Act."

In administering the above provision we do not contemplate making a detailed examination of the books and records of every recipient of a grant, or even a major part of them. However, selective checks may be made to provide reasonable assurance that grant funds are being properly applied or expended.

Sincerely yours,

JOSEPH CAMPBELL,
Comptroller General of the United States.

DEPARTMENT OF AGRICULTURE,
Washington, D.C., June 29, 1961.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives.

DEAR CONGRESSMAN HARRIS: This is in response to your request of May 22, 1961, for a report on H.R. 7088, a bill "To amend title III of the Public Health Service Act to authorize grants for improving domestic agricultural migratory workers' health services and conditions."

In view of the obvious need in many areas for better medical care for domestic agricultural workers and the favorable testimony of the Department of Health, Education, and Welfare on its Senate counterpart, S. 1130, we recommend passage of this bill.

The Bureau of the Budget advises that there is no objection to the presentation of this report from the standpoint of the administration's program.

Sincerely yours,

ORVILLE L. FREEMAN, *Secretary.*

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
June 5, 1961.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This letter is in response to your request of May 22, 1961, for a report on H.R. 7088, a bill "To amend title III of the Public Health Service Act to authorize grants for improving domestic agricultural migratory workers' health services and conditions."

This bill is identical with H.R. 5285 on which we submitted a favorable report to your committee on May 10, 1961. The views stated in that report also apply to H.R. 7088.

Sincerely yours,

WILBUR J. COHEN, *Assistant Secretary.*

DEPARTMENT OF AGRICULTURE,
Washington, D.C., February 19, 1962.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives.

DEAR MR. HARRIS: This is in response to your request of August 28, 1961, for a report on H.R. 8882, a bill "To amend title III of the Public Health Service Act to authorize grants for family clinics for domestic agricultural migratory workers, and for other purposes."

In view of the obvious need in many areas for better medical care for domestic agricultural workers and the favorable testimony of the Department of Health, Education, and Welfare on its Senate counterpart, S. 1130, we recommend passage of this bill.

The Bureau of the Budget advises that there is no objection to the presentation of this report from the standpoint of the administration's program.

Sincerely yours,

ORVILLE L. FREEMAN, *Secretary.*

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
February 14, 1962.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This letter is in response to your request of August 28, 1961, for a report on H.R. 8882, a bill to amend title III of the Public Health Service Act to authorize grants for family clinics for domestic agricultural migratory workers, and for other purposes, and your request of September 13, 1961, for a report on S. 1130, which—as passed by the Senate on August 25—is identical to H.R. 8882.

These identical bills would add a new section entitled "Grants for Family Health Service Clinics for Domestic Agricultural Migratory Workers" under part A of title III of the Public Health Service Act. Under this new section, Congress would be authorized to appropriate not to exceed $3 million each year to enable the Surgeon General (1) to make grants to public or other nonprofit agencies, institutions, and organizations for paying part of the cost of (i) establishing and operating family health service clinics for domestic agricultural migratory workers and their families, including training persons to provide services in the establishment and operation of such clinics, and (ii) special projects to improve health services for and the health conditions of domestic agricultural migratory workers and their families, including training persons to provide health services or otherwise improve the health conditions of such migratory workers and their families, and (2) to encourage and cooperate in intrastate or interstate programs, for the purpose of improving health services for or otherwise improving the health conditions of domestic agricultural migratory workers and their families. The bill further authorizes the Surgeon General to appoint an expert advisory committee to advise him in connection with the administration of this section, including the development of program policies and the review of grant applications.

H.R. 8882 and S. 1130, as it passed the Senate in a form identical to H.R. 8882, differ only in three respects from H.R. 5285 on which I reported to you in my letter of May 10, 1961.

1. The statement of purpose for which grants are authorized has been modified by adding specific reference to "establishing and operating family health service clinics for domestic agricultural migratory workers and their families, including training persons to provide services in the establishment and operation of such clinics."

Highlighting the establishment of family health service clinics, in line with the interest of agricultural producers as expressed by Senator Holland of Florida in the Senate floor discussion of the bill, is a constructive addition to the original proposal and one justified by the existing dearth of such services readily accessible to migrant workers and families in many of the places in which they concentrate for a part of each year. As Mr. Holland's testimony and the report of the Senate Subcommittee on Migratory Labor on S. 1130 (S. Rept. 699) indicate, Belle Glade, Fla., and Fresno County, Calif., provide pilot demonstrations of a workable pattern for the planning and conducting of family clinic services with primary responsibility at the local level, interagency cooperation, and participation and support by many community groups including the local medical society, growers, other local citizens, and migrants themselves.

The experience of these pilot projects also indicates the desirability of special orientation for professional workers unfamiliar with the migrant situation.

2. The bills delete references enabling the Surgeon General "to conduct studies, investigations, and demonstrations," and "to train Federal or other personnel for providing such services or otherwise improving such conditions."

This deletion is appropriate in view of the existing authority of the Public Health Service to carry on such activities.

3. The title of the bill now reads: "A bill to amend title III of the Public Health Service Act to authorize grants for family clinics for domestic agricultural migratory workers and for other purposes."

This change in title emphasizes the establishment of family clinic services as a major objective of the legislation.

For the reasons set forth above and in my letter of May 10, 1961, commenting on H.R. 5285, we would recommend the enactment of the proposal embodied in identical bills H.R. 8882 and S. 1130 as passed by the Senate.

We are advised by the Bureau of the Budget that there is no objection to the presentation of this report from the standpoint of the administration's program.

Sincerely yours,

ABE RIBICOFF, *Secretary.*

DEPARTMENT OF LABOR,
OFFICE OF THE SECRETARY.
Washington, D.C., September 2, 1961.

HON. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.

DEAR CONGRESSMAN HARRIS: This is with further reference to your request for our comments on S. 1130, an act, and H.R. 8882, a bill to amend title III

of the Public Health Service Act to authorize grants for family clinics for domestic agricultural migratory workers, and for other purposes.

These measures would carry out the same purpose as H.R. 5285 upon which we reported to the committee on June 21, 1961. We would appreciate, therefore, your consideration of our report on that bill as stating our views on S. 1130 and H.R. 8882.

The Bureau of the Budget advises that there is no objection to the presentation of this report from the standpoint of the administration's program.

Yours sincerely,

W. Willard Wirtz,
Acting Secretary of Labor.

The Chairman. The problem of migratory labor is a complex one and has many ramifications. The sole aspect with which this subcommittee is concerned this morning relates to health problems of migratory laborers. It is the purpose of this hearing to provide information as to what responsibility, if any, the Federal Government should have in the solution of this particular health problem and how this responsibility can best be discharged.

Do we have any Members who are here to testify? I know we will have later, because we have several bills by Members, and at this time I will introduce a statement by Mr. Zelenko from the 21st District of New York, to be included in the record.

(The statement of Mr. Zelenko follows:)

Statement of Hon. Herbert Zelenko, a Representative in Congress From the 21st District, State of New York

Mr. Chairman and members of the subcommittee, it is a distinct pleasure for me to submit a statement to this subcommittee on S. 1130, to amend title III of the Public Health Service Act to authorize grants for family health service clinics for domestic agricultural migratory workers.

In conjunction with Senator Harrison Williams of New Jersey, I have been actively fighting for legislation to improve the condition of the migratory laborer. I have sponsored 10 migratory labor bills personally and have the honor of chairing the Select Subcommittee on Labor, to which the majority of these were referred.

Senator Williams and I have met many times both with the President's Committee on Migratory Labor and privately to discuss the plight of the migrant worker. Our staffs have worked hand in hand until we have reached the point, I believe, where this great House of Representatives will be in a position to agree with the Senate and pass legislation favoring the migrant worker.

On March 7, 1961, I introduced H.R. 5285, amending title III of the Public Health Service Act to authorize grants for improving domestic agricultural migratory workers' health and conditions. Although covered by the language of my original bill and the original S. 1130, family health service clinics for migrant farmworkers and for families have been expressly designated by the Senate committee amendments as one of the health programs for which Federal grants are authorized.

Inasmuch as the Surgeon General now has adequate authority to conduct studies, investigations and demonstrations and to train Federal and other personnel, the Senate committee amendments to my bill, H.R. 5285, and to the original S. 1130, delete the language of the original bill authorizing him to conduct these activities in connection with this legislation. Since the difference between my original bill and the new Senate bill is not of a substantive nature, I, of course, wholeheartedly support the Senate-passed bill and have this date introduced an identical bill to eliminate any contention or problem that may arise.

My subcommittee held public hearings in Washington and in New York City last spring to consider four migratory labor bills. During those hearing days I was in a position to receive and evaluate much testimony regarding the status of the migratory worker. During the development and consideration of these bills the staff of my Select Subcommittee on Labor visited migratory work camps to make on-the-spot observations. In addition, numerous interviews and consul-

tations were held with migrant families, growers, State and local health personnel and others with firsthand knowledge of the serious problems, including those relating to health, although, of course, the health bill was not specifically before us.

The evidence we received from this intensive research demands remedial legislation.

Out of all these studies a common conclusion has emerged, that these workers live and work under conditions sharply contrasting with our general standards of living. The time for study has now passed and the need for effective action is imperative. Such action can only be activated through the exercising of leadership by the Federal Government.

It must be noted that the health problems facing agricultural migratory workers are not limited to any one State or, indeed, any group of States. The scope of the migratory health problems are interstate and can only be handled properly and effectively by Federal and State cooperation.

In conclusion, there has been a growing public awareness in recent years that the plight of the migrant worker is foreign to our American institutions. This long-festering sore in our society and in our economy provides a propaganda weapon for those who oppose our traditions and ideals. Failure to take prompt remedial action may be viewed as a repudiation of our moral responsibility to our own people, thereby abetting our adversaries in the struggle for the minds of men.

Thank you.

The CHAIRMAN. We will then take the witnesses from the Department of Health, Education, and Welfare.

I believe Mr. Jones, the special assistant to the Secretary for Health and Medical Affairs; accompanied by Dr. Aaron W. Christensen, Associate Chief for Community Health, Bureau of State Services, Public Health Service; and Dr. Donald Harting, Director, Center for Research on Child Health, Division of General Medical Sciences, National Institutes of Health, Public Health Service.

I assume you gentlemen are appearing together, but you will make the main statement, Mr. Jones.

STATEMENT OF BOISFEUILLET JONES, SPECIAL ASSISTANT TO THE SECRETARY FOR HEALTH AND MEDICAL AFFAIRS; ACCOMPANIED BY DR. DONALD HARTING, DIRECTOR, CENTER FOR RESEARCH ON CHILD HEALTH, DIVISION OF GENERAL MEDICAL SCIENCES, NATIONAL INSTITUTES OF HEALTH, PUBLIC HEALTH SERVICE; DR. AARON W. CHRISTENSEN, ASSOCIATE CHIEF FOR COMMUNITY HEALTH, BUREAU OF STATE SERVICES, PUBLIC HEALTH SERVICE; AND HELEN JOHNSTON, PUBLIC HEALTH ADVISER, MIGRANT HEALTH UNIT, DIVISION OF COMMUNITY HEALTH SERVICE

Mr. JONES. Thank you, Mr. Chairman.

Mr. Chairman and members of the committee, I appreciate the opportunity to appear before you today in support of H.R. 8882 and an identical bill (S. 1130), which passed the Senate on August 25 last year, to amend title III of the Public Health Service Act to authorize grants for family health clinics for domestic agricultural migratory workers. I shall address myself specifically to H.R. 8882.

The bill would provide grants for paying part of the costs of (1) establishing and operating family health service clinics for domestic agricultural migrant workers and their families; and (2) special

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projects to improve health services for, and the health conditions of, such workers and their families. The bill further authorizes the Surgeon General to provide technical assistance by the Public Health Service to encourage intrastate and interstate programs for the purpose of improving health services for such persons. Finally, it authorizes the Surgeon General to appoint an expert advisory committee to advise him in connection with the administration of this program, including the development of policy and review of grant applications.

Mr. Chairman, this bill represents a slight modification from five identical bills (H.R. 5285, H.R. 5849, H.R. 6114, H.R. 6480, and H.R. 7088), all of which have been referred to this committee. H.R. 8882 specifically authorizes project grant funds to be available for "establishing and operating family health service clinics for domestic agricultural migratory workers and their families, including training of persons to provide services in the establishing and operation of such clinics." Although activities of this kind would pe permissible under the other bills, we believe that this specific provision will serve a highly useful purpose in highlighting and giving special emphasis to this important kind of service.

Additionally, the earlier bills authorize the Surgeon General to conduct studies, investigations, and demonstrations and to train Federal and other personnel. Inasmuch as the Surgeon General has such authority under more general provisions of the Public Health Service Act, we do not believe this language in the original bills is necessary.

PROBLEM

This legislation proposes a substantive attack on a problem on which we have strikingly consistent evidence from National, State, and local studies, reports, and conferences over many years. Domestic agricultural migrants and their families comprise a population of almost 1 million persons—a population as large as that of any 1 of 15 States—who live and work for varying periods of time each year in about 1,000 counties. The major impact falls in 31 States, but nearly all States are affected in some degree.

We know that substandard living and working conditions make the health needs of migrants greater than those of the general population. Yet, the access of these people to community health services is limited by their poverty and lack of health knowledge, and by their physical isolation and mobility. Scattered local community efforts demonstrate effective ways to apply our health knowledge to this needy group. Such demonstrations are uncoordinated and inadequate to

meet the total need. Because the projects have no link with each other, one cannot build on what another has done.

Too often, migrant health becomes of widespread community concern only when an emergency occurs. It may be a child's death from insecticide poisoning. Or it may be the acute illness or death of young infants from diarrheal disease, an outbreak of diphtheria or typhoid fever, or a crippling highway accident. Then, local interest suddenly rises to a peak. Later it subsides, and the subject is quietly forgotten until the next crisis occurs.

WHAT COULD BE ACCOMPLISHED UNDER THE BILL

H.R. 8882 authorizes two mechanisms through which a solution to the migrant health problem can be approached. The principal one is the granting of funds by the Public Health Service to pay part of the costs of projects submitted by public or other nonprofit agencies. The other is expanded technical assistance by the Public Health Service, placing emphasis on encouraging and cooperating in intrastate or interstate programs to improve health services or otherwise improve migrants' health conditions.

The kinds of projects to be financed by grants will vary according to local and State circumstances. Special emphasis will be placed on service. The bill stresses family health service clinics such as those in Fresno County, Calif., and other localities, located where migrant families can reach them easily, and operated under circumstances which make their services truly accessible. Some projects will focus on developing effective ways to help migrants themselves assume greater responsibility for meeting their health problems, following the pioneering efforts in Belle Glade, Fla., and elsewhere. These efforts have included the employment of health aids who act as liaison between the migrant and the professional health worker; special meetings of migrant workers, crewleaders, or other members of the migrant group to help them prepare for migration; and other methods to help migrants improve their personal health practices and understand the use of community health resources.

Still other projects will focus on other specific objectives. For example, they may employ nurses to make regular visits to the quarters where migrant families live in order to help identify conditions requiring care, make referrels, and see that referrals are followed through. The effectiveness of nursing visits to teach families good practices and to help bridge the gap between migrants and their effective use of community health services has been well demonstrated.

Improvement in camp and field sanitation and safety requires concentrated effort in many places. Interarea and interstate projects to improve the continuity of planning and provision of health services to migrants are also greatly needed.

CONCLUSION

In summary, Mr. Chairman, we have ample evidence of the need for the type of national leadership and financial assistance provided through this proposal in order to help localities and States extend to the domestic agricultural migrant population the health services they need and that are generally available to other citizens. We strongly recomemnd favorable action on H.R. 8882 as a positive and constructive attack on the deplorable health conditions existing today among this Nation's domestic migrant workers and their families.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Jones, are you familiar with the pattern which workers take from the start of their work until they complete their seasonal employment?

Mr. JONES. In general, Mr. Chairman, we are familiar with the pattern. You are speaking primarily, I assume, of the mobility?

The CHAIRMAN. That is right.

Mr. JONES. Their movement?

The CHAIRMAN. That is right.

Mr. JONES. Yes, sir.

We have developed charts, information in specific detail, Mr. Chairman, as to the patterns of movement of these migrant workers.

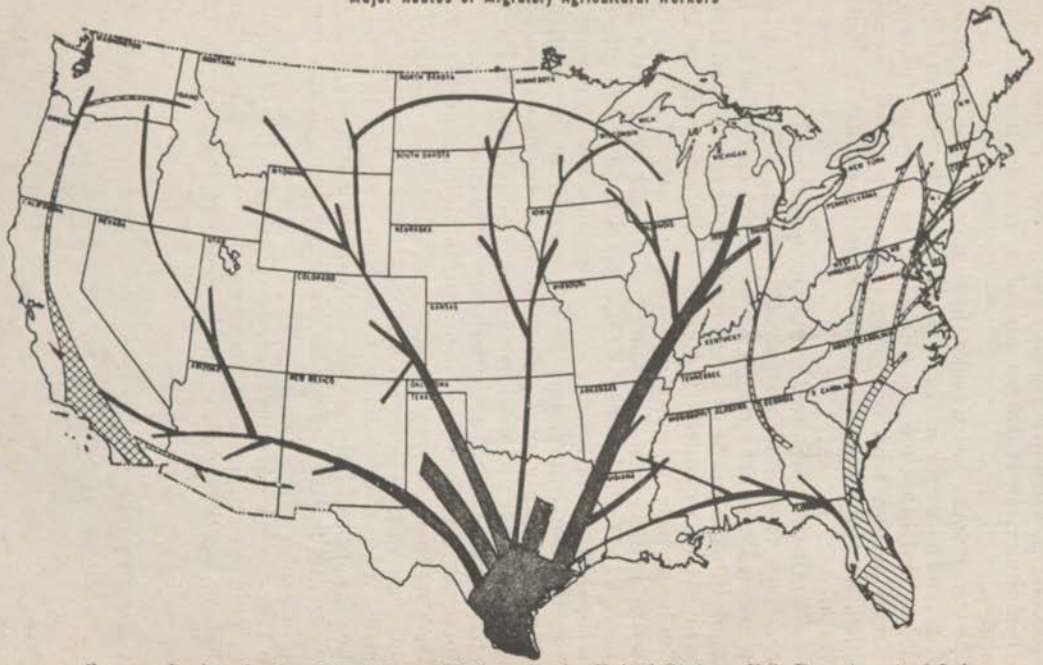
The CHAIRMAN. Would you discuss that briefly and then offer the chart for the record?

Mr. JONES. Yes.

(The chart referred to appears on p. 17.)

Migrants piece together short-term jobs.

Major Routes of Migratory Agricultural Workers



Source: Levine, Louis. Hired Farm Workers in the United States. U.S. Department of Labor, Bureau of Employment Security. June 1961.

Mr. JONES. In general, Mr. Chairman, the migrant workers have a home base in which they live perhaps 5 to 8 months of the year, and then, according to the pattern of crop harvesting, of the agricultural effort in which they are needed and in which they engage, they then move to other sections of the country. Generally, the pattern of movement would indicate that, aside from their home base, they generally live, most of them, in two additional localities, then the next largest group, probably in three different localities; and then the remainder, in scattered numbers, one or a multiple number of localities.

The CHAIRMAN. Let us take the east coast first and follow that, and then go to the west coast, and then to the Texas situation.

Mr. JONES. Mr. Chairman, it might be more useful to you if I call on Dr. Harting, who has been personally deeply engaged in this problem for some years, to comment more specifically if it is all right with you.

The CHAIRMAN. We will be glad to hear from Dr. Harting.

Dr. HARTING. Thank you, Mr. Chairman.

In general, the heavy work areas on the east coast are in the lower areas of Florida in the drained muckland that is producing our fresh vegetables that we are getting in the Washington market today.

The home base areas are not vacation areas, although many of us visualize them as such. They are really work areas for a major section of the year. With the onset of hot weather in the South, the developing crops—the crop areas—come up into the Carolinas early, over on the Eastern Shore, just to the east of us here, with asparagus harvest quite early in April, and later tomatoes and other crops. Then a heavy area of work is on Long Island, with a large concentration of migrants there in the midsummer periods.

Upper New York State has migrants in beans and the fruit harvest.

Then, as the cool weather brings on the harvesting of apples and fruits, some migrants move back South with a period of work in the Virginia area, and gradually move back into the Florida work areas, as the economics of the production of agriculture makes it profitable to bring in the large crops basically of fresh fruits and vegetables in that area.

In Texas, workers concentrate heavily in the Rio Grande area during the winter season, but then move to almost every State in the Union as the summer heat brings in the crops in the more Northern areas.

People move from this area of the country as far north as Washington and Oregon; into Montana, the Dakotas, and a fair number into the Midwest areas in Michigan, Ohio, Illinois, Wisconsin.

Actually, from Texas we have even the movement of some workers over into the east coast stream. In the Western States, the heavy work areas are in the southern California irrigated valleys, with an extensive intrastate movement by virtue of the variation in crop schedules and the variation of latitude of a large State like California, and on up into Oregon and Washington.

Other witnesses that I see here in the room I am sure can go into more detail regarding some of these patterns of work in both Florida and California.

The CHAIRMAN. Presently, what is the situation with reference to Florida? Has there been an impact there by virtue of Cuban refugees or others coming in for employment? Do they enter this picture at all?

Dr. HARTING. To the best of my knowledge, there has been only limited competition for agricultural work from the refugees.

Interestingly enough, there are, in a sense, specialized skills, and migrant workers have to develop the ability to earn a living doing at piecework rates the kind of work that has to be done in the various crops. One gets a certain amount of specialization among the people that get into it and learn how to earn a living this way. It is my impression that newly displaced labor, sometimes for a period of time, at least, has an awfully hard time earning the most meager living by doing this kind of work.

Fortunately, Dr. Brumback, I know is here, and will be able to speak much more directly to the impact of Cubans on this situation.

The CHAIRMAN. On page 33 of the chart, which Mr. Jones referred to, on migratory U.S. farmworkers, you show figures for annual earnings.

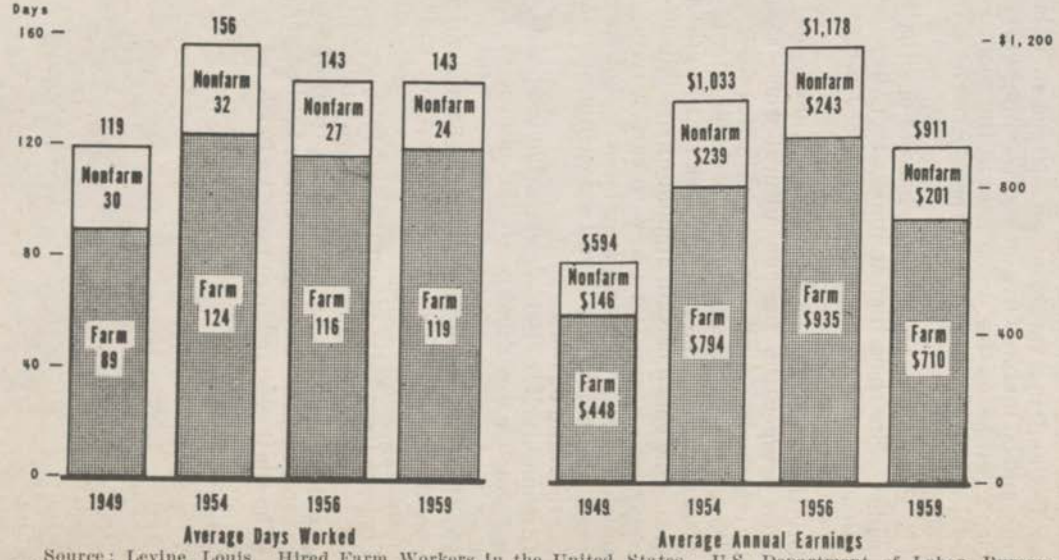
I believe from 1949, 1954, 1956, and 1959.

Now, that chart shows earnings of $146 for nonfarm employees. Is that figure correct? You show a total of $594 a year in 1949 under average annual earnings. This is the last page of this.

(The chart referred to appears on p. 20.

Duration of employment and annual earnings have been decreasing.

Average Days Worked and Average Annual Earnings of Migratory Workers Employed 25 Days or More During the Year



Source: Levine, Louis. Hired Farm Workers In the United States. U.S. Department of Labor, Bureau of Employment Security. June 1961.

Mr. JONES. Mr. Chairman, Miss Johnston of the Department, who is quite familiar with these figures, is here, and she can speak directly to this point, if you would allow.

Miss JOHNSTON. Actually, these data are chiefly from the Department of Labor. The chart book was prepared by the Bureau of Employment Security in the Department of Labor. Their estimates show that from both farm and nonfarm work the workers who spent a major part of their working time during the year in agriculture earned about $1,000 per worker in each of recent years.

The CHAIRMAN. About how many States are affected, would be affected by this bill?

Mr. JONES. Practically all of the States, Mr. Chairman. There are 31 which have a considerable stake in this problem, but all, with the possible exception of two, are affected one way or another.

These migrant workers, at one time or another, live in about a third of the counties of the United States, so it is a major national problem.

The CHAIRMAN. What happens to the children of these workers while they are employed?

Mr. JONES. This is a major problem, Mr. Chairman. They have difficulty in fitting into the pattern of community life because of the fact that they are there such a short time. Also, they are of such a low economic level that they are not able to provide for their children in ways that are expected prior to attendance at school, such as immunization, the normal health protection that schools require. Their clothes are inadequate.

There are efforts being made to assist them with the problem of adaptation to community life through other channels. This program is related only to the health.

I think it would be fair to say, Mr. Chairman, that the children of these migrant workers are ill cared for, at best; that they have problems of nutrition and various diseases, many of which can be prevented by a proper understanding of health protection. And if they could receive the kind of help that is provided for in this bill, the children would be much healthier and then, I think, would be able to use and adapt to the available community resources more readily.

The CHAIRMAN. Are there any restrictions so far as children are concerned? Do they keep children with the families for year after year, as long as they are engaged in this kind of work? Do they not have some kind of State laws that require them to go to school?

Miss JOHNSTON. Many States have compulsory State attendance laws for schoolchildren, and one of the problems of the schoolchildren which is really apart from their health status, is the fact that many States also have what they call crop vacations.

Now, a migrant child may move from one area where there is a crop vacation to another area where there is a crop vacation. This means that his education is interrupted almost throughout the year.

The local child will have a crop vacation and then go back to school. He does not move to another area where there is also a crop vacation.

However, this is a subject of a bill which is being heard, I believe, in another committee.

The CHAIRMAN. Is there legislation, you say, pending before another committee as to the education of these children?

Mr. JONES. That is correct.

The CHAIRMAN. Under this bill and under the Senate bill, what health services that are not immediately available to this group of local jurisdictions?

Mr. JONES. I think, Mr. Chairman, it would provide a number of health services that are not immediately available to this group of our citizens.

For one thing, they come in large groups into a community that has services established for the permanent resident population. Then, when this group comes in, it imposes an additional burden of a unique nature that the community is not prepared to adjust to, especially when the migrants are there only a short time and then move on to another community.

The basic service, I think, would be the family clinic in which public health workers would hold regular clinics, readily accessible to the migrant families, and through which could be provided the normal processes of health care, preventive medicine, immunization, and some health education. Emphasis would also be on sanitation and what is generally accepted as a normal environment for healthy living, to make this kind of environment available to the migrant worker families.

In addition, there would be an effort to bring these people up in terms of their own understanding to the point where they would understand the kinds of community health services that would be available to them, if they knew how to seek them out and to use them.

The CHAIRMAN. Would that be primarily in the field of prevention?

Mr. JONES. This would be the primary effort of this program, Mr. Chairman. By prevention, we would merely bring to these people the same kinds of understanding, and the same kinds of assistance, surveillance, and clinic service that would lead to better health across the board and avoid some of the common health problems they suffer which have been avoided throughout the Nation through our public health practices over a period of years.

The CHAIRMAN. Is it your theory at the present time that the families constitute a menace to the permanent residents?

Mr. JONES. It is not only a theory, Mr. Chairman, it is a fact.

There are incidents which could be cited to point out that diseases that have been virtually unknown in certain localities have broken out in epidemic form by virtue of transmission through the migratory workers. Therefore, the mobility of these workers and their families, and their lack of understanding of common health practices, plus the lack of availability of public health services to them, create a hazard in the permanent communities to which they migrate from time to time.

For example, there was an outbreak of diphtheria among migrants in Plainview, Tex., last winter. One death and a number of serious illnesses resulted in the permanent population.

Dr. Harting may wish to comment further on this.

Dr. HARTING. I would simply like to comment that the threat of illness from the migrants sometimes sets up a vicious cycle. One of the easiest ways of protecting the community from illness is by isola-

tion. This means that, essentially, one isolates the migrant community or camps functionally from the resident community.

This means, also, that one then isolates the migrants from the community's services.

We have frequently seen this, particularly in local communities concerned with schooling. How do you get the migrant children into school and not have the other parents concerned that they are bringing in disease, but, at the same time, how do you get the health services that are in the community available to the migrant children to help them. Where does one crack into this cycle?

We are aware of the threat of migrants to the community, but we certainly have the feeling that it is by virtue of the rights of the migrants to have their health needs met that the crucial need exists here.

The CHAIRMAN. Do a good many of the workers live in trailer camps or just how are they housed in these various communities?

Mr. JONES. Mr. Chairman, they are housed in deplorable conditions. I think those who have trailers are the more fortunate. They generally live in makeshift arrangements of one form or another. They are very inadequately housed.

Miss Johnston may wish to comment. She has seen many of these herself.

Miss JOHNSTON. I think you would be interested and we could submit some pictures for the record that we have taken within the last few years in nearby States as well as in some of the Western States that illustrate the kind of housing that migrants live in.

The housing ranges from relatively good, well organized camps—and there are some of these that house hundreds of families—to very isolated groups of two or three units on an isolated farm with possibly no toilet facilities whatever, and a drinking supply that is subject to contamination.

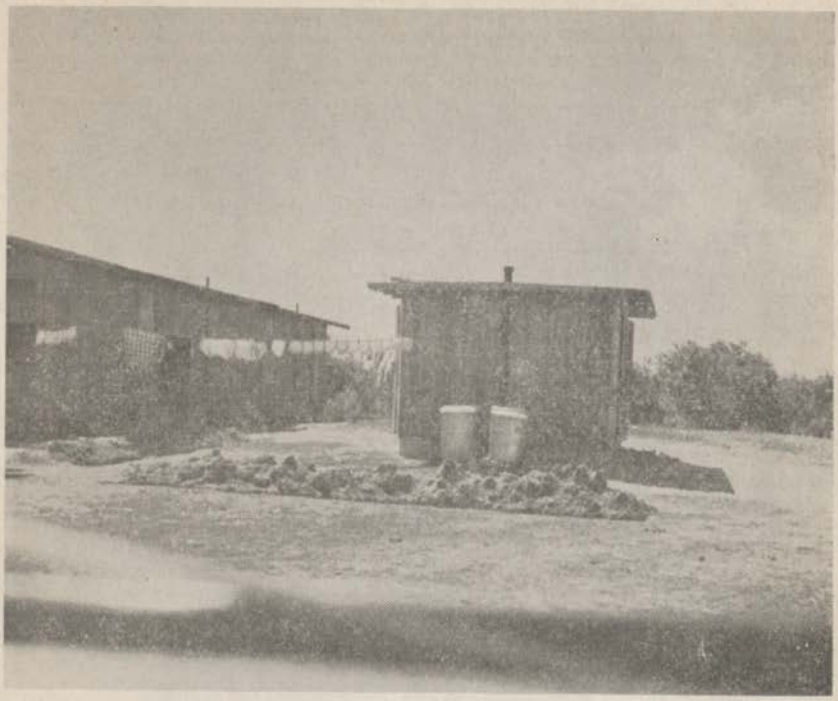
You have a wide range of circumstances. The average is poor. I have some photographs that are typical examples of the conditions that prevail in the United States.

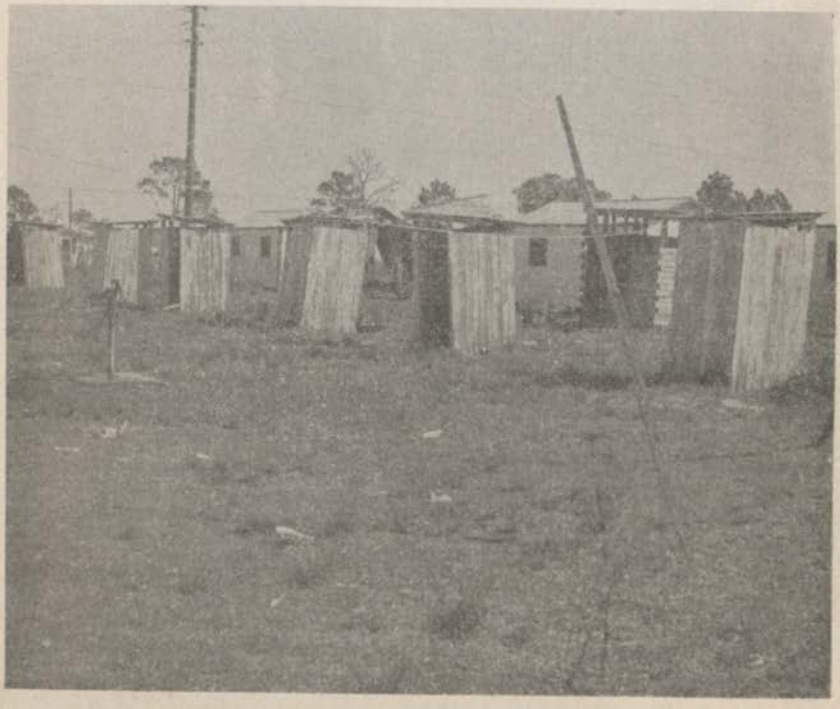
(The photographs mentioned appear on pp. 24–30.)

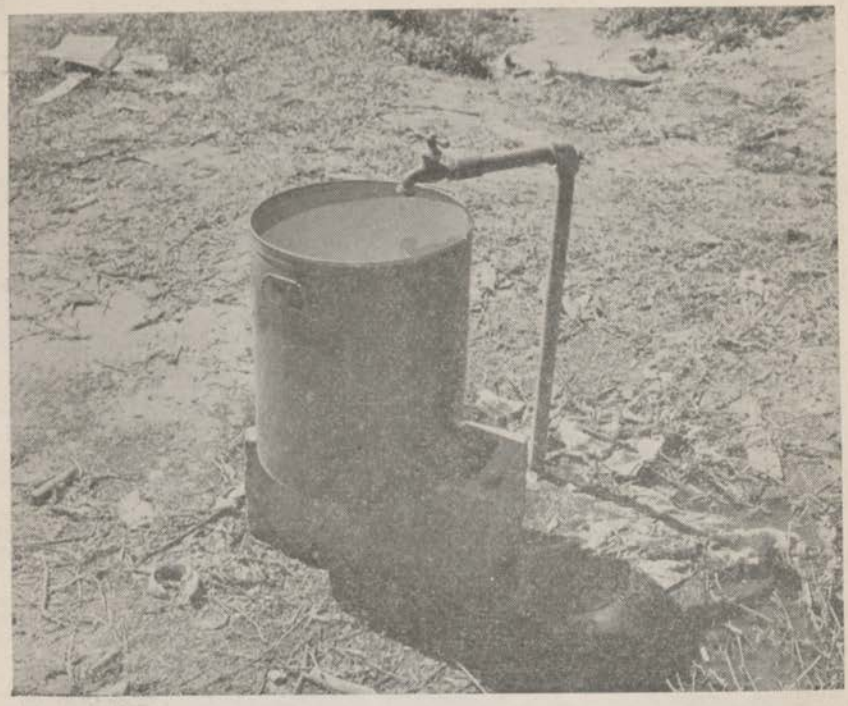
PHOTOGRAPHS—MIGRANT HOUSING

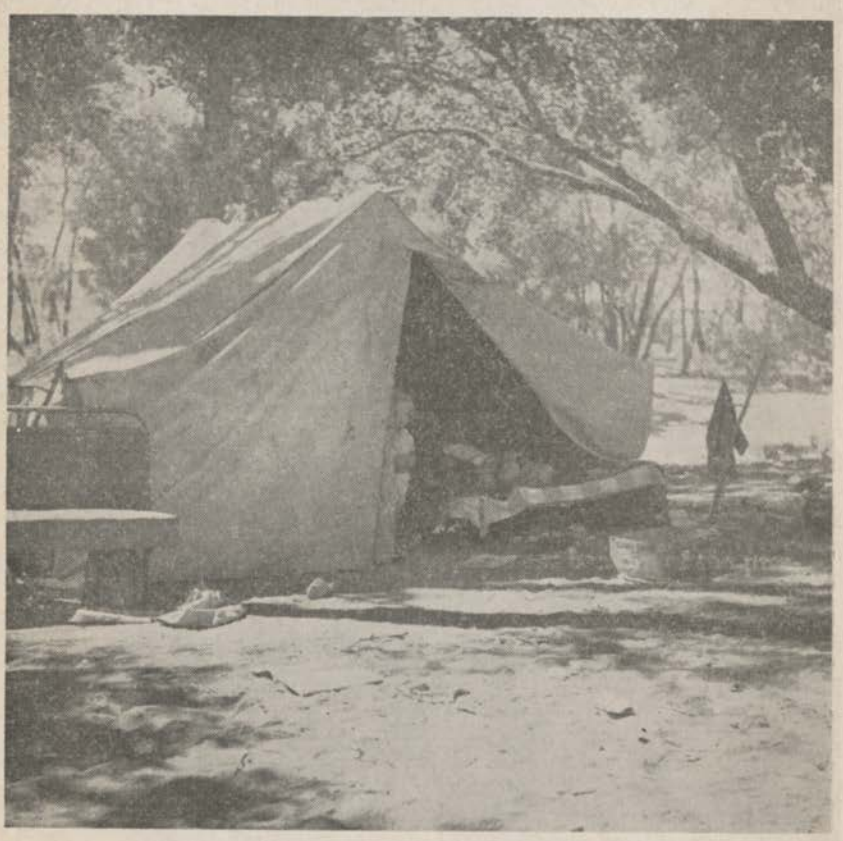
The following photographs illustrate the range in types of migrant housing and facilities that can be found in many migrant work areas over the United States. The photographs were made within the last few years in the following States: Maryland, Delaware, Texas, Colorado, and Florida.

Rarely do migrant agricultural workers and families use trailers. The trailers they use are sometimes made-over truck bodies or decrepit makeshifts, as substandard as much of the housing they are furnished. More desirable types of trailers are occasionally found in use by farm processing plant workers or by families that work for brief periods in fruit, in some cases at least in part as a family vacation experience.









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Mr. JONES. I think one of the communities that might be cited, Mr. Chairman, as having done a great deal in this regard is at Belle Glade, Fla., in Palm Beach County, which one of your members represents. They have done an excellent job of providing community health service, but even then I am sure their local resources are taxed considerably beyond what is fair in terms of the mobile aspect of the families that they tend to serve.

The CHAIRMAN. Are there any other members of the panel who would like to make a statement?

Mr. Schenck?

Mr. SCHENCK. Thank you, Mr. Chairman.

I would like to inquire as to just what is, in your concept, a family health service clinic.

Mr. JONES. A family health service clinic, Mr. Schenck, is a clinic that has available at certain times of the day, certain days of the week, or continuously, according to the volume of service to be rendered, doctors, nurses, health workers, who can see the entire family individually or as a group, and can diagnose problems that the family may have from a health standpoint, and provide such outpatient services as may be indicated for the conditions that are recognized.

Furthermore, for the more acute conditions that cannot be handled through the clinic type of examination, this clinic can then refer these individuals and these families to established community health services, even hospitals when hospitalization is indicated, and prevent a more serious condition by arranging treatment for need which has been recognized early.

The term "family" relates to the fact that the clinic serves the whole group of the migrant unit rather than just the principal worker or just the children.

Dr. Harting, you might wish to comment.

Dr. HARTING. Yes.

I think one might expect to find a fair amount of variation in the exact nature of family clinic services, according to the way the local community might want to design it. But the basic concept would be to have family health service clinics, instead of having specialized tuberculosis clinics, specialized maternal and child health clinics, and other special clinics which mean many trips for the families. Many of these families come from cultural groups that just have a hard time understanding our medical specialization, and, actually, I must say that many of our neighbors have this same feeling.

But at least it would make it possible with one trip in an evening to get care for the family's problems.

Now, this has been tried in some limited situations, and I believe in Ohio there have been some privately sponsored family clinics tried out. Certainly in the western area of Fresno they have tried this concept, essentially with the family health service clinic acting like a general outpatient arm of the county hospital, out closer to where the families work and live.

Mr. SCHENCK. I take it you envision the construction of some sort of facility?

Dr. HARTING. The facilities generally can be pretty simple for this kind of activity. Actually in the few places where they have been tried, the facilities have been provided by the growers, who were inter-

ested to have this service near at hand for their workers. The actual medical facilities can be relatively simple. The crucial thing is the personnel to provide the service.

Mr. SCHENCK. Now, as I understand, you are going to staff these family health clinics with doctors, nurses, public health employees, and so forth. Would that be the way it is done—and also are these staff personnel and equipment moved from one section or State to another? Could that not be done in a mobile unit of some sort?

Mr. JONES. It could be, Mr. Schenck. I think we should make it very clear that the program, as contemplated, does not provide that the Federal Government, per se, will establish these service units. It will provide grants to local public or nonprofit agencies who design a program generally under the aegis of the State health department to meet the particular conditions and needs of the migratory group in that particular location. They will use, then, local people on some kind of basis that is predetermined, according to the plan.

Mr. SCHENCK. Who would devote part of their time?

Mr. JONES. Who would devote part of their time, who may be taken from other kinds of local community health activities and devoted to this, because the problem has been focused and there has been money made available.

Mr. SCHENCK. Is there not already a shortage of this type of trained personnel in these communities?

Mr. JONES. There is a shortage generally, Mr. Schenck, but this kind of preventive work will eliminate much of the reason for a greater demand on the services of these health workers by preventing conditions before they happen. But once you let an epidemic develop, because of simple sanitary rules that have been ignored, you have a major call upon the health personnel, whereas a more limited call in advance of these more serious conditions will preserve and make our health personnel go further.

Dr. Harting, who is a physician, will comment.

Dr. HARTING. We have had an interesting experience on the question of getting personnel. It is true, in general, that there are real shortages; however, for summer periods and so forth we find that where there are funds available we can tap completely new sources of manpower for this kind of work.

In New York State, for instance, they are able to utilize in the summer the services of schoolteachers and biology people, people who have particular training useful as background for work in sanitation, that they would not be able to employ the year around.

In California, in the teaching area they have been able to get women who would not ordinarily accept employment on a year-round basis, but for whom it makes real sense to work 2 months or 3 months.

So it is quite a sizable, new manpower pool that could be tapped, I think, if the funds were available.

Mr. SCHENCK. Would there be any matching money required by the States or local——

Mr. JONES. Mr. Schenck, there is no formula built into this program, but it would be contemplated that grants under this proposal would be in stimulation of local activity that would provide resources much beyond the Federal grant. It would be, in essence, a matching program, but without a fixed formula.

Mr. SCHENCK. How many additional employees in Health, Education, and Welfare will be required to manage this program, if you are not going to furnish the personnel for the individual clinics?

Mr. JONES. Well, we may have some additional personnel, Mr. Schenck.

Mr. SCHENCK. How many?

Mr. JONES. It will probably be in the range of 25 to 50 across the whole health field: nurses, sanitary engineers, physicians, and others.

Mr. SCHENCK. What is the total number of employees in HEW now?

Mr. JONES. About 68,000. I will get the figure exactly for the record, Mr. Schenck.

(The information mentioned follows:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Total paid employment as of Jan. 31, 1962

Total, DHEW	73,347
Office of the Secretary	1,371
Food and Drug Administration	2,283
Office of Education	1,175
Office of Vocational Rehabilitation	227
Public Health Service	30,358
Freedman's Hospital	(893)
St. Elizabeths Hospital	3,415
Social Security Administration	34,518
Office of the Commissioner	145
Children's Bureau	225
Bureau of Federal Credit Unions	419
Bureau of OASI	33,328
Bureau of Family Services	371

Mr. SCHENCK. Mr. Jones, I was looking over this bill here by our colleague, Mr. Ryan, of New York, H.R. 8882, which is the bill upon which you have testified.

As I understand the bill, on line 1, page 2, it would provide for the expenditure of not to exceed $3 million in any one year. Do you think that that will be enough?

Mr. JONES. I think, Mr. Schenck, that this amount of money will result in the stimulation of a program of local activity that will bring about services greatly in excess of the $3 million contribution by the Federal Government.

For example, as a community organization presents a program in the request for a grant under this authorization, they would lay out a total operation that would involve some activity by local health officers, the provision of physical facilities, a place to hold clinics, and this kind of thing, so that the stimulation of this grant money will bring about a greatly expanded local interest and activity which will far exceed the $3 million contribution by the Federal Government.

Mr. SCHENCK. Mr. Jones, is it your theory that these family health clinics will be segregated clinics insofar as they will meet the needs only of the migratory workers?

Mr. JONES. The intention, Mr. Schenck, is to organize these clinics to serve the migratory families. They will not be exclusively of

service to the families if there are other local farmworkers who fit into the same category and can be served.

But the projects, as they are presented, will be reviewed in terms of service to the migratory workers and this will be the pattern. They may fit into a going community service; they may be an extension of a local community clinic which exists at one side of a county, for example, whereas the migratory workers are generally based at the other end of the county, and the extension will be a branch of the more permanent type of clinic. It will be an extension of community services at the local level.

Mr. SCHENCK. Mr. Jones, I wonder if you would know now what the total budget request for the Department of Health, Education, and Welfare is for the fiscal year beginning next July 1?

Mr. JONES. It is in the neighborhood of $5 billion, Mr. Schenck. I can give you the exact figure.

(The information mentioned follows herewith:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Appropriations and proposed supplementals, fiscal year 1962

Organizational unit	*Appropriations and proposed supplementals*
Food and Drug Administration	$26,383,000
Office of Education:	
Appropriated	579,791,455
Proposed supplemental (existing legislation)	16,155,000
Office of Vocational Rehabilitation	88,397,000
Public Health Service:	
Appropriated	1,391,083,000
Proposed supplementals (existing legislation)	2,359,000
St. Elizabeths Hospital:	
Appropriated	5,680,000
Proposed supplemental (existing legislation)	146,000
Social Security Administration:	
Appropriated:	
General funds	2,480,071,000
Trust funds	(271,892,000)
Proposed supplemental (existing legislation): General funds	85,000,000
American Printing House for the Blind	670,000
Freedmen's Hospital	3,736,000
Gallaudet College	1,857,000
Howard University	12,010,000
Office of the Secretary:	
General funds	15,567,000
Trust funds	(2,513,000)
Total:	
General funds	4,708,905,455
Trust funds	(274,405,000)

Mr. SCHENCK. Well, that is close enough. Now, in the past several days here we have been considering in this subcommittee a series of bills, Mr. Jones: one to add two Assistant Secretaries; one to establish a Child Health Clinic or Institute; and this bill.

Are the funds for these now included in the request for Health, Education and Welfare?

Mr. JONES. Yes, sir.

They are now in the planning for the President's budget for the next fiscal year, that is correct; yes, sir.

Mr. SCHENCK. They were included?

Mr. JONES. They were.

Mr. SCHENCK. In the budget that the President presented to the Congress?

Mr. JONES. That is correct; yes, sir.

Mr. SCHENCK. In anticipation of the approval of this legislation?

Mr. JONES. That is correct.

Just a moment, Mr. Schenck, I want to be certain about this answer.

Mr. SCHENCK. I would like to correct that statement. There is a provision in the operating budget of the Public Health Service for $250,000 that would relate to the direct operations of the Public Health Service in anticipation of this particular bill.

The $3 million of grant money which is a part of the bill was not in the budget and would have to be handled independently and separately.

Mr. HARRIS. I was a little confused as to whether you were asking if the funds for the additional Assistant Secretaries were included in the budget, or if the funds for this bill which is under consideration would include that. I wanted to get that clear.

Mr. SCHENCK. May I say to the distinguished chairman of the full committee my question was exactly that. We have had three different proposals here in the past 3 days, one of which was to add two Assistant Secretaries and the necessary staff, space, and so forth.

We have had a bill here, another series of bills, to establish an Institute for Children's Health, and so on, and there has been some excellent testimony on that.

Now, this one for another $3 million.

My question was: Were these three bills anticipated in the presentation of the Budget for the fiscal year beginning next July 1, and is the amount of money necessary for these three measures in the budget request?

If not, I suppose it would require a supplemental.

Mr. JONES. That is correct.

I would like to answer the question, if it is all right, Mr. Schenck, specifically for the record when I can check the details.

(The following information was submitted for the record:)

DIVISION OF COMMUNITY HEALTH SERVICES,
BUREAU OF STATE SERVICES,
February 21, 1962.

PROJECTED BUDGET FOR FIRST FISCAL YEAR OF PROPOSED MIGRANT HEALTH PROGRAM

The President's budget for 1963 now includes an item of $243,000 for direct operations of the Public Health Service under existing authority in the migrant health field.

With migrant health project grant authority, it is anticipated that an additional sum of $2,765,000 would be requested. A supplemental request for funds in this amount is anticipated in order to pay part of the costs of projects for which applications are submitted and approved, and to meet increased requests of States and localities for assistance including the temporary loan of personnel and equipment as well as consultation, especially on the interstate aspects of their migrant health programs.

PROJECTED BUDGET FOR FIRST FISCAL YEAR OF PROPOSED NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT

Of approximately $40 million now expended by the National Institutes of Health for research grants, training, and intramural activities in fields of child health and human development, it is estimated that some $20 million will be transferred to the new Institute.

It is projected that during the first year, costs for the development and maintenance of Institute staff and technical operations will be approximately $500,000. The President's budget for fiscal year 1963 will provide adequately for these expenditures. No supplemental request is anticipated for support of the proposed Institute.

Mr. JONES. I would like to point out that on the Assistant Secretaries bill there is only one additional one that involves money. The other is merely a change of title with no additional expense involved.

Mr. SCHENCK. I understand that, just the upgrading of one.

Mr. JONES. That is right, without any expense involved at all.

And on the bill creating the two Institutes at the National Institutes of Health, changing a title for the Division of General Medical Sciences to an Institute of General Medical Sciences, this is a redesignation of an existing program. The Institute of Child Health and Human Development is a new Institute, but its operation would amount to a transfer of activities already taking place, with about $20 million transferred to the new Institute. I will get you for the record the details related to the budget.

The CHAIRMAN. And if I remember it correctly, the testimony was that there would be no new construction required for the new Child Health and Human Development Institute?

Mr. JONES. That is correct.

It is primarily an extramural program. The research activities would go on in the some thousand institutions of the Nation which are supported in their research activities in the interests of these disease problems.

Mr. SCHENCK. The approval of that would relate to personnel, practically?

Mr. JONES. Yes.

Mr. SCHENCK. Now, Mr. Jones——

Mr. JONES. I might add there is no supplemental plan in terms of the Child Health Institute, but I will give you the details in the record.

Mr. SCHENCK. It is my understanding from reading the press, various releases in the press, that the Secretary of Health, Education, and Welfare is, or will, recommend certain changes in the general welfare program that is under the direction of the Department of Health, Education, and Welfare.

Mr. JONES. That is correct.

Mr. SCHENCK. And from these press releases, I understood that the Secretary is recommending that these folks who are able will be employed for the relief that they receive. If that occurs, then will that reduce the need for migratory farm labor?

Mr. JONES. I am not prepared to answer specifically this question, Mr. Schenck. My guess is that it will not, because the migratory farmworker group is a highly specialized group of people who work at the very lowest economic level. There are other bills, as has already been suggested, before other committees having to do with the

working conditions of the migratory workers, and it may well be that the new welfare legislation, if enacted, would help to some extent.

But we think this particular bill directed toward improvement of the health of these migratory workers will directly assist in removing such of those who are supported by welfare funds from welfare rolls by virtue of an improvement of their general health conditions and the conditions of their children.

Mr. SCHENCK. I recall reading also that in an area of considerable unemployment that those who were receiving unemployment compensation refused to pick apples. Therefore, migratory labor was brought in to do that work.

Do you envision these new regulations requiring those on unemployment compensation to do some work for their compensation? Do you anticipate that that will reduce the need for migratory workers?

Mr. JONES. I doubt it, Mr. Schenck, because the number of cases involved in this kind of situation is rather limited. It may have some small effect, but I doubt that it will have a great deal of effect of this nature, although I am not personally able to respond to this particular aspect.

I might say, Mr. Chairman, that Miss Johnston of the Public Health Service has spent a great deal of time with these families. She may from her experience know something of this situation.

Miss JOHNSTON. Actually, I think there is another side to this coin. Sometimes the employers do not want workers who are not qualified to pick whatever they have to be picked. We had some experience in a project in Michigan several years ago when there was some unemployment in Michigan.

Before the crop season opened, there were people up there who felt that the unemployed people in Michigan would get back into agriculture. Some of them had had agricultural experience years earlier. The people in Michigan felt that this might diminish the number of migrants who would be needed. They found that employers in Michigan did not want to have people picking their crops who were not qualified to do this type of work. It requires a type of skill that some industrial workers do not have.

The employers wanted the migrants because they knew they could do the work the way they wanted it done.

Mr. SCHENCK. You mean it requires certain skills to pick apples or berries or cherries?

Miss JOHNSTON. It requires a good deal of skill to avoid hurting the tree for future crops.

Mr. JONES. I can speak to this point by experience. I used to work on a truck farm that had fruits, berries, vegetables, myself.

I know by experience that I was not qualified to do some of the, what we consider menial, jobs of crop harvesting, because I was not skilled in protection of the parent plant. This is a problem.

Mr. SCHENCK. Is there any program that you know of, Mr. Jones, that contemplates the establishment of day care centers for these children of migrant workers so that their mothers can be employed?

Mr. JONES. I might say that there is another bill for this particular aspect of it that is not contemplated as part of this health legislation. I might say that the project that I referred to at Belle Glade, Fla., was

supported by the Children's Bureau of our Department over a period of 5 years by virtue of their interest in the children and their mothers.

Mr. SCHENCK. Thank you.

The CHAIRMAN. The gentleman from Pennsylvania?

Mr. RHODES. Mr. Jones, you are acquainted with the Belle Glade project. What sort of an operation is it? What type of people occupy those houses? They are rather dumpy looking homes to me. I was wondering if it is a State or Federal project?

Mr. JONES. The County Health Officer from that county is to be a witness on this bill. He is in the room, if you would like him to respond. I think he can give you specific information.

The CHAIRMAN. The Chair would prefer that we finish with the departmental witnesses.

Mr. JONES. If that is all right, Mr. Rhodes, I think he can give you important, specific information along the lines of your interest there.

Mr. RHODES. Thank you.

The CHAIRMAN. Mr. Nelsen?

Mr. NELSEN. I was wondering if I heard the testimony correctly. Was the statement made that the salary was $1,000 a month?

Miss JOHNSTON. A year.

Mr. NELSEN. I thought you said a month.

Miss JOHNSTON. $1,000 per worker was the average in each of recent years.

Mr. NELSEN. Does a large percentage of the migrant workers have their own trailer facilities for housing?

Miss JOHNSTON. I have traveled in a good many States that employ migrants. I have yet to see trailer facilities used as housing for migrants. Now, I am sure that there are some. I have heard about them. But I have not seen them. They are not extensively used.

The housing that you usually see is framework construction, often in barracks-like units. You have probably see some in Minnesota.

Mr. NELSEN. Some do have their own trailer facilities, do they not, as they travel around in house trailers, for example?

Mis JOHNSTON. I beg your pardon?

Mr. NELSEN. Some have trailer housing, do they not, as they travel around?

Miss JOHNSTON. A few may, but this is quite unusual.

Mr. NELSEN. No more questions, thank you.

The CHAIRMAN. The gentleman from New York?

Mr. O'BRIEN. I have no questions, Mr. Chairman.

The CHAIRMAN. The subcommittee is honored to have our distinguished chairman of the full committee with us. Mr. Harris, do you have any questions?

Mr. HARRIS. Thank you, Mr. Chairman, but I would wait if you have some questions yourself.

The CHAIRMAN. I have finished.

Mr. HARRIS. First, I would like to go back to a question that was asked by our colleague from Ohio, Mr. Schenck. You say that in HEW there are approximately 68,000 employees?

Mr. JONES. I would like to get the exact figure for the record, Mr. Chairman. In the neighborhood of 68,000.

Mr. HARRIS. How many of those are in the Social Security Administration?

Mr. JONES. I do not remember the exact figures, Mr. Chairman. May I provide that for the record?

Mr. HARRIS. Yes.

(See table entitled, "Total Paid Employment as of January 31, 1962," appearing on p. 33.)

Mr. JONES. I think we have about 33,000, about 30,000, in the Public Health Service, which accounts for about half of the total employment. Social security would be—I just do not recall those figures, Mr. Chairman. I can get them for you in detail.

Mr. HARRIS. There are so many in social security, so many in the Welfare Department.

Mr. JONES. So many in the Office of Education, and then we have Food and Drug Administration that accounts for a good many of them. We have St. Elizabeths Hospital, which accounts for 3,000 or more.

Mr. HARRIS. Those in Food and Drug, those in the hospital program, are not part of the Public Health Service?

Mr. JONES. No, sir.

Mr. HARRIS. And the Public Health Service, itself, has approximately 30,000?

Mr. JONES. That is correct, yes, sir.

Mr. HARRIS. All right.

You have said that the total budget for HEW for the next fiscal year would be approximately $5 billion?

Mr. JONES. $5 billion, yes, sir.

Mr. HARRIS. How much of that would be Public Health?

Mr. JONES. Around $1 billion.

Mr. HARRIS. In other words, the $4 billion, or 80 percent of it, is in some other phase of HEW programs?

Mr. JONES. Yes.

It would be closer to $1,450 million, I think, for Public Health Service in the 1963 budget proposal.

Mr. HARRIS. Now, this is a grant program?

Mr. JONES. That is correct, practically, except for the $250,000 for extension of the community services of the Public Health Service for purposes of the migratory health program. Then that would be for this year.

For the next year, it would be up to half a——

Mr. HARRIS. So that I can get a little better picture of it—please explain what that is; $250,000 for what?

Mr. JONES. For this next year, for the 1963 budget.

Dr. Christensen, who has handled these budget figures, can be quite specific about it, Mr. Chairman.

Dr. CHRISTENSEN. The bill, as we see it, would require $3 million to implement it; $2,500,000 would be for project grants to communities and $500,000 for direct operation.

We anticipate that the $500,000 would be for the employment of personnel which probably would include about three teams, and these teams would move along with the migratory streams as they go northward with the migratory workers, in taking care of the interstate relations and seeing to it that the health needs of the migrants are being met as they go along.

Mr. HARRIS. How many people will be on each team?

Dr. CHRISTENSEN. There will probably be in the neighborhood of five to eight people on each of the teams. One of the problems is that there needs to be a continuity of treatment as they progress northward along the stream and this would be what these people would do, and part of it would be for the assignment of personnel to States to further assist the States in broadening their program for this particular area.

Mr. HARRIS. You are getting me a little more befuddled as you go along.

Dr. CHRISTENSEN. There is $2.5 million for grants, which would be for project grants.

Mr. HARRIS. In the first place, I do not see how in the world you can take three teams of five to eight people and accommodate all the migratory workers that you have here.

Mr. JONES. Before you came in, Mr. Chairman, we pointed out that this is a stimulatory program, and that the $3 million in total is not intended to take care of the health needs of 1 million people in the migratory group.

It does intend, through the half million dollars of direct operations available to the Public Health Service, to make possible the coordination among the States and local communities involved in the interstate-intercommunity aspect of the migratory worker problem.

The other $2.5 million would involve grants to communities for their own development of programs which they would contribute to greatly.

Mr. HARRIS. I want to get to that a little later. Let us take one thing at a time.

Mr. SCHENCK. Will the gentleman yield on this point?

Mr. HARRIS. Yes.

Mr. SCHENCK. As I understood the explanation, the staff at the local level is to be composed of local and State people, and, as I understood this situation, that these so-called teams are to be so-called organizing or coordinating teams.

Mr. HARRIS. Well, that comes out of the grant.

Mr. JONES. No, sir, that is out of the direct operations. These coordinating teams are the function of the national agency in order to bring these programs together. It is a national problem that can be handled only through a national agency in terms of the correlation among the States, and the teams would be for purposes of coordination and correlation, working among the various communities that cross State lines, and this would be a Public Health——

Mr. HARRIS. Would the personnel on the local level be part of this three-team operation? That the $500,000 would go to?

Mr. JONES. No, sir. This would be a Public Health Service direct operation. But the local people would organize and develop the community program through grants, stimulatory grants, to the local communities.

Mr. HARRIS. That is what I thought.

Mr. JONES. That is correct.

And then the team would help provide and develop additional support for the local service of the migratory workers, while they were in their home communities.

Mr. HARRIS. But the half million dollars would not go for that supplemental work?

Mr. JONES. No, sir.

Mr. HARRIS. The half million dollars goes to the three-team operation?

Mr. JONES. That is correct, you are quite correct.

Mr. HARRIS. Is that not a little bit excessive for 24 or 25 people?

Dr. CHRISTENSEN. In addition to this, Mr. Chairman, there would be personnel and also equipment that would be assigned to the States, and some of the personnel might be assigned by the States to the local communities to assist in the development and operation of their programs.

Mr. JONES. I might point out that one of the problems that makes the assignment of health personnel and the assistance of these teams important, Mr. Chairman, is the language difficulty. Some of these migratory workers who are natives of this country speak only Spanish. They go into sections of the country where there are no health workers who can do this.

Mr. HARRIS. I am not questioning that.

Mr. JONES. Yes.

Mr. HARRIS. I think that is true.

But I am going back to the point of a half million dollars for 20 to 24 people.

Mr. JONES. These three teams do not represent the total use of the $500,000. In addition there will be the assignment of equipment and also specialists to State and local health units to assist in specialized problems, technical assistants.

Mr. HARRIS. How many of these specialists are you going to have to have to assign in this field?

Dr. CHRISTENSEN. There will be about a total of 51 persons that will be employed for this purpose. This will include the members of these teams that I have talked about. It will include the personnel assigned to the States. It will include the backup people that will be needed to assist them.

Mr. HARRIS. The additional personnel other than the teams referred to, will they be people assigned to go to the individual States?

Dr. CHRISTENSEN. Some of these personnel will be assigned to the States and to the communities, other than the teams I have mentioned.

Dr. HARTING. Mr. Schenck raised the question earlier about the availability of personnel. This is a spotty problem over the country, and I comment on the point that many kinds of personnel can be hired on a temporary basis, and new sources of professional personnel can be tapped.

On the other hand, we know there are many areas of the country in which services will need to be provided in which the State or local area will have difficulty in getting certain kinds of professional health personnel.

We have found in other situations that the Public Health Service's ability to hire and have people be part of our personnel system enables the Service to employ people who can then be loaned to work in some isolated areas. Frequently this is the only way of getting the technical people into the area.

These kinds of people would be carried as part of what we have in the budget as direct operations or technical assistance.

Mr. HARRIS. In other words, I suppose it could be appropriately said that this is a small point 4 program for some of our own people.

Mr. JONES. I would put it another way, Mr. Chairman.

Mr. HARRIS. I would agree that it is time we were beginning to think about a point 4 program for our own people, since we are thinking about it for all the world.

Mr. JONES. I would say the same thing and reinforce what you said and say we are bringing to a neglected group of our own citizens the kinds of health services that other groups already are accustomed to receiving.

Mr. HARRIS. But I do think that we should have a very definite understanding. Here you have got a direct operational group proposed. You have teams that are organized to tell the local people what to do or, as you say, "coordinate" things.

Then you are going to have somebody in direct control who will stay on the job to see that the coordination is carried out, I suppose.

Mr. JONES. Yes, and the technical assistance in the organization of these peculiar and unique kinds of services for this special group. This is technical assistance, actually, using the analogy of the point 4 program.

Mr. HARRIS. I cannot see, Mr. Jones, where there is any special kind of assistance needed to take care of people like that in any community of the country except perhaps where the language problem might be a barrier.

Mr. JONES. It is chiefly a question of aid in organization, Mr. Chairman.

Mr. HARRIS. The clinical facilities and things of that kind—I do not think that we have to have a point 4 program to help them develop that. I do not know of any place in the country that they do not have some local facilities, if we can just get them interested and give money to them.

Mr. JONES. Yes, sir.

Much of the problem has to do with the fact that the people are here in this community that gives one kind of service today and they are gone into another one tomorrow, and the services do not match, and these people, themselves, do not know how to take advantage of the services that may be available to them.

Dr. HARTING. There is a certain amount of economy that can be achieved by some coordination. Some of the problems are those of continuity of service as people move.

Mr. HARRIS. Yes. Well, I have some very grave questions about this alleged economy that is brought out of these Government programs. We had a reorganization of Congress one time and it was going to do great things for the American people. And I think you will find that the cost of Congress in its operations now is probably two or three times what it was before we had the reorganization.

I do not believe that I have ever observed one of these Government programs develop, laudable as they be, where you observe any real economy that comes out. That is just one of the regional results that you get out of them, so I do not believe that I could sell that idea much on the floor of the House.

Mr. JONES. I think, Mr. Chairman, part of the economy comes in the saving of other costs of health care for these people by this preventive medicine program, which is not now available to them. This is one of the kinds of saving that we are talking about.

Miss JOHNSTON. Actually, under the present circumstances, one of our problems is that there is duplication of some services for migrants, simply because they move from one area where a special thing is being emphasized, to another area where the same thing is being emphasized.

Mr. HARRIS. You mean they vaccinate them for one thing in one place and they get to another place and they vaccinate them for the same thing?

Dr. HARTING. Four times in a season.

Mr. HARRIS. I imagine they would be hollering.

Miss JOHNSTON. This is a problem that the States present to us. It is one of the reasons that we would be interested in helping them establish some continuity.

Mr. HARRIS. Now, the $2.5 million, that is the grant phase of it. You grant that to whom?

Mr. JONES. To public or nonprofit private agencies, Mr. Chairman, in a local situation. Generally, it will be a State health department or a unit of it which will use this as a stimulatory grant to develop a community service where the migrants are.

Mr. HARRIS. Is this through local clinics or local Federal aid?

Mr. JONES. Both. We mentioned earlier the family clinic concept in which the total family of the migrant worker would be seen in a clinic setup where they can get to the clinic for general diagnostic and outpatient treatment work of general medicine type.

Then problems which need special attention that cannot be given in this context will be referred to an existing community health facility.

Mr. HARRIS. This does not establish any clinic?

Mr. JONES. Except in terms of the actual family-type clinic where the migrant workers are. The clinic may be an outpost of an existing community service. A County Health Department may have a clinic at one location to serve the permanent residents. But they get an influx of migrants who are located in an entirely different section of the county and the migrants cannot come——

Mr. HARRIS. While we are at that point, let me ask you this question:

Is there not a county health officer in practically all of the counties of the United States?

Mr. JONES. No, sir. Would you comment?

Dr. CHRISTENSEN. No, sir, there are not health departments in all of the counties in the United States.

In some of the rural areas there are very few health departments, although a fairly large percentage of the national population is covered by local health services. When you get out to the rural areas where the migrants will be, health services are very, very limited, and in many places clinics do not exist at all and health departments do not exist at all.

Mr. HARRIS. Do health officers? Is there a health officer?

Dr. CHRISTENSEN. No, sir, there is not a health officer in all of the counties of the United States.

Dr. HARTING. I do not have the exact number, but it is something like a thousand counties of the three thousand that do not have organized local health departments with a health officer.

Mr. HARRIS. I thank you gentlemen. I wanted to get that general information. But the $2.5 million estimated as authorized in this program then would go to these nonprofit health units, clinics, and so forth?

Mr. JONES. Public and private nonprofit.

Mr. HARRIS. Would that go through the State agencies?

Mr. JONES. For the most part, it would go through the State health agencies, yes, sir.

Mr. HARRIS. For the most part?

Mr. JONES. Yes, sir.

Mr. HARRIS. How is that part going that does not go through it?

Mr. JONES. I think it would almost exclusively go. But it would be permissible for a grant to be made to a local Hill-Burton Hospital, for example, for an outpatient service conducted by the staff, if this were designed for the migratory workers. With a little "seed" money to help provide a nurse or an aid who would organize the service, the hospital might provide service at its own expense.

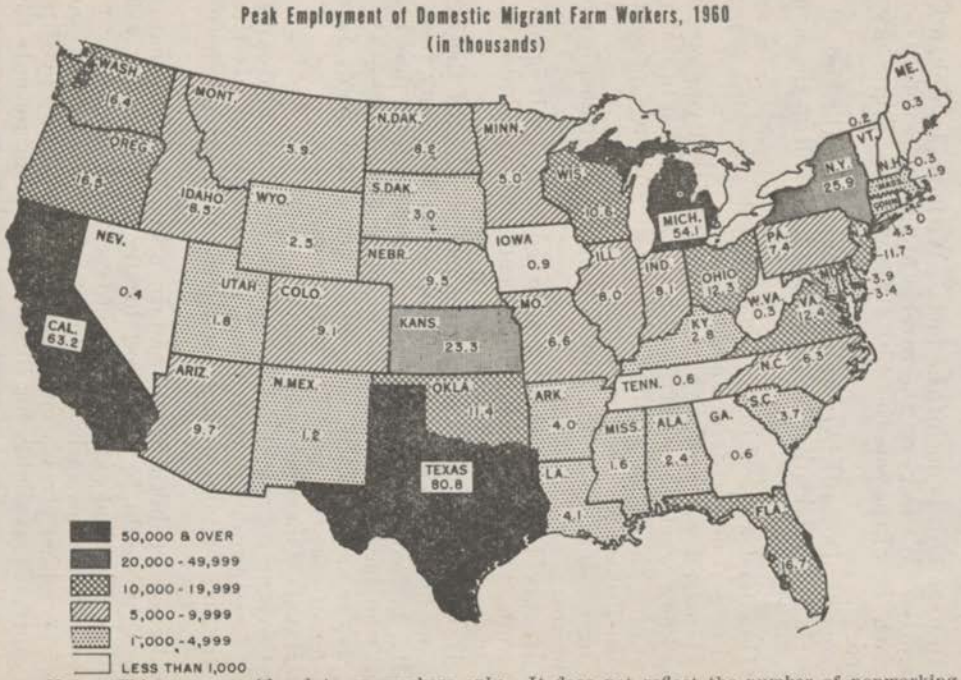
But practically all of the grants would be expected to be channeled through the State health departments.

Mr. HARRIS. I have heard that the most acute need for this would very likely be in California and Florida. Is that substantially true, or would that be a little misleading?

Mr. JONES. We pointed out, Mr. Chairman, that there are 31 States that have some substantial involvement, and all but perhaps 2 are involved to some degree. I think there is a concentration in California, in Texas, Michigan, New York and Florida. We have presented to Mr. Roberts and will have for the record a chart of this kind of coverage.

(The chart referred to follows:)

U.S. migratory farm workers are employed throughout the nation.



NOTE: This map provides data on workers only. It does not reflect the number of nonworking family dependents who accompany workers for part or all of a crop season.

Source: Levine, Louis. Hired Farm Workers in the United States. U.S. Department of Labor, Bureau of Employment Security. June 1961.

Mr. HARRIS. This shows concentration in California, Texas, and Michigan?

Mr. JONES. Yes, sir.

Mr. HARRIS. And then next to that, New York and Kansas?

Mr. JONES. That is correct.

Mr. HARRIS. It is a little bit surprising to see such a concentration of this type of operation in Michigan. I am not surprised at Texas or California.

Mr. JONES. This is one of the facts. We have, I think, a list of all the counties. We have on the reverse of the large sheet that we left with you a list of the counties with the numbers of migratory workers involved.

(A copy of "Domestic Agricultural Migrants in the United States," Public Health publication No. 540, may be found in the committee's files.)

Mr. HARRIS. I was looking at this pamphlet.

Mr. JONES. These are work areas.

Mr. HARRIS. I was looking at this pamphlet that you gave me here. Do you know whether or not there is any opposition to this program from any of the farm groups? They are the ones primarily that would be affected by these programs, are they not?

Mr. JONES. It is the Public Health people that are deeply concerned, Mr. Chairman.

Mr. HARRIS. I know they are concerned with it. It is supposed to help people who are working in agricultural-type industry.

Mr. JONES. I know of no opposition, myself.

Dr. HARTING. Mr. Chairman, after modification of the bill in the Senate, we have been aware of no opposition from any farm groups. Actually, in many local areas and in many States it has been farm groups who have assisted in the development of these services because, as far as the health services are concerned, many farmers see this as a real asset to them. You are correct.

Mr. HARRIS. One other question.

The Government would put $2.5 million in grants in areas where the streams of migratory workers flow. Is there any way to estimate how much the local clinics or organizations would extend in this direction?

Mr. JONES. I think it would be fair to say, Mr. Chairman, that the amount that would be expended locally would greatly exceed the $3 million. To what extent, is hard to estimate. Some of it will be in the form of services such as buildings, facilities, plants; some of it, time of personnel already employed; some of it, employed personnel made especially available for this program from not only the public and nonprofit agencies, but some private voluntary agencies will participate; some of it, farmer users themselves will provide. It is a stimulatory grant program, actually.

Mr. HARRIS. Yes, I remembered you said that, but I wanted to try to find out just what kind of a stimulant it will be.

Mr. JONES. If our previous experience with programs of this sort is any indication, I think it will be quite stimulatory, and I think it will be fair to say greatly in excess of the $3 million. Would this be your judgment?

Dr. HARTING. Yes.

Mr. HARRIS. I think in some of the foreign aid programs, it is contended that we get four for one. For each dollar we spend, why, there are three others spent. Would you say it would reach that extent?

Mr. JONES. I would say that would be reasonable to assume, Mr. Chairman.

It will vary from community to community, and this is why no specific matching formula is suggested, because this would be unrealistic in terms of the impact of these migrant workers, community by community.

Mr. HARRIS. Is this number of migratory farmworkers increasing or decreasing?

Miss JOHNSTON. I think that the Department of Labors' pamphlet, which has been submitted, indicates that the number has been remaining fairly constant in recent years.

Mr. HARRIS. Have you had any reports where there were serious diseases that would break out in a community as a result of infections from migratory workers?

Mr. JONES. Yes, sir.

We referred, Mr. Chairman, before you arrived, to a situation in Plainview, Tex., where as a direct result of the influx of migratory workers, an epidemic of diphtheria broke out, resulting in a death and cases of the disease in epidemic numbers which was quite a tragic occurrence for the community.

Typhoid fever has broken out in areas that had not previously had typhoid fever in recent years, and diarrheal diseases.

Mr. HARRIS. I want to concur in what you said a moment ago about the capability of people to do certain work. I would not want to limit it to capability. I would also want to include the willingness of the individual.

I had some experience as a boy picking peaches and getting fuzz all down your neck. I do not think you could get many of these people in certain areas who are on the so-called unemployment relief rolls to engage in that kind of activity. I would also say, speaking with reference to capability, that in the harvest on many occasions I have seen people who really knew how to harvest fruit and pack it. They could just work circles around someone else who did not have the knack to do that kind of work. I might also say for the information of our city boys that I was raised on a farm, myself. I have worked in the cottonfields a great deal during my life, as much as any farm boy. I could chop cotton and plow cotton, and keep up I think, with anybody. But I have tried to pick cotton, and my dad and I would take three rows. He would pick two of them and I would pick one.

He would pick just about twice or a little bit more cotton than I would pick, and I would work my darn head off trying to do it. I simply could not get it.

There are some people that can; there are some people that cannot. And I decided that I was not going to while my life away picking cotton. That is all.

The CHAIRMAN. The chairman had the same experience. I went to work in a drugstore. I think, unless there are other questions of the subcommittee, we wish to thank you.

Mr. JONES. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Ryan, the gentleman from New York, who is the sponsor of this bill, has been here for some time, and the Chair would like to call on him to testify at this time.

STATEMENT OF HON. WILLIAM FITTS RYAN, A REPRESENTATIVE IN CONGRESS FROM THE 20TH CONGRESSIONAL DISTRICT OF THE STATE OF NEW YORK

Mr. RYAN. Having listened to excellent testimony on the part of the previous witnesses and the Department, I do not believe it is necessary for me to testify at length.

I have a statement which I would ask to be included as a part of my remarks, if I may have consent to revise and extend my remarks.

The CHAIRMAN. Without objection, your prepared statement will be printed at this point in the record.

(The prepared statement of Mr. Ryan follows:)

STATEMENT OF HON. WILLIAM FITTS RYAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. Chairman, I appreciate this opportunity to testify in behalf of my bill, H.R. 8882, which would authorize a program of Federal grants to improve health services for domestic agricultural workers and their families.

Every year the American migrant farmworker helps to harvest crops worth billions of dollars. During the course of a year, he and his family may travel from Florida to New York, or from Texas up to Montana and back. They may help to harvest the citrus and cotton in Arizona, or the peaches in Georgia, the potatoes in Idaho, the beets in Colorado, or the apples in Washington. Harvesting these crops enriches our diet and contributes to our standard of living. My own State of New York is indebted to these migrant farmworkers because they have helped us maintain our rank as one of the Nation's leading farm produce States. But there are many other States and communities which depend upon this labor force, for, as you know, there were more than 1,000 migrants employed in every State except seven during 1959. There is no doubt, then, that they form an essential part of our farm economy.

Wherever he and his family may go in search of work, whether up the east coast or the west coast, they travel through a land of plenty. Most of them live, however, in a world of poverty and disease. This paradox of poverty amidst plenty, preventable disease in the midst of one of the most highly developed health care systems in the world has been described by Dr. Hector Garcia who said:

"The children of migrant parents are born into a world completely of their own. An anemic mother, and possibly a tubercular father—a life that will take him into his world where he may possibly die within 1 year, either from diarrhea, tuberculosis, or malnutrition. His infancy would be a very close association with his brothers and sisters. Their home would be 1- or 2-room shacks, with no inside running water and no flushing toilet facilities. If he lives to be of school age, he could possibly go to many schools on different occasions at different places, but will never average more than 3 years of schooling in his lifetime. However, he will have done better than his parents who may be completely illiterate. His future life will be one of wandering, poverty, and more sickness. If he lives to be adult, he may average as high as $60 a month; that is, if he is not displaced by cheaper labor.

"If he is displaced, his average may go down to $300 a year, or even less. He will live, if he is lucky, in a substandard home, and may die an early death from tuberculosis.

"At an early age he will travel with his parents on his 'Via Dolorosa' on a caravan of hardship, suffering, and exploitation. He will always have to be competing with greater numbers of imported cheap labor. As a migrant, his world will be from the Atlantic to the Pacific, from the Great Lakes to the Rio Grande. It will be his world, however, only in that the only piece of property that he will own will be his grave."

My bill is directed toward bringing the benefits of our society into the world of these migrant families by helping them to receive some of the basic health services that are available to other American citizens.

Mr. Chairman, it seems unbelievable to me that in this day and age there could be a group of people in this country whose level of health compares to that of

the general population in the year 1900. Back in 1900, the communicable diseases were the leading causes of death in this country. These diseases included influenza and pneumonia, tuberculosis, and the infectious digestive diseases such as diarrhea and gastritis, etc. We have conquered most of these diseases through sanitation, better nutrition, and immunization. Yet today, these are still the diseases which plague the migrant worker and his family.

The President's Commission on Migratory Labor reported in 1951 that infant mortality, maternal mortality, dysentery, smallpox, and typhoid were far more prevalent among migratory workers than among the general population. More recent State and local surveys indicate that this situation has not improved in the last 10 years.

For example ,in 1959 the Florida Board of Health reported that diarrhea was the most common cause of infant death and severe illness among migrant children after the first month of life. There is also recent evidence that this disease is prevalent among migrant families in other States as well.

A special consultant for the Senate Subcommittee on Migratory Labor recently prepared a report on the health conditions of these families. He found evidence from several State surveys showing that tuberculosis and venereal disease are more prevalent among migrants than in the general population as a whole.

He also found evidence that such simple preventive health methods as immunization are sometimes virtually unknown among some migrant groups. For example, a 1957 report of the health of migrants in Idaho showed that almost none of the children had received any immunizations against diphtheria, whooping cough and tetanus. Similar findings were reported in localities in Texas, Illinois, Florida, and California.

Other testimony before this subcommittee brought out the fact that in a 1959 tuberculin survey of migrants in Hollandale, Minn., 66.4 percent of the migrant group aged 15 or more had positive reactions to the tests compared with only 13 percent for the general population.

The American Public Health Association has reported very succinctly also on the health condition of these families. This association summarized the findings of nearly all the studies made of these families during the past two decades as follows:

"The health needs of domestic seasonal agricultural workers, particularly those migrating from their home communities, are greater than those of any other socioeconomic group in the United States. These people have health problems similar to, but more severe, than those of stable rural farmworker's families. Studies continue to show: high infant mortality rates, high communicable disease, rates, low prenatal care rates, high premature birth rates, high accident rates, low immunization levels, serious needs for dental care, and little realization of the needs for or utilization of preventive and early treatment."

Mr. Chairman, this summary sounds like a health report that might come from one of the undeveloped nations of the world—not from the United States. But this is an accurate picture of health in the migrant's world. This picture shows the ugliest kind of human waste because it can be prevented. This alone should move us to action.

These diseases are not only devasting to the migrant and his family, however, they also endanger others. Disease epidemics among these transient groups take place in established communities throughout this country. Local residents as well as the migrant are subjected to diseases that medical science has conquered and controlled.

For example, in November 1960, a diphtheria epidemic broke out in a community in Texas. In early November, 7 cases were reported in two migrant families. By the middle of February, diphtheria had spread to more than 70 persons, including 43 local residents. These residents, as well as the migrant families, were exposed to a very serious disease which is almost unknown in most of this country. A similar incident occurred in the fall of 1959 when residents of a community in Virginia were exposed to a typhoid epidemic which broke out among migratory workers in the community. In both instances, immunization could have prevented these epidemics. But everywhere along the line of their trails, these migrant families had for some reason missed out on this basic public health service.

Migrants usually work in rural counties or in remote areas where the services of public health nurses and doctors are not readily available. They live on the fringes of our communities, strangers to basic health services which the rest of us have accepted and known all our lives. They usually remain strangers

because they do not have access to these health services. Sometimes it is simply because they have no means of transportation to get from a labor camp to a doctor or a health center. Again, since they are unaccustomed to regular health care, they may not use preventive health services, or take care of a medical problem in its early stages because to do so would mean the loss of part of their meager earnings.

It is also quite often impossible for communities to stretch their health services to meet the seasonal impact of these migrant groups. Some communities have meager health resources even for permanent residents. Another part of the problem is that no single community or State feels that this is their problem alone.

There are, of course, some health programs for migrants which are in effect now. But generally these are few, scattered, and uncoordinated. The results of this lack of coordination have been documented by epidemics such as those just mentioned, and by many cases reported from social workers and nurses. One such case involved a child who had been born with a crippled foot. At one of their stops along their line of travel, a doctor put a cast on the baby's foot. After the family left, the mother removed the cast because the baby cried. Later when the baby came back, the only alternative was surgery. After the baby's foot had been treated, the family moved on again but there was great doubt that the child received any followup treatment. Again, this illustrates that most of our public health programs are not adapted to a transient population.

An example of the type of program which has been successful in reaching these migrant groups in the Westside family clinics in Fresno County, Calif. These clinics operate as outpatient clinics of the Fresno County Hospital with no residence requirements for eligibility. They are conducted at night when the workers can come for help and these services are taken directly to the migrant in his labor camps. Housing for the clinics is provided mostly by the growers, and they are staffed with volunteer doctors and nurses on loan from the public health department. These clinics were first made possible by a grant from a foundation. Their success has been proved by the fact that there was a significant drop in infant death rates. Once the highest in the Nation, the death rate among infants was cut in half in 3 years. There was a decline in the rate of death for diarrhea from 43 in 1954 to 9 in 1956. The success of these clinics is still further illustrated by the fact that in 1951 when they were first opened, 881 people came in the first 3 months. In 1958, 1,333 came in the same 3 months of the year.

Similar projects have been started in Florida and Colorado with special grants from the U.S. Children's Bureau and other States and communities have tried to meet the health needs of these groups. New York State, for example, operates a program for migrant families through district offices of the State Health Department. Public health nurses and other health personnel visit work camps to take services directly to the family. New York is one of the few States which has no residence requirements for public aid of any kind. In 1957 it was reported that $79,000 in State welfare funds went for hospital care for these families and another $10,000 for medical care. But the fact remains, that most communities cannot bear the cost of providing such services for the temporary influx of these families.

Experts have pointed out that we need a chain of health services for migrants throughout the country similar to those projects in California, Colorado, Florida, and other States which have developed flexible programs geared to the particular needs of the migrant. While the health care of these families remains primarily a local responsibility, the interstate nature of the problem calls for increased Federal responsibility. We have seen that communities and States alone cannot completely solve this problem.

My bill would give the Federal Government a more active role in helping communities to set up this chain of migrant health services. Federal grants to public or nonprofit agencies could stimulate the development of special services for these groups which might never be developed otherwise simply because the extra money required is not available. Some of our best projects have been started first with grants, either from a foundation, as in the case of the Fresno County project, or from a special grant from the Children's Bureau, as in the case of projects in Florida and Colorado. Federal project grants and technical assistance would be used in conjunction with established community health services to encourage and assist them in family health service clinics geared to meet the special needs of the migrant and his family.

My bill also provides for special project grants to develop improved methods of providing health services for this group and for training personnel especially to serve this group.

The $3 million authorized annually by my bill would also be used by the Surgeon General to encourage the development of a coordinated chain of services for these families. This is essential if we are to prevent such tragedies as the outbreak of epidemics and the physical maiming of children through neglect.

An expert advisory committee would assist the Surgeon General in administering and developing this program.

Mr. Chairman, I believe that legislation such as this is necessary if we are to make any real progress in improving the health condition of these American migrants. I believe that Federal Government has a proper responsibility in this area. My bill recognizes the need for increased Federal leadership, technical assistance, and encouragement to States and localities in solving the problem of providing health services to a transient group of people.

It is time we ended this particular American tragedy. The "Grapes of Wrath" should be a "period piece" not a comment on the current American scene.

Mr. RYAN. I believe that the importance of this proposal has been stressed by the Department this morning in terms of what it can accomplish in aiding communities throughout the areas which feel the impact of the migrant laborers to meet their health needs and to set up family clinics. It would not only stimulate local activity, but also help the communities, into which the migrant laborers go, meet health problems which may be created, such as diphtheria epidemic which broke out in the Texas town. Diphtheria was practically an unknown disease at that time, but it broke out because of the influx of migrant labor.

Repeatedly the migrant laborer suffers diseases which are practically unknown among other groups of our population: diphtheria, tuberculosis, even diarrhea becomes a very crucial disease among migrant workers.

This bill (H.R. 8882) would give the Federal Government an active role in helping communities to set up a chain of health services to aid migrants. Federal grants to public or nonprofit agencies would stimulate the development of special services which might otherwise never be developed.

We have an example in the Fresno, Calif., area, which has clinics established by foundations. I believe that legislation such as this is necessary if we are to make real progress toward improving the health conditions of the migrant laborers, and I think that the Federal Government has a proper responsibility in this area.

Through technical assistance and encouraging the States and localities to meet the problem, we will do a great deal to alleviate the conditions which have been described, sometimes very shockingly, by reporters who have traveled and who have worked with the migrant laborers during the past year.

It seems to me that it is time that we end what in some areas is a tragedy, and that is the exploitation of migrant workers. "The Grapes of Wrath" should be a period piece, not a comment on the current American scene.

I thank you, Mr. Chairman and members of the committee, for the opportunity to appear in support of this measure.

The CHAIRMAN. Mr. Ryan, is there any difference in your bill, H.R. 8882, and the Senate-passed bill, S. 1130?

Mr. RYAN. My understanding is, Mr. Chairman, that they are identical in language, and they provide for the establishment of health service clinics for migratory families.

The CHAIRMAN. I believe that is all I have.

Any questions, gentlemen?

Mr. HARRIS. Except I would like to say, Mr. Chairman, that I join the chairman and other members of the committee in extending welcome to our colleague. We are glad to have his testimony.

Mr. RYAN. Thank you very much, Mr. Chairman.

Mr. O'BRIEN. I would like to join in that welcome, and I would like to ask you one question.

I notice that the largest number of workers in any migrant camp in New York State is Suffolk County, which is quite close, of course, as we know, to New York City.

Do you happen to know where the bulk of those workers come from? Do any substantial number come from New York City?

Mr. RYAN. I would say not, Mr. O'Brien. I think most of them are migrant laborers who work their way up along the East Coast moving with the crops. Suffolk County, of course, has a big truck farming industry. Potatoes is a large part of it.

Mr. O'BRIEN. That is part of the stream?

Mr. RYAN. This is part of the migratory stream.

Mr. O'BRIEN. The reason I asked the question is we have had the testimony here from time to time about the possibility of unemployed people going in and doing this work. Now, we have a great number of unemployed people in New York City because it is a large city. We also have Newburgh, which is familiar to some people, which is not too far from Suffolk County. But, apparently, there is no effort, no desire, no movement on the part of any of those people to perform this stoop-over labor.

Mr. RYAN. It is difficult for people who have been raised and who have spent their lives in the city to move into truck farming areas.

Mr. O'BRIEN. I understand that.

And it is not because they are loafers who do not want to work. It is just the kind of work that they cannot perform. They are just not good, and the farmer probably would not want them, would not take them.

Mr. RYAN. The farmer would not want them, either. I am familiar. I have not spent all my life in the city of New York—I was raised in an area where there is a considerable amount of cherries, berries, tomatoes. In Western New York we now find that migratory labor is coming in and doing the stoop labor, even picking cherries, whereas high school children used to pick the cherries, but it is not being done to the same extent any more.

Mr. O'BRIEN. Thank you very much.

The CHAIRMAN. Any further questions?

Thank you very much, Mr. Ryan.

Mr. RYAN. Thank you, Mr. Chairman.

The CHAIRMAN. Next will be Dr. C. L. Brumback, director of the Palm Beach County Health Department, director of the Palm Beach County Welfare Department, and director of the Palm Beach County Home and Hospital.

Doctor, it is a pleasure to welcome you to our subcommittee. We appreciate the fine work of the gentleman from Florida, and I believe you are in his district. I am sure, in the opinion of other members of the committee, you are certainly welcome, and we appreciate your fine work.

Mr. ROGERS of Florida. I do want to welcome Dr. Brumback, too, particularly because I think he will be helpful to the committee on this problem. I think he is as knowledgeable on some of the difficulties that have arisen on migrant health problems as any I know, and he has done a terrific job in Palm Beach County in this field, and I welcome his testimony.

STATEMENT OF C. L. BRUMBACK, M.D., DIRECTOR, PALM BEACH COUNTY HEALTH DEPARTMENT; DIRECTOR, PALM BEACH COUNTY WELFARE DEPARTMENT; AND DIRECTOR, PALM BEACH COUNTY HOME AND HOSPITAL

Dr. BRUMBACK. Thank you very much.

Mr. Chairman and gentlemen, I certainly appreciate this opportunity of being here today and testifying before you. I have a prepared statement here. However, perhaps rather than read all of this, I can spend my time more profitably answering questions and speaking from experience, because we have had this type of family clinic that has been discussed here today.

We have had this type of activity going on in Palm Beach County for several years.

The CHAIRMAN. Without objection, you may file your formal statement.

(The statement of Dr. Brumback follows:)

STATEMENT OF C. L. BRUMBACK, M.D., DIRECTOR, PALM BEACH COUNTY HEALTH DEPARTMENT

Of all public health problems in this country none are more acute, persistant, or more difficult to solve than those pertaining to domestic agricultural migrants. In Palm Beach County, Fla., public health workers spend a large part of their time trying to solve these problems.

Agricultural migrants and their families have the usual health problems of people of their socioeconomic group, compounded and magnified by their movement from one place to another and their frequent lack of residence anywhere. They have tuberculosis, venereal disease, dysentery, heart disease, and cancer. The crowded and often insanitary conditions under which they live aggravate these conditions. They are denied welfare benefits available to residents under the same circumstances because many have not been able to establish residence in any State or county.

The tragic stories of sickness, suffering, and death—often preventable and unnecessary—have been told so many times that they have become commonplace, except to the migrants themselves and to whose responsibility it is to deal with each of these problems as it arises: The pregnant woman who has had no prenatal care and for whom there is no place to deliver her baby; the child whose teeth are already rotting away; the baby dying from filth borne dysentery—the list is endless.

In place of clinics available to residents but not to migrants because of lack of transportation, or lack of residents qualifications, clinics catering to the special needs of migrants are proposed, mobile if necessary so that they can go where the migrants are. Such clinics should be prepared to serve entire families, to immunize, to find cases of disease, to diagnose, and to treat. Physicians, dentists, and nurses are needed, sensitive to problems of migrants, understanding

their culture. Social workers prepared to help with the complex, seemingly impossible-to-solve family problems are needed. Nutritionists can help to fit an adequate diet into a limited budget by choosing available foods that migrants will eat. Educators can teach good health habits in language the migrants understand. Sanitarians will see that better housing and a more healthful environment is provided.

These proposals will cost money, but this money is already being spent. It is spent for the far-advanced case of tuberculosis requiring years of care who could have been treated in months if a chest X-ray had been available. It is spent for emergency hospitalization for a mother and baby for whom no prenatal care was provided. It is spent by taxpayers, farmers, purchasers of food who must pay for our failure to provide health services to migrants which are available to residents.

How do we propose to improve health conditions of domestic agricultural workers? Funds are needed for:

(1) Family clinics, mobile if necessary, offering maternity care, well and sick child clinics, immunizations, dental care, chest X-rays, venereal disease treatment and follow-up, and all types of diagnostic and treatment service which can be provided on an outpatient basis.

(2) Health education, provided by people trained in techniques adapted to the migrant culture.

(3) Nutrition services, provided by nutritionists who can adapt their programs to migrants' eating habits and budgetary limitations.

(4) Sanitary supervision of migrant labor housing, work, and recreational areas, provided by qualified engineers and sanitarians.

(5) Social services provided by trained social workers familiar with migrant problems.

(6) Hospitalization available through programs using combinations of Federal, State, and local funds.

(7) Coordination of health services from one county and State to another must be promoted through use of records and other means of communication.

All services for migrants should use existing community resources augmented with additional staff and equipment. Training opportunities should be provided for personnel so they may be prepared to work with migrants.

Attention must also be given to improvement of techniques for working with agricultural migrants through special projects available to State and local public health agencies.

S. 1130 will help a great deal toward correcting inadequacies in health care of domestic agricultural migrants.

Dr. BRUMBACK. Thank you, Mr. Chairman.

In 1954, we started our first formal project or program, although we had been working with agricultural migrants prior to that time, and since that time we have been working with several so-called projects or demonstration programs financed, in part, by the U.S. Children's Bureau.

As part of this type of program, we have established family clinics. We have carried these programs, these clinics, out to the agricultural migrants. The clinics have included as the staff which provided the services: physicians, including general practitioners and pediatricians, nurses, a social worker, a nutritionist, a sanitarian, a health educator, and certain people that we have designated by the name "liaison worker," simply because we had no better name to give them—people who came from the migrant group and who could interpret to these people what we were trying to do, and interpret back to us why they did not attend clinics or what their attitude was toward these services.

The question was asked with regard to why migrants did not avail themselves of services already available. There are many reasons for

this. These people often are not located in places where they can readily take advantage of the programs that are provided. They are isolated in camps and work areas that are far removed from any of the existing clinics.

For this reason, we find it necessary to take the services to them.

At the present time we have in Palm Beach County clinics that are operating several nights a week because—here is another factor: We find that if clinics operate in the daytime when the migrants are working, they cannot take advantage of these services.

So we have these clinics that operate in the evenings when the people are off work, and they operate out of a trailer. We have a clinic trailer which we take to the people, out to the farms. The question was asked as to the farmer's attitude toward this. These farmers welcome this service. They ask for it. They feel that they are left out if they do not get the service.

If it happens that we cannot provide a clinic on a particular day, we hear from the farmer about it.

Not only do they welcome the service, but they help us to plan and carry out the program. They actually have provided some of their own personnel, to help us keep records and to set up the clinic, to provide extra space for it and so forth.

So we know from experience that these services can meet a very real need, not only on the part of agricultural migrants, but on the part of residents, because if resident workers happen to be in the area where we have these clinics, we do not exclude them. We invite them to come in also.

Another thing that we have noticed is that this program has stimulated the total public health services that we provide to the general population. I do not know what there is about it, but it has improved our total program tremendously, simply having this going on in Palm Beach County.

A question was asked about local matching money. I can say that this has been provided; at least twice as much local matching money as has been provided through the Federal Government, and probably the estimate would be larger than this, because we have used many of our regular staff on these services that are provided to migrants.

I would be happy to answer specific questions that any of you might have.

The CHAIRMAN. Thank you, Doctor.

First of all, could you give us an estimate of the value of crops that are gathered by migrant laborers in Palm Beach County alone?

Dr. BRUMBACK. It seems to me that that estimate—and this is an estimate—would be in the neighborhood of $100 million. I will be happy to supply more accurate figures, Mr. Chairman.

The CHAIRMAN. You gave your estimate as $100 million?

Dr. BRUMBACK. A year; yes, sir. This is one of the large vegetable-growing areas in the State.

(The information mentioned above, appears as follows:)

Estimated value of agricultural products, Palm Beach County, fiscal year 1959–60

Vegetables	$60,932,000
Carlot equivalents, 33,363	50,876,000
Sugar and byproducts	20,000,000
Grain and grasses	100,000
Beef	10,000,000
Dairy, milk[1]	7,500,000
Dairy byproducts	3,000,000
Citrus	900,000
Cut flowers	2,500,000
Nursery	5,000,000
Poultry	1,000,000
Honey	110,000
Miscellaneous, tropical fruit, wood soil, rabbits, sod	2,500,000
Total	164,418,000

[1] Number of head, 17,500.

Figures supplied by county agricultural agent.
Prepared by Palm Beach County Industrial Information Service.

The CHAIRMAN. Is it true that when the crops are ready for harvest that you must act very fast in order to gather them in before you have a change in weather that might destroy the crops?

Dr. BRUMBACK. Yes; this is absolutely true. If we do not have the laborers there at the time when the crops are ready for harvest, they may be lost.

The CHAIRMAN. Is there any other source of labor for the gathering of these crops that you know anything about?

Dr. BRUMBACK. No, sir; there is not. The residents do not want to do this kind of work. They are not qualified for this type of service. The amount of help that we get from year-round residents is negligible.

The CHAIRMAN. In how many counties of your State of Florida would you say that this same practice is followed?

Dr. BRUMBACK. By "this same practice," you mean family clinics?

The CHAIRMAN. The use of migrant workers in gathering citrus and other crops.

Dr. BRUMBACK. I cannot give you the exact number of counties. It includes a very large proportion of the State, if we include citrus. The major vegetable-producing areas are Palm Beach, Broward, Dade, Collier, and Lee Counties. About five, or I would say maybe six, counties are involved in extensive vegetable producing.

Then we have quite a number that are involved in citrus.

So I should say perhaps 20 or 25 counties of the State would have quite a number of agricultural migrants.

The CHAIRMAN. I wonder if through some of your State services, perhaps the State customs commission or the State chamber of commerce, you could supply for the record the value of these crops that are gathered by migrant workers?

Dr. BRUMBACK. Yes, sir; I would be very glad to do that.

The CHAIRMAN. I would like to have that for the record.

Now, at the present time, how much is this health help costing Palm Beach County a year?

Dr. BRUMBACK. You mean the combination of Federal——

The CHAIRMAN. For migrant workers, and I believe you said you did make it available to others in the area if they wanted to take advantage of it?

Dr. BRUMBACK. Yes, sir.

Federal, State, and local money combined?

The CHAIRMAN. No, just the local .

Dr. BRUMBACK. Just the local?

The CHAIRMAN. And State.

Dr. BRUMBACK. Local and State money.

I would estimate in the neighborhood of about $125,000 a year for health services to migrants is State and local money.

The CHAIRMAN. Do you have any estimate of how much money you would receive under this bill if it were approved?

Dr. BRUMBACK. Yes, sir.

We have been getting in the neighborhood of $37,000 to $40,000 a year for Palm Beach County. The total amount approved for the past 5 years, that is, 1956 to 1961, included Collier County. Now, this amount has been increased to about $60,000 a year, practically all of which will be spent in Palm Beach County.

The CHAIRMAN. In other words, the ratio would run anywhere from 4 to 1 to 2 to 1 at present?

Dr. BRUMBACK. Yes, sir.

The CHAIRMAN. And you have then engaged in this program now for, I believe you said, 5 years?

Dr. BRUMBACK. Actually, our first project was conducted in 1954 and 1955. This was the initial project which demonstrated the need for service, and then we went into a 5-year program from 1956 to 1961, and we are on our second 5-year program now.

The CHAIRMAN. Do you have personal knowledge of any onset of epidemic or infectious disease that has been prevented, in your opinion, by this program?

Dr. BRUMBACK. Oh, yes.

We can substantiate this statistically. We know of dysentery, tuberculosis, venereal disease and others. We have incidence figures. We know that diseases have been prevented or picked up in early stages where they could be successfully treated, and the cost has been materially reduced.

In our program of obstetrics, for example, we have materially reduced the incidence of tetanus.

When I first went to Palm Beach County, the greatest cause of death among newborn infants delivered by midwives, who delivered a very large proportion of all of these babies, was tetanus of the newborn. This has dropped down to zero. We have not had a case of tetanus of the newborn in our county for several years.

The CHAIRMAN. What about the use of vaccines and other inoculant agents? Are those furnished by the local health departments or are those furnished by Federal money?

Dr. BRUMBACK. Those are furnished by our State, sir.

The CHAIRMAN. And the physicians and nurses who administer these vaccines are local people?

Dr. BRUMBACK. A combination of local and those provided by Federal funds.

The CHAIRMAN. Do you have some health personnel who volunteer their services? I mean doctors, dentists, nurses, and so forth.

Dr. BRUMBACK. Yes, we do.

A very large proportion of our service is provided by volunteers, particularly practicing physicians and dentists, many of whom give their time for this purpose, providing diagnostic and treatment service free of charge.

I might say that when indigent people are admitted to hospitals, the doctors receive no remuneration whatsoever for their care.

The CHAIRMAN. Do you think that this bill is necessary in order to obtain this?

Dr. BRUMBACK. I think it is very necessary. I think it will help to meet a great need, and I do not know of any other way of doing it.

Mr. RHODES. Dr. Brumback, when I went through Florida recently, I saw a sign on one of these migrant camps. I believe it was called the Belle Glade Housing Authority project. Is that a State or Federal housing authority?

Dr. BRUMBACK. I remember you asked a question about housing and I would be glad to answer it. This particular housing project was built by the Federal Government under the old Migratory Labor Act. However, it was turned over to the local community and is now operated as a nonprofit operation under the Belle Glade Housing Authority.

We have another authority in the Glades area, the Pahoke Housing Authority, which is operated in a similar way. However, I would like to say that these particular camps house only a relatively small fraction of the total number of agricultural migrants.

Mr. RHODES. I thought perhaps that was the case. I asked the question because it did not seem to make much sense to have that kind of housing under a State or Federal program.

Dr. BRUMBACK. That is right.

There is only a relatively small proportion of the total number of migrants that can be housed in this type of project.

Mr. RHODES. Could you tell us, Dr. Brumback, where these migrant workers come from that live in these projects?

Dr. BRUMBACK. The Atlantic coast stream goes up and down the Atlantic coast from Florida to New York and even beyond. Ordinarily, New York State is the northern limit of their migration.

This comprises most of the colored agricultural laborers. We do have some laborers that go up the Central States as far north as Michigan, but this would be relatively few.

Then we do have a proportion of our workers who are offshore labor; that is, British West Indians and Puerto Ricans. This group, however, is a minority of the workers in Palm Beach County.

Mr. RHODES. How long do they remain in these migrant camps?

Dr. BRUMBACK. They start coming in, in October, and they remain well into May or even up to June, in many cases.

Mr. RHODES. And what do they do on their return? Do any of them have permanent homes, or do they just keep wandering around to other camps?

Dr. BRUMBACK. Relatively few have permanent homes. Some have established a place that they call their home back in Florida, but very few of them do have a place to which they return. Mostly, they have

to obtain their own housing wherever they go, and this may be a different place each year.

As a matter of fact, they may move from one place to another in the same county.

Mr. RHODES. Thank you, Dr. Brumback.

I want to add, also, that our colleague who represents your district so well is very much interested in this subject and I have had the opportunity on many occasions to discuss this with him.

Dr. BRUMBACK. Thank you, Mr. Rhodes.

The CHAIRMAN. Thank you, Mr. Rhodes.

The gentleman from Florida?

Mr. ROGERS of Florida. I want to thank the gentleman from Pennsylvania for his kind comments. Actually, we have another Congressman from Florida here. He spends part of his time in Florida, and helps us on our problems, and we appreciate it.

Actually, on this migrant health problem there is an educational feature as well, I believe, because I have noticed in inspecting some of these areas that they have no conception, many of them, of sanitation and health procedures or requirements. I wonder if you might comment on that just a little bit.

Dr. BRUMBACK. Yes, I would like to very much.

There is certainly an educational factor involved in all of this work, and we have spent a great deal of our time on education. We find that many of these people have no concept of health as we understand it. If we are going to make these services available to them, it is absolutely necessary for us to adapt the services to the migrants' concepts.

For example, it is useless for us to talk about nutrition, if we are speaking of foods that the migrants cannot afford, or that they will not eat. We have to adapt our recommendations to their particular concepts and their income.

And, also, in the field of sanitation—this is a very important part—it is not of much value for us to improve sanitation in these camps and housing areas if the migrants do not know how to take care of what we provide.

Mr. ROGERS of Florida. And also I know we had a great number of problems where a mother would want to work as well as the father, and she might have as many as 8 or 10 children, and she would leave maybe the oldest child to take care of all of the other children, and the health problems involved there were just amazing.

You might comment on some of the problems you found along those lines.

Dr. BRUMBACK. Yes, I would like to.

This is one of our most serious problems, trying to find a way to take care of the children while the parents are in the field. We have had some tragic accidents that have occurred to children when they are left with older brothers and sisters. There are not nearly enough child-care center. We need more of these.

And this would certainly help to prevent many unfortunate accidents and illness among these people.

Mr. ROGERS of Florida. Thank you very much, Dr. Brumback, for your testimony. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Doctor. I appreciate your appearance.

Our next witness will be Dr. Bruce Jessup, consultant in rural health, California State Department of Public Health, Berkeley, Calif.

Doctor, we are very happy to welcome you to our hearing. We are very happy to have California so well represented by the distinguished gentleman, Mr. Moss, and we are very grateful for his services, not only on this subcommittee, but the full committee.

Mr. Moss, would you like to say a word about Dr. Jessup?

Mr. Moss. Mr. Chairman, I speak not only for myself, but for at least 12 of my colleagues from California. This is a matter of grave concern to us. It is a problem in many areas of our State, and under the leadership of our State department of public health we have initiated programs aimed at seeking solutions.

We have not first sought outside assistance. We have tried to render all possible assistance from our own resources. I think Dr. Jessup is well qualified to tell the California story, and I am pleased to welcome him to the committee.

The CHAIRMAN. Thank you, Mr. Moss.

Dr. Jessup, you may proceed as you wish. If you prefer to file your formal statement and then make your oral statement, you may do so.

STATEMENT OF BRUCE JESSUP, M.D., CONSULTANT IN RURAL HEALTH, CALIFORNIA STATE DEPARTMENT OF PUBLIC HEALTH, BERKELEY, CALIF.

Dr. JESSUP. I would, Mr. Chairman, in the interests of the committee's time.

I will submit for possible inclusion in the record three items: One is a study that Mr. Moss referred to, "Health Conditions and Services for Domestic Seasonal Agricultural Workers and Their Families in California," done during the summer of 1961 at the request of Governor Brown.

Secondly, a statement supporting strongly favorable consideration by this committee and also by the Congress of S. 1130 by the American Public Health Association.

Thirdly, a similar statement in strong support of this measure by the Association of State and Territorial Health Officers.

The CHAIRMAN. Is there objection?

Without objection, the statements referred to will be filed, along with your formal statement.

(The statements of Dr. Jessup, the American Public Health Association, and the Association of State and Territorial Health Officers, follow. The study entitled, "Health Conditions and Services for Domestic Seasonal Agricultural Workers and Their Families in California," may be found in the files of the committee.)

STATEMENT OF BRUCE JESSUP, M.D., CONSULTANT IN RURAL HEALTH, CALIFORNIA STATE DEPARTMENT OF PUBLIC HEALTH, IN BEHALF OF THE AMERICAN PUBLIC HEALTH ASSOCIATION

Mr. Chairman and members of the subcommittee, my name is Bruce Jessup. I am a private practitioner of pediatrics from Palo Alto, Calif. Presently, I am on leave from my practice and serving full time with our State health department working to help local communities improve their medical service for the families of farmworkers. Today I am speaking for the some 13,000 members of the American Public Health Association in support of S. 1130.

Mr. Chairman, in the interest of the committee's time, may I ask your permission to submit for inclusion in the record three documents which contain detailed references and positions.

1. A report dated October 1960 to Governor Brown on "Health Conditions and Services for Domestic Seasonal Agricultural Workers and Their Families in California."

2. A statement of support by the American Public Health Association in 1962 urging passage by the Congress of S. 1130.

3. A resolution of endorsement of S. 1130 by the Association of State and Territorial Health Officers.

There is urgent need for limited Federal assistance that this legislation will provide to States and local communities in their efforts to extend and improve local health services for this long disadvantaged group. The migrant farmworker's health problem is one which crosses State boundaries. It is a difficult problem, clearly involving Federal, as well as local and State responsibility.

I propose to touch only briefly on the long recognized and documented shocking health conditions of our country's seasonal agricultural workers. Material just submitted for the record includes references to numerous health reports and studies from Colorado, Michigan, New York, Maryland, New Jersey, Idaho, Washington, Oregon, and Texas covering the period from 1910 to the most recent report by Dr. Brumback from Florida published in 1961. There is unanimous agreement among all who have studied and reported on the migrant's health, that this group of families has more medically uncorrected conditions, lower utilization of preventive medical care, and higher morbidity and mortality rates than any other socioeconomic group in our population. These findings are not contested. I prefer to concentrate my remarks on our conviction that the manner in which S. 1130 proposes congressional assistance is the most appropriate and effective way of assisting the local communities who bear the major responsibility for provision of medical care when it cannot be borne by the individual family.

There are many and varied factors which are responsible for the important and unique difficulties encountered in making medical services available to the some half million migrant American farm families that move from State to State as they follow the crops. The temporary nature of their work, their seasonal unemployment with attendant low annual family income; their mobility and lack of familiarity with medical resources when they are away from home; the relative sparsity of medical services in many rural communities; the inability of already strained medical care resources to meet added demand for medical care; the physical distance of the farm labor camps from hospitals and doctors' offices; language, cultural, and educational barriers, are among the factors which complicate this medical care problem. There is an intense interest in tackling the problem now in the most effective manner within the existing framework of American medicine.

In California during the last 2 years we have consulted with many groups on how this difficult problem can best be approached. We have talked with local groups; with physicians and nurses; with hundreds of farmworkers; with school teachers, hospital administrators, and county supervisors. We have sought the suggestions of growers. At the State level we have met with State department representatives and legislators, with officers of grower groups, the medical and dental associations, the PTA, and others. We believe that there is responsibility for action at local, State, and Federal levels, as well of course, as individual worker and employer responsibility. All expect the farmworker to do everything he can to provide his family with medical care. California growers are willing to pay their fair share of the medical bills. It is notable, however, that many of our State's growers only employ picking crews, for example in grapes or peaches, for as little as 2 to 6 weeks a year. The county taxpayers in California are presently paying large sums for rural indigent medical care. In some of our agricultural counties $3 to $4 million a year of local tax money is spent on just the county hospital, where upward of a third of the patients in some areas are seasonal farmworkers and their families. All of these groups are willing to do their part; but in dealing with this problem which involves migration across county and State lines to meet agriculture's needs for seasonal labor, there is need for leadership, financial support, and coordination from State and Federal jurisdictions.

Last May California's Governor Brown signed into law S. 282, introduced by Senator O'Sullivan from Colusa County, which accepted limited State re-

sponsibility for health services for domestic agricultural workers. The measure made it possible for the State health department to provide coordination and leadership to efforts of public and private, State and local organizations, in improving health services in local rural communities. An appropriation of $75,000 was made available through the State health department to these communities for exploratory demonstration programs. This legislation received overwhelming support including the specific endorsement of the California Farm Bureau Federation, State Grange, and California Medical and Dental Associations. I firmly believe that our experiences last year with this mechanism of providing funds and technical assistance, limited though they were, clearly demonstrates that the provisions of S. 1130 will have far-reaching constructive effects throughout the United States in moving toward solid improvements in migrant health conditions.

The California programs in 15 major farm counties last year were limited to demonstrations. They merely showed, but did show clearly, what might be done with adequate support. Present health conditions even in the isolated communities where these new programs were undertaken are not such as to satisfy farmworkers themselves or growers. Additional support, including that proposed in S. 1130, is urgently needed.

Perhaps a brief description of some of our local California programs in migrant health will be of interest. All of these projects were designed by rural communities to meet the health needs of local farm families. All projects were submitted to and approved by a State advisory committee on farmworkers' health. This committee was composed of representatives from the California PTA, California Medical Association, California Dental Associations, California Farm Bureau Federation, California State Grange, farm labor groups, and others.

One county, Yolo, added a public health nurse to increase staff time available for making immunizations against polio, tetanus, whooping cough, and smallpox, and for referral of needy families to local medical services. Colusa County, for 3 months during the prune season, hired an extra nurse and a premedical college student to survey the migrant families' medical needs; to consult with growers on how to meet these needs, and on their camp sanitation problems. In Colusa they carried preventive medical services and health education to the workers in the field and camps in a "mobile station wagon clinic."

In Sutter and Yuba Counties a preventive medicine, early treatment, and health education clinic was set up for 3 months during the peach harvest in the largest farm labor camp in the area. This program is patterned after the Fresno County Westside Clinics. Local physicians and nurses staffed the clinic which saw 1,200 patients, did prenatal checks, and treated minor illnesses. The improvement in health conditions that resulted from this work was hailed by the camp director, workers, and the community. The county hospital superintendent reported that instead of having dozens of babies admitted to the hospital with infectious diarrhea last summer only a few required treatment. An estimated $6,000 of tax money was believed saved in the reduction of hospitalization costs alone for children with diarrhea from just this one large camp.

Four other counties, Merced, Monterey, Santa Cruz, and Tulare, increased their nursing staffs, and conducted clinics at night; one in a firehouse, another in a country school, some with Spanish-speaking nurses and doctors.

Kern County recruited and trained five migrant farmworkers, four of them Mexican-Americans, to be "community health aids." These aids helped build a bridge between the medical resources of Kern County and the isolated communities where the migrants lived and worked.

Our California experience clearly shows the following:

1. Special methods of providing medical care to migrant farm families are needed.

2. Local health services must and can be decentralized.

3. Leadership, additional public funds, and coordination of existing health resources are essential and possible.

4. Additional health resources for migrant farm families are needed.

While I have restricted my comments in the main to our California experiences, I do not dish to leave any impression that this is a problem unique to California. This is a problem involving the health of over 500,000 Americans in some 900 counties in 31 States of this Nation. While in California we need to work especially to develop continuity of health services, particularly with Texas, Oklahoma, Arkansas, Washington, Oregon, and Arizona, there are other migrant

streams such as those fanning out from Texas into the upper mid-central States and from Florida up the east coast to New York and Connecticut. All of us in agricultural States need this legislation to assist in the coordination of health services for migrant farm families who are essential to our agricultural economy.

In conclusion, passage of S. 1130, and the acceptance of limited and appropriate Federal responsibility relative to the health of migrant agricultural workers, is backed by a solid history of professional studies, recommendations and demonstrations extending over the last 25 years. S. 1130 will provide precisely the kind of assistance that is needed with the design and execution of specific health programs in the hands of local communities who know their particular health problems and resources. The provisions of the bill, though modest, would further constitute a substantial incentive and stimulation to extended local and State action.

We respectfully request favorable consideration of S. 1130 by this committee and by Congress.

STATEMENT OF THE AMERICAN PUBLIC HEALTH ASSOCIATION

The American Public Health Association wishes to bring to your attention its deep interest in, and full endorsement of S. 1130 as passed by the Senate. This legislation would enable the U.S. Public Health Service to assist States and local communities in their efforts to extend health services for domestic migratory workers and their families. Favorable consideration by the Congress is urgently needed.

The American Public Health Association, with some 25,000 public health workers in its 49 affiliated societies and branches throughout the United States, has for many years been deeply concerned about the serious need for congressional action to assist in efforts to overcome the nationwide difficulties inherent in the provision of truly available health services to these disadvantaged farmworkers. The classical Federal responsibility for leadership, stimulation, coordination, and support of local health efforts for these people is as clear as their economic importance to American agriculture.

National concern over the striking health needs and paucity of services for domestic farmworkers, though manifest for the last 25 years, has recently assumed a new urgency. New important advances in medical knowledge and medical care in this country have greatly improved health conditions generally and among medically indigent families in urban areas. Simultaneously, the gap between what we know how to do and what we are actually doing to meet the acute medical needs of these disadvantaged farmworkers in rural areas has widened. Documents by such public health authorities as Leland, Mott, Roemer, Leone, Johnston, Axelrod, Koos, Howard, Blankenship, and Safier have clearly outlined the problems and recommended action. In the last several years, reports of studies and isolated demonstration health projects for migrants have come from California, Idaho, Oregon, Minnesota, Florida, Maryland, New Jersey, New York, Texas, Colorado, Michigan, and Washington. Calls for action on the health problems of migrants have, in the last 3 years, come from the east coast migratory farm labor conference, the southwest regional conference on migratory labor, the mid-American conference on migratory labor, and the western interstate conference on migratory labor.

These studies and reports have for two decades revealed the following findings with great consistency:

1. The health needs of domestic seasonal agricultural workers, particularly those migrating from their home communities, are greater than those of any other socioeconomic group in the United States. These people have health problems similar to, but more severe, than those of stable rural farmworker families. Studies continue to show high infant mortality rates, high communicable disease rates, low prenatal care rates. high premature birth rates, high accident rates, low immunization levels, serious needs for dental care, and little realization of the need for or utilization of preventive and early treatment.

2. Low economic and education levels, mobility, lack of resident status, geographic isolation from medical facilities, plus cultural factors and language barriers contribute to the health problems of migrants.

3. In isolated instances where the social, economic, geographic, and cultural characteristics have been taken into consideration in offering services to this group, and where funds have been made available, the improvements in health conditions among this group in various parts of the United Sttaes has been striking. However, these local efforts have been uncoordinated, sporadic, and totally inadequate.

In 1959 the Governing Council of the American Public Health Association endorsed the following resolution:

"Whereas studies in various parts of the country disclose great need for the development of comprehensive health services to the migratory worker and his family, especially the migratory farmworker, in concert with other community services such as those for welfare, education, and employment: Therefore be it

"*Resolved*, That the American Public Health Association request the President and the Congress of the United States to provide adequate financing for the continuation and strengthening of Federal services through the Department of Health, Education, and Welfare directed to migratory workers and their families * * *."

Dr. Malcolm Merrill, when president of the American Public Health Association in 1960 stated: "It will be necessary to provide initiative and incentive at the Federal and State level if additional health services are to be provided for the domestic migrant," and recommended, "the provision of project grant authority to the Public Health Service and the provision of appropriations to the Service to the end that they could strengthen the hands of the States through grants-in-aid, through the project mechanism.

All agree that in this difficult health problem there is classical need for appropriate community action at the local, State, and Federal level. The long history of documented need and the difficulties of isolated local health programs to cope with the special health service problems of this migratory group is clear. Similarly, conditions that exist today, such as those documented in the 1960 report of the State Health Department in California (hearings before the Subcommittee on Migratory Labor, July 1960, pp. 1795–1853) show an urgent need for assistance to local communities.

Several States are acting to accept State responsibility. In California, for example, the State legislature in 1961 passed S.B. 282, making it possible for the State department of public health to maintain a program to assist applying local community health agencies, through studies, coordination, and limited technical and financial assistance, in their efforts to extend their own local health services. Coordination and planning with Texas, Oklahoma, Arizona, Oregon, and Washington will be needed to effectively assist local health agencies. The State legislation in California has the support of the California Farm Bureau Federation and the State Grange, the California Medical Association, California Dental Association, Council of Local Health Officers, California Council of Parents and Teachers, as well as many other groups. While there are sharp differences of opinion on many of the understandably controversial aspects of the farm labor problem, the widespread concern over the serious health problems and interest in prompt action is striking. Informed people in all groups feel that the difference between the health services provided foreign farmworkers under Public Law 78, and the services available to domestic workers and their families who are citizens, are indefensibly great.

Certainly action by the Congress during this session through passage of S. 1130, acceptance of limited Federal responsibility to assist growers and health workers in bettering the health conditions of these farmworkers, cannot be called precipitous. Such congressional action, if taken, will be backed by a solid history of professional studies and recommendations over the last 25 years. The provisions of the bill, though modest, would constitute a substantial incentive and stimulation to State and local action.

We cannot too strongly recommend favorable consideration of S. 1130 by this subcommittee and by the Congress.

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS

That the Congress of the United States be petitioned to give favorable action during this year to the principles embodied by S. 1130 as passed by the U.S. Senate authorizing grants for health services to domestic migratory labor; and that the secretary of the association inform the Surgeon General, the Secretary

of the Department of Health, Education, and Welfare, and the Congress of this recommendation; and that the several State and territorial health officers contact their individual Governors and Congressmen in behalf of this bill.

Recommendation of the Association of State and Territorial Health Officers at their annual conference, November 8–10, 1961, Washington, D.C.

Dr. JESSUP. I would just like to proceed for a moment informally and then be available, if there are any questions from the members of the committee.

I am a private practitioner of pediatrics on leave from my practice in Palo Alto, Calif., for the last year, working on this problem full time with the California State Health Department.

Today, I have the privilege of representing the 13,000 members of the American Public Health Association.

Much of the problem has already been well covered. We can say that these people have the most difficult health problem and the poorest health conditions, of any socioeconomic group in the United States today. I believe this is unquestioned. Documentation has already been submitted today. I have submitted additional material for the record.

There are reports from California, from Florida—as Dr. Brumback has brought to our attention today—from Michigan, from New York, from Minnesota, from some 15 other States, since 1910, which have documented the very serious health problems of domestic farmworkers in the United States.

This matter is uncontested as far as the seriousness of the health needs of farmworkers is concerned.

In California, during the last couple of years, we have consulted, as Mr. Moss has said, with many groups on how this very difficult problem can best be approached from the State standpoint. We have talked with local groups, with the growers themselves, all over California in 25 different agricultural counties. We have talked with local physicians, with the California Medical Association, the California Dental Association, with schoolteachers in rural areas, with local public health nurses. At State level we have talked with the heads of the various departments of State government, with the California Farm Bureau Federation, which strongly has supported action on this, with the State Grange, and other concerned groups.

We have talked with all groups in an effort to get a consensus of suggestions on what the State can appropriately do. All expect the farmworker will do everything he can to provide his family with health services.

The California growers—and there was a question this morning about this—are perfectly willing to meet their fair share of the medical expenses of their workers.

I would like to call attention to the fact that in California there are many growers who only use a crew of pickers for as little as 2 to 6 weeks a year, in peaches or grapes, for example. We all feel that it is unreasonable to expect the growers to pick up the whole bill for 52 weeks a year.

But the growers are very anxious to do their fair share in meeting the expenses of their workers on a proportionate basis.

At the local level, county taxpayers in California are presently paying large sums for rural indigent medical care. In some of our agri-

cultural counties $3 to $4 million a year is spent of local tax money on the county hospital bill alone.

I can think of three counties in which at least a third of the patient load of these local county hospitals is made up of farmworkers and their families.

So the local agencies are meeting their particular responsibility.

However, in this problem, as has been called to our attention today, the families are crossing State lines. It involves migration across county lines, as well. And there is general agreement among all the people we have talked to that there is need for leadership, for financial support, and for coordination from both State and Federal jurisdictions.

A word on what we have done as a State in California to try to meet the State responsibility.

Last May, Governor Brown signed into law S. 282, introduced by Senator O'Sullivan from Colusa County. This measure accepted limited State responsibility for health services for these families. S. 282 made it possible for our California health department to provide coordination for public and private agencies working to improve health services at the local level.

An appropriation of $75,000 was made available through the State health department budget to applying, interested, concerned counties, so that they might, if they cared to, develop demonstration projects and exploratory programs in migrant health.

This legislation received overwhelming support, including specific endorsements from the California Farm Bureau Federation, the California State Grange, the California Medical Association, and the dental associations.

I firmly believe that our experience last year with this mechanism of providing funds and technical assistance, limited though they were, has clearly demonstrated that the provisions of the legislation before you gentlemen today is the appropriate way for Federal support to be applied in this important and acute problem. I believe that through the mechanism that S. 1130 provides, there will be solid improvement in migrant health conditions.

The California programs in 15 major farm counties last summer were limited to demonstrations. They merely showed, but did show clearly, what might be done with adequate support. Present health conditions even in the isolated communities where these new programs were undertaken are not such as to satisfy either farmworkers or the growers.

Additional support, such as is proposed in S. 1130, is urgently needed.

Just a word on what some of the local programs did.

All of the programs were designed on the local level by the local private doctors, health departments, and growers. All were approved by the California State Health Department Advisory Committee on Farm Workers' Health. This committee had active representatives on it from the California Parent-Teachers Association, from the Farm Bureau, the Medical Association, the Grange, from labor groups, and others.

One county, Yolo, added one public health nurse to increase the staff time available for doing immunizations against polio, whooping

cough, tetanus, and diphtheria, and for referral of needy families to existing local medical services.

Colusa County for 3 months during the prune season hired an extra nurse and a premedical student to survey the migrant families' health needs, to consult with growers on their suggestions as to the best way to meet these needs, and on their camp sanitation problems. In Colusa they carried preventive medical services and health education to the workers in a mobile station wagon field clinic.

In Sutter and Yuba Counties, located in the northern Sacramento Valley, a preventive medicine, early treatment, and health education clinic was set up for 3 months during the peach harvest in the largest farm labor camp in the area—about 2,000 people. Local physicians and local nurses staffed the clinic, which during the peach harvest season saw some 1,200 patients, did prenatal checkups on the mothers and treated minor illnesses.

The improvement in the health conditions in Sutter and Yuba Counties in this particular camp was such that the project was hailed by the camp director, the workers, and the community.

The program was conducted much along the line that Dr. Brumback's group in Florida and the Fresno Westside Clinic have demonstrated so well. The county hospital superintendent, on the economic side, reported that, instead of having dozens of babies admitted to the hospital with infectious diarrhea last sumer, only a very few required hospital treatment. In fact, an estimated $6,000 of tax money was believed saved in the reduction of hospitalization costs alone for children with diarrhea from just this one camp.

This was the cost of the whole operation of the whole clinic for 3 months.

Four other counties, Merced, Monterey, Santa Cruz, and Tulare, increased their nursing staffs, conducted clinics at night, one in a firehouse, one in a county elementary school. Some had Spanish-speaking doctors and nurses. Kern County carried on what many believe was the most interesting project of all. The health department trained five migrant farmworkers. Four of them were Mexican-Americans. They trained them to be what they call community health aids. These aids helped build a bridge between the medical resources of Kern County and the isolated communities where the farm workers lived.

We believe that our California experiences clearly showed the following:

First, that special methods of providing medical care to migrant farm families are badly needed.

Second, that local health services must, and can, be decentralized and extended.

Third, that leadership, additional public funds, and coordination of existing health resources are essential.

And, lastly, that additional health resources for migrant farm families are presently needed.

In conclusion, I would like to state our opinion that the passage of S. 1130 and the acceptance of limited appropriate Federal responsibility relative to the health of farm workers is backed by a solid history of professional studies, recommendations and demonstrations extending over the last 25 years. We strongly urge its passage.

We feel it will make a great difference in improving the services avaliable to these important people, who are essential to our agricultural economy.

The CHAIRMAN. Thank you, Dr. Jessup.

I think you have made a very clear, full and adequate statement on the situation, and I compliment you on your statement.

Would it be a fair statement to say that these migratory workers do a job in gathering literally billions of dollars of crops that would not, or could not, be done by other types of labor, and that they are a necessary segment of our economy?

Dr. JESSUP. Yes, sir.

In California—Mr. Moss may correct me—I believe our agricultural output per year is in the neighborhood of $3 billion last year.

Mr. ROGERS of Florida. Would the gentleman yield?

Is it true that you can find a few domestic laborers as such that will do what we call stoop labor, picking many of the crops that would have to be harvested? As a whole, however, isn't it difficult to find enough domestic laborers to actually do this work? And isn't that what has necessitated the influx of these migrant workers?

Dr. JESSUP. Yes, sir, I believe that is it.

It takes skill, too, and also a lot of times these people live way out of town, and a lot of the ordinary workers in town, industrial workers, do not care to do this work or do not hear about the job.

One thing, of course, that does affect how many people you can get to do this work is the wage that is offered, and the conditions under which the people live.

The CHAIRMAN. In other words, if we did not have these workers, many of these crops would simply stay in the fields and would not be gathered and, therefore, would be wasted, as far as our economy is concerned.

And were it not for the need and for the demand of the agricultural sections of our country, this system would never have come into being in the first place.

Dr. JESSUP. Yes, sir.

And it is due in California particularly because of our very specialized type of agriculture.

In many California counties the growing season is essentially all year long, 365 days. We can raise four or five crops. We raise something over 200 different crops in California. In Florida it is similar.

The CHAIRMAN. There has been a lot of thing said here today about taking people who are on relief or who go on unemployment compensation and filling this need. This job requires special skills, does it not?

Dr. JESSUP. Yes, sir.

The CHAIRMAN. In other words, you could not take an unemployed aircraft worker and put him out trying to gather grapes. He would simply be lost, as far as picking apples or gathering citrus or anything else, as far as any value to the farmer would be concerned.

Dr. JESSUP. That is true.

The CHAIRMAN. That is all I have.

Mr. Rhodes?

Mr. RHODES. I would like to ask Dr. Jessup if he has any records as to where these migrant workers come from?

Dr. JESSUP. We have some information on that, yes, Mr. Rhodes. We have several streams, first, one group comes from Texas, westward, then up through El Centro and Imperial County, into the lower San Joaquin Valley, moving on up through the San Joaquin Valley into the Sacramento. Some of them proceed from there on up into the apples in Oregon and Washington.

A second group moves up from Texas into Idaho for the potatoes and then across through Colorado for some picking. They come into the central part of California.

We also have a large group that comes from Arkansas and from the Central States.

We saw a lot of them in the camps last summer, and we talked to many of them. All you have to do is drive out to the camps and see out-of-State license plates on the cars. The Midwestern group are still moving. We get a lot of people from particularly Oklahoma and Arkansas.

We, of course, have a lot of farmworkers that stay in California and move about. They may move into two or three counties, but stay in our State. California is 800 miles long.

Mr. RHODES. Do you feel that is an argument for Federal help in this field?

Dr. JESSUP. Yes, sir.

Many of us feel that 1961 statistics point this up. We had at least 125,000 Americans that came across the California State line, or had come across the State line last September 1961, from other States in connection with the harvesting of our California crops. To me, this is an interstate problem.

Mr. RHODES. I noticed here that California has a 12-month crop span. Does that mean that some of these migrant workers become settled permanently in some of these areas, going from farm to farm?

Dr. JESSUP. I do not know any that are able to get very much work in January and February during the rainy season. The only area that there is much crop work at that time of the year is in the lettuce in Imperial, and there are not too many domestics there.

But there is harvesting 12 months a year, someplace, going on in California, yes, sir.

Mr. RHODES. Thank you.

The CHAIRMAN. The gentleman from California?

Mr. MOSS. Mr. Chairman, I would like to make just a few observations.

We in California do have a growing season of approximately 12 months. You find some of these people engaged in agricultural labor want to work in certain crops and they follow those crops, while others prefer different crops.

There are different techniques involved. These people develop considerable skill in the harvesting of crops. It is difficult for us to try to depend upon the recruitment of the temporarily unemployed who might have been engaged in industry or in business, and utilize them for agricultural work, although I would say that the impact of our laws is aimed at persuading them to go into this type of labor when it is available.

But I can recall that during periods of rather severe depression, California agriculture has depended upon the migrant or has depended upon a source of foreign labor to harvest its crops.

I can look back over the years in California, and we had the orientals and then we had the Indians, the Hindus, and the Filipinos, and now we look to Mexico for part of our supply of labor. But it has not been the type of work attractive to, or capable of attracting, the unemployed domestic worker who is more desirous of nonfarm work or nonfarm labor.

We have a rather liberal program through our county hospital system in California of providing health care. Migrant or foreign agricultural workers place a very real burden on the counties. Even utilizing the county facilities, the addition of some Federal money to effect coordination and to undertake part of the educational program would permit more effective utilization of, and employment of better preventive steps to minimize the overall impact on, the facilities that are provided very generously by our local taxpayers.

I think it is a problem that is not confined to the community in which these farmworkers are temporarily housed, or in which they are temporarily employed. This flow of laborers moves freely between many States, and in some areas there are excellent facilities for providing health care for them if they have the knowledge where to seek it.

In other areas there are no facilities, and we need to have a better coordinated program which would upgrade the health of these people.

I want to compliment Dr. Jessup, not only on his statement, but on the excellent work he has done as consultant to the State department of public health.

The CHAIRMAN. Thank you, Doctor.

Our next witness is Mr. Olonzo Fike, housing hygiene training consultant, Maryland State Department of Health, Baltimore, Md.

STATEMENT OF OLONZO P. FIKE, HOUSING HYGIENE TRAINING CONSULTANT, MARYLAND STATE DEPARTMENT OF HEALTH, BALTIMORE, MD.

Mr. FIKE. Honorable Mr. Chairman and members of the committee, I am delighted and honored to be here today to testify in support of S. 1130 to expand and improve health services for, and the health conditions of, migratory workers.

I realize there are four different types of statements. I have heard that the first type is like a dog's tail. It is bound to occur.

The second is like a cat's tail. It is fur to the end.

The third is like a rat's tail. It is straight to the point.

And the fourth is like a rabbit's tail. It is just a mere suggestion.

I would like to make this statement, a combination of the latter two—straight to the point and brief.

The State of Maryland has critical problems in meeting the housing and sanitation needs of migratory workers who are employed seasonally. I am sure that this committee is aware that the problems which I shall mention are not peculiar to Maryland alone, but that these problems are present to a greater or lesser degree in all States using migratory labor.

We made a survey of migrant labor camps in 1957. I will not go into its details because you have the full statement before you, which gives those details.

As a result of the study, minimum housing standards were developed which were adopted by the Maryland State Board of Health on October 30, 1959, and became effective for statewide application on February 1, 1960.

The regulations are administered by the county health departments with the assistance of the State department of health. We have enjoyed a fine cooperative effort on the part of the Governor's Commission on Migratory Labor, the department of employment security, the department of labor and industry, the State department of public welfare, and the State department of education.

After 2 years of operation under these regulations, we are gratified to report the correction of most of the defects mentioned earlier. We now have approximately 100 camps operating in Maryland.

Our main difficulty has been in securing the cooperation of the migrants in the proper use and care of provided facilities.

It is at this point that we feel that assistance from the Federal Government will be most helpful, namely, the provision of training materials and personnel to orient the migrant to the proper use and care of provided equipment.

Another area where we need assistance is in the more detailed and careful screening of personnel for the labor force. For example: I am constantly confronted with complaints concerning those migrants who are chronically, physically, and mentally ill, who become serious burdens in the various counties using migrants. The migrant program could be materially strengthened by careful screening to reduce the number of such persons that normally accompany the healthy worker in the migrant stream. By attacking this problem at the source of the stream, much better service can be rendered to the chronically ill, and, I might add, to the program at large.

We stand at a point where these problems must be resolved if we are to have a successful migrant program. These problems stand as a bottleneck to our progress in the important activity of preventive medicine. I urge this subcommittee, on the part of the Maryland State Department of Health and the American Public Health Association, to take prompt and favorable action on S. 1130, and thus assist us in achieving a higer standard of living for our agricultural migrants.

In the words of St. Paul in 1 Timothy 5:8:

> If any provide not for his own, and specially for those of his own house, he hath denied the faith * * *

We must keep faith with those who are all but the forgotten part of our people.

Thank you very much for affording me this opportunity to appear before you.

The CHAIRMAN. Thank you, Mr. Fike, for a very brief and very fine statement. We appreciate your contribution.

Any questions?

Mr. RHODES. I only have one question, Mr. Fike.

Mr. FIKE. Yes, sir, Mr. Rhodes?

Mr. RHODES. Do you have a good percentage of elderly migrant workers?

Mr. FIKE. Yes; we have.

In fact we have people in all age groups. We have some very small children, even babies, and some migrants who are quite elderly.

Mr. RHODES. What about the age bracket from, say, 18 to 25?

Mr. FIKE. I am sorry, Mr. Rhodes, I am not able to give you that figure. I will be glad to see what I can do about obtaining this information for you.

(The information requested was furnished in the booklet "They Follow the Sun" published by the Florida State Board of Health. The booklet may be found in the files of the subcommittee.)

I would like also to submit this as a part of the record, if I may. The title is "Progress in Meeting Problems of Migratory Labor in Maryland," which will give you quite a few facts with referencee to our program.

The CHAIRMAN. How many pages in that report?

Mr. FIKE. I would say there are about 30 pages. You may not want to use all of it.

The CHAIRMAN. We will be glad to have it filed for the records of the subcommittee. We are going to have a rather voluminous record, and I think, unless you insist on it, I would prefer to file it with the committee.

Mr. FIKE. That will be quite all right.

The CHAIRMAN. Thank you again for your statement.

Mr. FIKE. You are very welcome.

The CHAIRMAN. We will include a statement by Mr. Robert M. Isenberg, executive secretary of the Department of Rural Education, NEA, at this point in the record.

(The statement of Mr. Robert M. Isenberg follows:)

STATEMENT OF ROBERT M. ISENBERG, EXECUTIVE SECRETARY, DEPARTMENT OF RURAL EDUCATION, NATIONAL EDUCATION ASSOCIATION

The Department of Rural Education, NEA, is an organization whose major membership is composed of county superintendents of schools. The education of migrant agricultural workers and their children has long been a continuing concern of this department.

We support H.R. 5285, to amend the Public Health Service Act to provide for grants for improving health services for domestic agricultural migrant workers.

Education and health conditions for these neglected people will increase their educational opportunity, especially in two ways:

It will increase the migrant child's capacity to learn, for obviously a sick child is less educable than a well one.

It will create more willingness on the part of communities to welcome migrant children into the public school system. It is unfortunate, but understandable, that local parents sometimes resent the migrant child's attendance in the local school because of the danger of communicable diseases. If health services, including health education, are more available to migrant families, this tension can be appreciably eased.

As educational opportunities for migrants are expanded, through legislation currently before another committee of the House, it can be anticipated that health conditions will improve. Thus health and education programs are interdependent, especially for these people who need special services to help them on the way toward a standard of living more comparable with other segments of our society.

We urge the committee to act favorably on H.R. 5285. We commend the chairman and members of the committee for their attention to this legislation and appreciate the opportunity to present this statement.

The CHAIRMAN. If there is no objection, I would like to insert into the record a series of articles published in the Raleigh Times, July 3–7, 1961, by Brandt Ayers, Times staff writer.

[From the Raleigh Times, July 3–7, 1961]

The Migrant Worker in North Carolina—Part I

ARMY OF DESPAIR BEGINS ITS ANNUAL ODYSSEY

(First in a series by Brandt Ayers, Times staff writer)

An army of despair is again making its wretched odyssey through North Carolina. At its peak now, it will number 12,000 before October.

These are the nomads of the cabbage fields, the cotton acres, and the tobacco rows. The ragged, pinch-faced men and women Government calls migrant laborers.

Most are now living in subhuman squalor, "a jungle" as a Shiloh minister who visits their camps calls them.

The State employment security commission, which arranges to bring them here and assigns them to growers, paints a rosy picture of the camps.

But ministers of the North Carolina Council of Churches on their weekly, often daily visits see the worst of them as they are: blighted, stinking hovels, filthy and overcrowded.

The awful irony of this picture is that the recent session of the legislature had an opportunity to do something about it.

A bill was introduced and passed in the senate to require permits to establish a camp and give the State board of health authority to set up standards for them.

It was tabled in the lower chamber and never revived. Similar legislation in the 1959 session met the same fate.

The Reverend Morton R. Kurtz, of Durham, executive secretary of the North Carolina Council of Churches, the only group actively doing something about the problem, gave this statewide view of the situation:

"* * * they are dirty; refuse lies around; open, unsanitary latrines; too few toilet facilities for the number of workers; no screens, often not enough windows; people lumped together in rooms, sometimes different families in the same room—a great opportunity for immorality * * *."

Friday, the Raleigh Times called on Curtis B. Gilliam, assistant farm placement supervisor of the employment security commission.

He talked of tremendous advances. There has been some in the past 5 years, but as the Reverend Dr. Kurtz put it, "There is a long way to go."

Gilliam showed pictures of new concrete block camps he termed, "like motels," and showed off certificates from county health boards he said were required before the employment commission could place workers at camps.

He admitted some county health departments were rather lax but he indicated conditions were actually quite good.

The Council of Churches representative in the Carteret County area, the Reverend Jack Mansfield, pastor of the Camp Glenn Methodist Church in Morehead City, said:

"Certification is made by the county sanitarian. What his requirements are is a very nebulous thing; nobody knows what these requirements are."

How bad is the situation?

An index of progress is how many concrete block camps, the best, there are in the three major migrant areas of Henderson County, Pasquotank-Camden, and Carteret.

There are 34 camps in these 3 areas. Four of them are of concrete block construction. All four are in the Hendersonville area.

The workers come in a mighty stream, mostly from Florida, jammed together in buses and closed trucks.

First they come in a trickle for the cabbage harvest in May, the stream swells and they push north as far as New York, then they swing back, passing through western North Carolina to pick the late beans in October. And then they vanish for another year.

They come through the efforts of the employment security commission.

Crew leaders are contacted in Florida. The crew leader is told to get a certain number of workers and be at a certain camp at a specified time.

They gather the unemployed farm laborers and lead their divisions of the forgotten army on their yearly, tragic march.

The Migrant Worker in North Carolina—Part II

A Stark, Personal Migrant's Drama

(Second in a series by Brandt Ayers, Times staff writer)

Morehead City-Beaufort.—Outside the dejected frame shack, a strong wind from the ocean twirled a leaf from a Sunday school book into a pile of refuse.

It fluttered fitfully. The wind caught it in a little whirlpool and sent it dancing into the white, sandy road.

Inside, the same wind blowing through the boards of the filthy shack played a mournful accompaniment to the lament of one of America's disinherited—a migrant laborer.

Her name is Henrietta, which she wrote in large, childlish letters on a pad for this reporter. She is 30, a Negro from Atlanta.

She is a slender girl. Two hornlike tufts of wiry hair gave her a wild look. She talked in the half-whine of the South, telling of a stark, personal drama.

Patting the sagging, dirty mattress on which her pile of rags lay, she said: "I lost my baby on this bed."

Three weeks ago the man she had been living with in that small room had given her a terrible beating. And she miscarried the child of 3 months.

When she returned from the hospital, "Mr. Johnny wanted me to work in the potato field," she said.

"Please help me, please help me, y'all; I want to go home," she pleaded.

The "Mr. Johnny," Henrietta referred to, is Johnny Kirkland. He is crew leader of a band of migrant laborers from Pahokee, Fla., on the edge of the Okefenokee swamp.

Early this year Kirkland was contacted by the State employment security commission and told when and where to go in North Carolina, what his crew would be working, and how large a crew he would need.

Then Kirkland led his division in the army of despair "up the road" as the workers say. They will go as far north as New Jersey before they are finished for another year.

In the twin cities of Morehead City and Beaufort this week there are only about 300 migrants left. The main tide has swept north to Elizabeth City and beyond.

Before October, when the migrant stream pours back down through Hendersonville in the west, the number will have reached 12,000.

And despite the happy comments of employment security that, "The worst of the problem has been solved," most of these laborers live in subhuman squalor.

Of the four camps the Raleigh Times reporter-photographer team visited, one fulfilled the minimum sanitation standards required by the Carteret County Health Department. There are 15 camps in the county, and the people close to the problem say that 1 camp is the only decent one there.

The picture the Times saw was this: Open piles of refuse, crumbling outhouses used by men and women; filthy, unscreened rooms, occupied by as many as 10; unsanitary water supplies; no bathing or washing facilities; and flies crawling over food left in the open because there was no place else to put it.

A typical day for these workers sometimes begins at 5:30 a.m. and ends at midnight.

Back-breaking labor, crawling on their knees in the potato rows, fills the void from first light to dark.

In many cases, they do not even get three good meals. In almost all cases they never get a bath, and live anywhere.

Carteret County for the most part turns its face away from these dejected, disinherited people but when they look squarely at them the reaction is despair, impatience, and to a large degree hopelessness.

"It is a terrible problem," says a minister.

"There is no plan for these migrant laborers in trouble," says one county worker.

"They don't appreciate what the growers do for them. We are dealing with the scum of the earth. Animals," said another county official.

And the same official shrugged, "It's a terrible situation that's wrong, that's terrible. But what are you gonna do about it? What can you do about it?"

The Migrant Worker in North Carolina—Part III

VILLAINS, HEROES IN NORTH CAROLINA MIGRANT CAMP

(Third in a series by Brandt Ayers, Times staff writer)

MOREHEAD CITY-BEAUFORT.—"How's the hand, William," asked the tall, young man bending to light the old Negro's cigarette.

"It still hurt some," the graying 60-year-old farmhand said, holding out his right palm, unbandaged and festered where a broken bone had cut the surface.

"Mr. Johnny, he wants me to work. He say if I don't I has to leave the camp."

The "Mr. Johnny" the old Negro referred to is Johnny Kirkland, crew leader of a group of migrant laborers, mostly from Florida.

These crew leaders, along with county and State governments, and in some cases the growers, are the villains of the shameful conditions in migrant camps.

The tall man straightened to his full 6 feet, 5 inches and looked down, "William, don't you think you'd better let us help you go home?"

The workers call the young man, "the big good man."

He is chairman of the Carteret County Migrant Committee and is one of the heroes of the uneven fight against disease and squalor bred in the blighted migrant shacks.

His name is the Reverend Jack Mansfield, pastor of Camp Glen Methodist Church in Morehead City.

The Reverend Dr. Mansfield wears another hat in this fight as a member of the North Carolina Council of Churches which is spearheading the statewide battle on a person-to-person basis.

Mansfield's offer to help the injured old man go home was made Monday in a filthy hovel in Beaufort.

Earlier that afternoon he made the same offer to Henrietta, a migrant from Atlanta, who had miscarried in an equally filthy shack after being given a terrible beating.

He could do no more.

As Miss Georgia Hughes, director of Carteret County's Welfare Department, says, "welfare has little to offer these people because of residence requirements. There isn't a State plan, a county plan, or a Federal plan for migrants in trouble."

These migrants follow the ripening of the crops from Florida through North Carolina and as far as New York from May to October in a march of despair 12,000 strong.

But because they are in North Carolina less than 12 months the State has no legal responsibility for their health or housing.

Despite the boasts of the State employment security commission that no migrants are placed in uninspected camps, and of tremendous advances in the past 5 years, they live in subhuman squalor.

An index of progress is how many concrete block camps, the best, there are in the three major areas of Henderson, Camden-Pasquotank, and Carteret Counties.

There are 34 camps in these areas. Five are of concrete block construction and all of them are in Henderson.

The Raleigh Times visited camps in Carteret County and found only one ideal camp. It was a model because it had garbage cans and spigot with running water.

At other camps, the Times saw and learned migrants defecate through open boards in their shacks, have no garbage disposals, bathing, or clothes washing facilities.

These farm laborers, who are required to have no health certificates, drink from unsanitary water supplies, have no chance to bathe, often not enough food. At one place some 60 men and women live crowded together in a converted fishhouse.

The camps were inspected once by the Carteret County Health Department—before the season opened. A sanitation official did not have a clear idea of what conditions were.

There is concern in Carteret County, however, and in other migrant areas, but by too few and the help is spasmodic, stopgap, and unofficial.

The Carteret County Migrant Committee is operating with assets of $300 and debts of $500.

But Mansfield summed up the spirit of the group, "We don't really care. If someone gets sick tonight we'll put him in the hospital. We'll pay them (hospitals) somehow or other."

Editor Ruth Peeling of the Carteret County News-Times, which has pleaded for voluntary help, says, "The Ministerial Association (underwriters of the migrant committee) has done the work. If the ministers hadn't put the plan into action, we'd be right back where we were 5 years ago."

One of the plans put in action is the mobile clinic.

It is a weathered trailer which four doctors give a night a week to man.

Traveling into Carteret's 15 camps, they give first aid and check for venereal diseases. Mansfield says the VD rate this season is about 11 percent. Many a prim minister would blanch at this and the drinking and immorality.

Not Mansfield. He has worked so closely with it he doesn't have time to be affected by the squalor.

About the drinking and what it denotes, he says:

"I can't blame them for drinking. I don't drink myself and don't particularly like it. But if I had to work 15 hours a day and live like they do, I would drink."

The Migrant Worker in North Carolina—Part IV

NO SINGLE SCAPEGOAT FOR MIGRANTS

(Fourth in a series by Brandt Ayers, Times staff writer)

MOREHEAD CITY-BEAUFORT.—Who is to blame for the harvest of squalor now being reaped in North Carolina by migrant laborers?

There is no one villain.

Conditions in which these people live and work are barely adequate at best and in the majority of cases is subhuman.

Responsibility for these conditions must be shared by the U.S. Congress, State, and county government, migrant crew leaders, the growers, and the workers themselves.

First, how bad are conditions?

Of the 34 camps in the 3 major areas of migrant labor—Henderson, Camden-Pasquotank, and Carteret Counties—only 5 are of the best type, concrete block.

The Raleigh Times went to Carteret County to observe the plight of the migrants and found:

People crowded into filthy frame shacks, no bathing or clothes washing facilities, unsanitary water supplies, open garbage disposals with few garbage cans provided, no place to keep food, inadequate toilet facilities, and no official health clinics.

Naturally, these conditions breed physical and moral disease. A Morehead City minister pointed out the venereal rate among these workers, who handle our food, is 11 percent.

The State employment security commission, which arranges to bring the migrants here for the harvest, boasts none are placed at camps that have not been certified by the local health department.

This is not the case.

As Carteret County Sanitation Officer A. D. Fulford says, "You approve one house, they (the growers) rent that to a permanent tenant. They'll move 'em into a house that's not approved—wherever they can stick 'em, a horse stable or cow stall."

Fulford admits he checked the camps only once, before the season started in May. He has not been back.

At one Morehead City shack about 15 migrants used an open, unsanitary water supply from a nonregulation "openmouth" pump.

These workers were in the crew of Johnny Kirkland, of Pahokee, Fla., and were working for D. S. (Danny) Oglesby. About the house, Fulford says, "I'm under the impression he doesn't have a permit."

Fulford places a large portion of the blame on the migrants themselves, "If they had the intelligence to be sanitary they wouldn't be migrant workers. We're dealing with the scum of the earth—animals."

And he puts his finger on one personality that has major responsibility, the crew leader. "The crew chief is the main one. All he's interested in is the money," says Fulford.

The crew leader is the middleman.

He deals with employment security before the season, gets harvest assignment, collects his crew, transports them to the harvest and pays them after the grower pays him.

His power is great. Most crew leaders withhold part of their crew's pay for services. In some cases the workers never get their pay.

Since he holds the power of the purse over his crew he could require them to keep clean and maintain their rooms, as one good chief does, Jack Passmore, of Pensacola, Fla.

And he could refuse to work his crew unless they had time off for meals and better living conditions, thus exercising power over the grower who must get his crop picked quickly for marketing when it ripens.

Beyond this stopgap solution, the answer must come with Federal or State legislation giving government strong tools to remove this blight from North Carolina.

The North Carolina General Assembly killed one bill that would have forced some sanitation measures in the camps. And the Federal program was halted in 1948 by the 80th Congress.

Happily, the general assembly did provide legislation this year requiring that migrants, in effect, must be hauled in either buses or closed trucks.

Although farmers are exempt from the act, it will minimize the chances for a repeat of the June 1957 tragedy in which 20 migrant workers died when their open truck crashed near Fayetteville.

County Sanitarian Fulford asks this question of the future, "It's a situation that's wrong, that's terrible. But what are you gonna do. What can you do about it?"

The Federal Government was answering that question until 1948. It may have to answer it again.

The Migrant Worker in North Carolina—Last Part

LIVING DIFFERENT UNDER U.S. CONTROL

(Last in a series by Brandt Ayers, Times staff writer)

MOREHEAD CITY.—It is 14 years ago in this same city, June 1947.

The potatoes lie fat and ready in the rows under the gray, eastern North Carolina earth.

The ripening is the signal for armies of Negro farmhands to rise out of the Deep South to take them and then press further north for yet another ripening.

While this army is encamped here, it lives in orderly columns of houses under the supervision of a Farm Security Administration director and his staff.

One year later, the Republican 80th Congress toppled this simple but efficient structure, and with it vanished the health clinics, washhouses, bathhouses, sanitary privies, and recreation facilities.

From 1948, conditions in migrant camps worsened quickly.

Now, in this ocean city and its sibling, Beaufort, the migrant laborer lives in subhuman squalor appropriate to the station of the despised, disinherited American.

Hear the comment of a large grower, Mrs. K. W. Wright of Beaufort: "I realize the camps could be better, but they won't take care of what you give them."

And that of County Sanitarian A. D. Fulford: "If they had the intelligence to be sanitary they wouldn't be migrant workers. We're dealing with the scum of the earth. Animals."

A different view is taken by Nelson W. Stephenson of Raleigh in his thesis prepared in 1950 for a master of science degree in rural sociology at State College.

Stephenson had been a camp director himself under the Farm Security Administration (1942–47) and he wrote from experience as well as painstaking research.

Origin of the migrant laborer he traces to the abandonment of one-crop agriculture and the consequent demand for purely seasonal labor.

And he says, that once accustomed to decent conditions they demand more—a contradiction of the opinion they would destroy more.

He also suggests by its very nature the migrant problem needs a Federal solution.

Why is it a Federal problem ultimately?

Voluntary agencies like the Red Cross are hard pressed by other demands, the workers are not citizens of the State and are not entitled to its aid, the grower feels little responsibility for so short a time, and the community does not claim them.

Vountary agencies in North Carolina, such as the North Carolina Council of Churches and the local migrant committees, now are doing something about the problem.

One young program in Carteret County—a combination of Federal, State, and voluntary action—may be the hope for a better, broader program of the future.

This "homemaker program" established with Federal help as a pilot program for 1 year in Carteret has been "very effective," says the Reverend Jack Mansfield, chairman of the Carteret Migrant Committee.

The program made funds available to the committee to hire two Negro women to work in the camps caring for children, teaching better sanitation, and following up on the purely voluntary health clinic's visits.

The proved their worth in one grisly case.

Henrietta, a 30-year-old Atlanta woman, miscarried a 3-month-old baby in a filthy Morehead shack after a terrible beating from the man sharing the room.

When she returned from the hospital, the two "homemakers" tried to make her more comfortable.

Henrietta and her tragic plea, "Please help me; please help me, y'all; I want to go home," are a sort of symbol of the plight of the migrants.

She is home now, but when the potatoes ripen again in another June she will come again, her few belongings tied in a soiled blanket.

When Henrietta in another year joins again the march to the harvest, 12,000 strong, will it again be a march of the disinherited, a march of despair?

The CHAIRMAN. Do we have anyone else who would like to testify with regard to this bill?

If not, this will conclude the hearings on these bills, and the committee will be adjourned.

The record will remain open for additional statements that are to be supplied by witnesses.

Thank you very much.

(The following material was submitted for the record:)

STATEMENT OF HON. HARRISON A. WILLIAMS, JR., A U.S. SENATOR FROM THE STATE OF NEW JERSEY

Mr. Chairman and members of the subcommittee, I wish to express my deep appreciation for the opportunity to submit a statement in behalf of the bill to establish health programs to improve health services for domestic migratory workers. The Senate Subcommittee on Migratory Labor, since its formation in August of 1959, has studied the circumstances of our migratory farmworkers in great detail. It was in response to the need for improved health care which this study made evident, that I, as chairman of the subcommittee, introduced S. 1130. Our original S. 1130 was identical to bills H.R. 5285, H.R. 6114, H.R. 6480, and H.R. 7088, introduced by Congressmen Zelenko, Kowalski, Farbstein, and Cohelan, respectively. As amended, S. 1130, which reflects changes we found advisable after detailed study of the situation, is before you today. Its companion legislation is H.R. 8882, introduced by Congressman Ryan of New York, and H.R. 10227, introduced by Congressman Zelenko, of New York.

The chairman of this subcommittee is to be commended for his timely attention to this matter: States and local communities are ready to respond to the Federal assistance and programing embodied in this measure. Passage of this bill to improve health service for domestic migratory workers would result in immediate action.

The purpose of the bill is to bring to migratory farmworkers the public health services which are generally available to our other citizens. At present there exists a large gap between our health knowledge and its application to migrants' health needs. Their usual lack of immunization, poor sanitary and safety condi-

tions, and low educational level cause migratory workers and their families to have a greater need for health care than our general population. Several factors, however, militate against the provision of even routine health services for these workers. Their poverty and their mobility lead many communities to reject responsibility for the health needs of the migratory population. Moreover, some communities with a large annual influx of migrants simply lack the resources to expand local health services to meet migrants' needs.

The need to improve health services to migrants is vital to community residents as well as to the migrants themselves, because the health of any migratory people has an impact on permanent residents, too. The impact may be in the form of actual disease transmitted from migrants to residents such as occurred in Plainview, Tex., last winter where diptheria spread from a handful of cases among migrants to a total of more than 50 in the city of Plainview. There is danger that this will occur again this year: Three cases of diptheria have appeared in a migrant labor camp in Collier County, Fla. Community damage may also be in the form of unpaid doctor or hospital bills left at the end of a crop season by a migrant whose illness might have been prevented by routine health care and early detection.

The pending legislation authorizes the expenditure of up to $3 million annually to provide leadership and financial assistance by our national health agency to help communities and States extend existing health services to this segment of our population. I firmly believe that this bill is designed to cope with migratory farmworker health problems with maximum efficiency. With such a program, local health agencies would be in an excellent position to avail themselves of the knowledge and research facilities of the Public Health Service while maintaining freedom to adapt that experience to their own situations in an efficient way.

This legislation places emphasis on the use of grants for paying part of the cost of establishing and operating family health service clinics similar to the demonstration projects now in existence in Fresno County, Calif., and Palm Beach County, Fla. These clinics have no residence requirements for eligibility. They provide a wide range of services for all family members including such standard protective procedures as immunization, health instruction, and early care for illness or injury, a type of care that is usually far less costly than that required when a condition has reached a crisis stage.

Other standard procedures which could be assisted through the bill's project grants would include expansion of local nursing staffs so that nurses could visit migrant families on a regular schedule, assist them with their health problems, and make referrals as needed. They could also include services to assure migrants a safe water supply, to set up a system whereby their health emergencies could be readily cared for, and to expand methods of passing on health information to them effectively. The precise form of the health service to be offered would, of course, vary with the needs of the community.

The bill is also designed to facilitate planning to provide health services to migrants in a manner adapted to their situation, and to link services from one area to another. At present, the migrant finds himself confronted by a set of conditions in one place different from those he has encountered in any other place. He knows neither where to go nor what he may expect. This legislation provides greatly needed funds for the pivotal job of linking the system of health services for migrants. Through this measure it will be possible to establish means for local health facilities to learn from those in other areas; to enable the establishment of common elements in programs which are necessarily varied to fit local needs, so that health facilities will be comprehensible for incoming migrants; to assure transmittal of information on migrants' health from one crop area to another; and to enable continuity of health care for those migrants no matter where they travel.

The movement of the people in response to the demand for their labor makes national leadership and financial assistance essential, not to take on the total responsibility for migrants' health care but to help localities and States work more realistically toward a solution to a problem all of us share. The national leadership and assistance provided through the Public Health Service under this bill will encourage local and State initiative both in strengthening and adapting their own services to the migrants' health problems and need, and in working with other localities and States to provide a basis for greater continuity of effort and service than now exists. This, in turn, will provide a setting in which migrants can more realistically be expected to take greater responsibility for themselves.

Action to provide long-overdue health facilities for these citizens is urgent: Action by the Federal Government in partnership with States and local communities is the only reasonable, efficient means of accomplishing this task. This bill, Mr. Chairman, is a good bill, and a realistic one. I urge its passage in the House of Representatives. The House and Senate have worked well together on other problems of migratory farm workers, and we shall be more than happy to lend any assistance to this committee which it might find helpful. By our cooperative efforts, I believe we can do much to solve these problems which have plagued the migratory farm labor force so long.

STATEMENT OF THE FRIENDS COMMITTEE ON NATIONAL LEGISLATION REGARDING FARM LABOR APPROVED AT THE ANNUAL MEETING, WASHINGTON, D.C., JANUARY 20, 1962

MIGRATORY FARM LABOR

At the present time, our agricultural economy requires the use of many more workers at harvest time than at other seasons. To meet this need, some 500,000 U.S. citizens, 400,000 Mexicans, and 24,000 other foreign nationals work their way northward each year as migrant laborers. These workers are among the poorest paid in our economy. They are predominantly of minority groups. This compounds their handicap. The problem is accentuated by increasing farm mechanization and industrial automation. Long-range redevelopment of agricultural areas will ameliorate the situation. However, this does not eliminate our responsibility to help meet the immediate and continuing needs of migrant workers.

Some employers have provided suitable wages, transportation, housing and generally favorable conditions of employment. Sometimes they have been unable to do all they would like because of marketing situations, which are either closely controlled by large-scale purchasers or chaotic due to competitive pressures especially involving perishable crops.

In many cases, however, the migratory labor situation is characterized by substandard wages, inadequate annual earnings, poor housing, dangerous transportation, unsatisfactory educational opportunities for migrant children, and inadequate medical care and welfare services. Migrant workers play an important role in furnishings food for our tables. The worth and dignity of each individual should be respected, and each should have adequate opportunities to develop his God-given talents. We believe that migrants, their families, and our society as a whole would benefit if local, State and Federal activities affecting migrants are improved or expanded as follows:

Individual growers, local Friends meetings, and church and civic groups should take more responsibility for providing friendly assistance and needed community services on a nondiscriminatory basis to migrant laborers and their children. The workers' isolation from normal community contacts creates a situation in which immoral and degrading influences may flourish.

Domestic migrant workers should receive at least the same assurance of safe transportation, adequate housing and pure water and sanitary facilities, and working conditions comparable to those guaranteed imported laborers. Federal registration and regulation of interstate farm labor contractors (crew leaders) are essential features of such protection.

State and local departments of public welfare should provide in their planning for needs of migrant workers. Special educational programs geared to a transient population should be established to train migrant adults and assure migrant children an adequate education. Day care centers are needed for children whose parents work in the fields. State extension programs emphasizing health, nutrition, home economics and child development should be made more widely available to migrant families. Residency requirements for State and Federal health, education, rehabilitation and welfare programs should be waived for migrant workers. State and Federal programs should be expanded so that domestic migrant workers will be eligible for unemployment insurance and workmen's compensation. Farm workers should receive complete coverage under the Social Security Act. Additional safeguards are needed to assure that migrant workers actually receive the protection to which they are now entitled.

Cooperative labor pools, self-help housing projects and other cooperative solutions may also help alleviate the migrants' plight. Adequate housing should

be provided for migrant workers through mandatory legislation, adequate enforcement, and Government financed assistance.

Many migratory farm workers from other countries are imported under the Mexican importation program, Public Law 78, and the Immigration and Nationality Act. While continuation of the present importation of Mexican workers under Public Law 78 may be necessary, the law should be amended and interpreted to assure that foreign contract labor does not have an adverse effect on the wages and living conditions of the domestic labor force.

FARM LABOR IN GENERAL

The migratory farm labor force supplies from one-third to one-half of the Nation's farm workers. Migratory farm labor problems cannot, therefore, be divorced from the question of farm labor in general. While this statement cannot deal with the broad issues of farm labor, the following recommendations are applicable to both migrant and nonmigrant workers:

State and Federal child labor laws should be strengthened to prohibit all children under 16 from working on farms during school hours and to prescribe working conditions and hours for youth outside of school hours. Appropriate exceptions in regulations on hours and working conditions should be made for children working on farms operated by their parents, relatives and close friends.

Federal and State minimum wage laws should be extended to cover workers on large-scale, nonfamily farms. The transition to full equality between farm and nonfarm workers should take place over a sufficient period of time to prevent hardship to growers. In considering the application to the agricultural economy of State and Federal labor laws guaranteeing the right to organize and bargain collectively, the cooperation of growers and workers should be enlisted.

STATEMENT OF FAY BENNETT, EXECUTIVE SECRETARY, NATIONAL SHARECROPPERS FUND

The National Sharecroppers Fund wishes to express its strong support of H.R. 5285, to provide $3 million annually in Federal financial support to local health agencies for establishing and/or operating health service clinics for migrant workers.

We believe the subcommittee is aware of the special health needs of migrant workers. Working in the Nation's third most hazardous industry, living under generally primitive and unsanitary conditions, unable to pay medical costs because of their extreme poverty, migratory workers are often denied whatever health facilities are available because they are not residents in areas where they come to work.

We find it hard to believe that foreign farmworkers, imported under Public Law 78 and the Puerto Rican worker program, are entitled by the conditions of their contracts to free or inexpensive medical care, while American citizens are forced to suffer disease and even death because of the lack of proper treatment.

H.R. 5285 is a step toward public acceptance of migrant workers as a national responsibility. By providing assistance to areas with a high seasonal influx of migrants, the quality of medical care given to all persons using it should improve. It should be remembered that in many rural areas of this country, existing health facilities are not adequate to care for even the resident population of hired farm workers and low-income farmers. When clinics are established in such areas for the use of migrant workers, their facilities should not be restricted to migrants, but should include residents as well.

The success of Federal assistance to local public health agencies provides a pattern for implementing this legislation successfully and effectively, with little administrative overhead.

The National Sharecroppers Fund, which has worked for over 20 years to improve conditions for America's farm workers, believes that passage of this Senate-approved bill will hasten the day when the situation of migrant workers will no longer be the "shame of America."

[TELEGRAM]

NEW YORK, N.Y., *February 14, 1962.*

Hon. KENNETH ROBERTS,
Chairman, House Subcommittee on Health and Safety,
House Office Building, Washington, D.C.:

The National Child Labor Committee endorses fully House Resolution 5285 to improve and enlarge health services for domestic migratory farmworkers. Its passage will give much needed assistance and encouragment to States and localities in the establishment of special health programs for these important workers and their families. We sincerely urge prompt and positive action by your subcommittee to expedite early enactment of this bill.

ELI E. COHEN,
Executive Secretary National Child Labor Committee.

BUREAU OF HEALTH,
DEPARTMENT OF PUBLIC AFFAIRS,
Trenton, N.J., March 17, 1961.

Re H.R. 5285.

Hon. KENNETH A. ROBERTS,
Chairman, Subcommittee on Health and Safety, House Committee on Interstate and Foreign Commerce, House of Representatives Office Building, Washington, D.C.

DEAR SIR: I wish to call to your attention the importance of H.R. 5285 which would authorize grants for improving the health services and conditions of domestic agricultural migrant workers.

Having carried out two research studies on the health problems of agricultural migrant workers (Texas-Michigan-Public Health Service Migrant Study, 1957–58; and, Measures of the Migrant Farm Labor Population and Certain of Its Health Problems, Doctoral Thesis, Johns Hopkins University, 1960) I am intimately familiar with the need for more studies and the training of professional health workers in this field. This bill would provide a very significant step forward in this direction.

I strongly urge that your committee favorably report this bill for action of the Congress.

Very truly yours,

JOHN B. ATWATER, M.D.

THE AMERICAN PARENTS COMMITTEE, INC.,
Washington, D.C., February 20, 1962.

Hon. OREN HARRIS,
Chairman, Committee on Interstate and Foreign Commerce,
House Office Building, Washington, D.C.

DEAR MR. HARRIS: The American Parents Committee wishes to bring to your attention its interest in, and endorsement of, the legislation before your committee relating to health services for domestic migratory workers and their families.

The American Parents Committee is a nonpartisan, nonprofit organization working for Federal legislation on behalf of the Nation's children. Our board of directors and national council consists of organizational representatives and public spirited citizens concerned with the welfare of children. Better services for migrant children is one of our major legislative goals by decision of the directors at a meeting of the board, November 17, 1961.

A strange anomaly exists in the United States. The children of farm migrant families, one of our most needy groups, continue to get health care almost by accident instead of by plan.

The family health service clinics proposed by H.R. 8882 and the companion bill, S. 1130 (passed by the Senate last August), would help to overcome the

community neglect migrant children have suffered because their parents' work requires that they move from harvest to harvest. With the added effort of the Public Health Service to link the services of family clinics, even though they happen to be located in different States, migrant children should start receiving the immunizations and other services they need.

The American Parents Committee strongly supports H.R. 8882 and the companion bill S. 1130.

Sincerely yours,

(Mrs.) Margaret K. Taylor, *Executive Director.*

New York State Citizens, Committee on Farm Labor,
New York, N.Y., February 14, 1962.

Mr. Kenneth A. Roberts,
Chairman, Subcommittee on Health and Safety, Committee on Interstate and Foreign Commerce, House Office Building, Washington, D.C.

My Dear Mr. Roberts: The New York State Citizens Committee on Farm Labor wishes to express its support of H.R. 5285 providing grants for improving the health services and conditions of domestic agricultural migratory workers.

The New York State Citizens Committee feels that such aid is crucially needed for these workers who stand lowest on the economic scale but who work in the third most hazardous industry in the United States. These workers, the least able to afford medical care, live and work for the most part under conditions that contribute to a high rate of disease and disability. Yet in most States, because they are migratory workers, they are deprived of welfare assistance, workmen's compensation, or any type of reliable, planned, or dependable health service.

We urge, therefore the passage of H.R. 5285, realizing, however that $3 million is woefully inadequate for even the purposes of this bill. Nevertheless we hope that this legislation will result in a greater awareness on the part of large-scale agricultural employers, communities and States as to the need for a coordinated, planned program to improve the health and conditions of farmworkers.

The New York State Citizens Committee commends the Subcommittee on Health and Safety for holding hearings on H.R. 5285. We hope you will make this letter a part of the record of the hearings.

Sincerely yours,

Thomson C. McGowan, *Chairman.*

(Whereupon at 12:30 p.m., the hearing was adjourned.)

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