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MIGRANT HEALTH SERVICES

GOVERNMENT

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HEARINGS
BEFORE THE
COMMITTEE ON MIGRATORY LABOR
OF THE
COMMITTEE ON
LABOR AND PUBLIC WELFARE
UNITED STATES SENATE
NINETIETH CONGRESS
FIRST SESSION
ON
S. 2688

TO AMEND THE PUBLIC HEALTH SERVICE ACT FOR
MIGRANT HEALTH SERVICES

DECEMBER 7 AND 13, 1967



Printed for the use of the Committee on Labor and Public Welfare

U.S. GOVERNMENT PRINTING OFFICE

87-443

WASHINGTON : 1968

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MIGRANT HEALTH SERVICES

THURSDAY, DECEMBER 7, 1967

U.S. SENATE,
SUBCOMMITTEE ON MIGRATORY LABOR OF THE
LABOR AND PUBLIC WELFARE COMMITTEE,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to call, in room 4232, New Senate Office Building, Senator Harrison A. Williams, Jr. (chairman of the subcommittee), presiding.

Present: Senator Williams.

Also present: Frederick R. Blackwell, counsel; and Boren Chertkov, associate counsel.

Senator WILLIAMS. We will convene this hearing of the Subcommittee on Migratory Labor of the Labor and Public Welfare Committee.

I know that we are the beneficiary of the fact that many of our witnesses today were gathered in Washington for other purposes and made themselves available for our hearings today. We certainly appreciate it.

Existing authority for the migrant health program expires June 30, 1968. Some \$9 million is authorized for the program for this fiscal year, but only about \$7.2 million was appropriated.

The proposed legislation would authorize \$13 million for fiscal 1969, \$15 million for fiscal 1970, \$20 million for fiscal 1971, and such amounts as may be necessary for fiscal 1972 and 1973.

The migrant health program was enacted into law in 1962 and by the end of the first year of operation we had 31 projects serving migrants in 114 counties in 20 States. The program has been steadily expanded since then and we now have 115 projects serving migrant farmworkers in 300 counties in 36 States and Puerto Rico.

Yet the need far outdistances the available services.

We are operating this year with \$7.2 million. We could use almost double that amount of money simply to do a more effective job in the existing projects. In addition, we have many applications for new projects which the Public Health Service has been forced to turn down because of lack of funds.

The migrant health program provides the kind of health care which most families have long regarded as routine care. That is, prenatal and postnatal care, obstetrics service, immunizations, examinations, and treatment for ordinary ailments.

But it does this with a difference. The migrant health program, operating through the various State health departments, goes out into the migrant labor camps and, indeed, into the field sometimes, to find its patients and bring the care to them.

Before this program was launched, there simply was no medical care available for migrant farmworkers, except for grave emergencies and frequently not even then.

We have made some progress, since then. But we have a long way to go. It is still the exception, rather than the rule, for the migrant farmworker and his family to have available even the barest minimum of medical services.

To illustrate: In 1964 the infant mortality rate among migrants was at the level of the country as a whole for 1949. The maternal mortality rate in 1964 was the same as the national level of a decade ago.

Mortality from tuberculosis and other infectious diseases among migrants in 1964 was two and a half times the national rate, approximating the national rate of more than a decade ago.

Of the more than 1 million migrants, including workers and their dependents, 750,000 still live and work outside the areas served by existing migrant health projects. This group includes, by conservative estimates—

1. Over 6,500 persons with diabetes who are without adequate medical care.

2. Over 5,000 migrants with tuberculosis who are traveling and working with their disease undetected and untreated.

3. Over 300 children under the age of 18 who have suffered cardiac damage as a result of rheumatic fever. These children are unlikely to receive treatment for prevention of reinfection and further cardiac damage. Such treatment is ordinarily readily available to most nonmigrant children in their communities.

4. Approximately 9,800 children who have undiagnosed and untreated iron deficiency anemia. This increases their susceptibility for childhood infection and interferes with their normal growth and development.

5. Over 250 infants who will die in the first year of life as a result of congenital malformation or disease. Early, adequate medical care will not be available for these infants.

6. Over 16,000 expectant mothers who will find it difficult to obtain prenatal care. Infant and maternal mortality can be expected to be significantly higher under such conditions.

7. Between 20,000 to 30,000 individuals who have enteric parasitic infestations—resulting in most cases from poor sanitation. Such a problem is almost nonexistent in the general public.

Just 2 months ago, in one of the wealthiest States in the nation—a migrant with an emergency illness was rejected by four hospitals because he could not assure payment of the bill. At the fifth hospital, where he obtained attention, doctors said the patient had only about 2 hours left to shop around for hospital treatment.

The time for extending and expanding the programs for improving the health of migrant workers is now. We are past the time for waiting.

We can give you the program and you are the men who carry it through. You are the men who are directly responsible for the operation of this noble program, and we are honored to have you present to us your experience, your observations.

We are privileged to start this morning with a panel of doctors from the public health services in some of the States that have the primary need, and are the chief benefactors of the proposed legislation. What we are trying to let you do by this legislation is bring accepted, what we call routine, regular medical care to people who before this program were left out. That is what we are trying to do and you are doing it.

We have two bills, one in the Senate and one in the House. One is a 3-year bill. One is a 5-year bill. The Senate bill that I introduced is a 5-year bill, really modest amounts, gentlemen, when you compare it with expenditures for other things.

(Public Laws 87-692 and 89-109, and S. 2688, follow:)

Public Law 87-692
87th Congress, S. 1130
September 25, 1962

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 Representatives of the United States of America in Congress assembled, That title III of the Public Health Service Act (42 U.S.C., ch. 6A, subch. 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. There are hereby authorized to be appropriated for the fiscal year ending June 30, 1963, the fiscal year ending June 30, 1964, and the fiscal year ending June 30, 1965, 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 and 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 operating 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 programs for the purpose of improving health services for or otherwise improving the health conditions of domestic agricultural migratory workers and their families."

Approved September 25, 1962.

Public Law 89-109
89th Congress, S. 510
August 5, 1965

AN ACT To extend and otherwise amend certain expiring provisions of the Public Health Service Act relating to community health services, and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Community Health Services Extension Amendments of 1965".

IMMUNIZATION PROGRAMS

SEC. 2. (a) The first sentence of subsection (a) of section 317 of the Public Health Service Act is amended by striking out "and" before "June 30, 1965" and by inserting "and each of the next three fiscal years," immediately after "June 30, 1965,". The second sentence of such subsection is amended by striking out "the fiscal years ending June 30, 1963, and June 30, 1964" and inserting in lieu thereof "any fiscal year ending prior to July 1, 1968". The third sentence of such subsection is amended by striking "and tetanus" and inserting in lieu thereof "tetanus, and measles", and by striking out "under the age of five years" and inserting in lieu thereof "of preschool age".

(b) Subsection (a) of such section is further amended by adding at the end thereof the following new sentence: "Such grants may also be used to pay similar costs in connection with immunization programs against any other disease of an infectious nature which the Surgeon General finds represents a major public health problem in terms of high mortality, morbidity, disability, or epidemic potential and to be susceptible of practical elimination as a public health problem

through immunization with vaccines or other preventive agents which may become available in the future."

(c) Subsection (b) of such section is amended by striking out "of limited duration", by striking out "against poliomyelitis, diphtheria, whooping cough, and tetanus" and inserting in lieu thereof "against the diseases referred to in subsection (a)", and by striking out "who are under the age of five years" and inserting in lieu thereof "of preschool age".

(d)(1) Such section is further amended by striking out "intensive community vaccination" wherever it appears in subsections (a), (b), and (c) and inserting in lieu thereof "immunization".

(2) The heading of such section is amended by striking out "INTENSIVE VACCINATION" and inserting in lieu thereof "IMMUNIZATION".

(e) Paragraph (1) of subsection (c) is amended by inserting "on the basis of estimates" after "advance"; by striking out the comma after the word "reimbursement" and inserting in lieu thereof "(with necessary adjustments on account of underpayments or overpayments)".

MIGRATORY WORKERS HEALTH SERVICES

SEC. 3. (a) Section 310 of the Public Health Service Act is amended by striking out "for the fiscal year ending June 30, 1963, the fiscal year ending June 30, 1964, and the fiscal year ending June 30, 1965, such sums, not to exceed \$3,000,000 for any year, as may be necessary" and inserting in lieu thereof "not to exceed \$7,000,000 for the fiscal year ending June 30, 1966, \$8,000,000 for the fiscal year ending June 30, 1967, and \$9,000,000 for the fiscal year ending June 30, 1968".

(b) Such section is further amended by inserting "including necessary hospital care, and" immediately after "agricultural migratory workers and their families," in clause (1)(ii) of such section.

GENERAL PUBLIC HEALTH SERVICES

SEC. 4. (a) The first sentence of subsection (c) of section 314 of such Act is amended by striking out "first five fiscal years ending after June 30, 1961" and inserting in lieu thereof "first six fiscal years ending after June 30, 1961".

(b) The third sentence of subsection (c) of section 314 of such Act is amended by striking out "\$2,500,000" and inserting in lieu thereof "\$5,000,000".

SPECIAL PROJECT GRANTS FOR COMMUNITY HEALTH SERVICES

SEC. 5. The first sentence of subsection (a) of section 316 of such Act is amended by striking out "first five fiscal years ending after June 30, 1961" and inserting in lieu thereof "first six fiscal years ending after June 30, 1961".

Approved August 5, 1965.

LEGISLATIVE HISTORY

HOUSE REPORTS: No. 249 accompanying H.R. 2986 (Committee on Interstate and Foreign Commerce) and No. 676 (committee on conference).

SENATE REPORT No. 117 (Committee on Labor and Public Welfare).

CONGRESSIONAL RECORD, volume 111 (1965):

March 11: Considered and passed Senate.

May 3: Considered and passed House, amended, in lieu of H.R. 2986.

July 26: Senate agreed to conference report.

July 27: House agreed to conference report.

S. 2688, 90th Cong., first sess.]

A BILL To extend and otherwise amend certain expiring provisions of the Public Health Service Act for migrant health services

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 310 of the Public Health Service Act is amended by striking out "not to exceed \$7,000,000 for the fiscal year ending June 30, 1966, \$8,000,000 for the fiscal year ending June 30, 1967, and \$9,000,000 for the fiscal year ending June 30, 1968", and inserting in lieu thereof "not to exceed \$9,000,000 for the fiscal year ending June 30, 1968, \$13,000,000 for the fiscal year ending June 30, 1969, \$15,000,000 for the fiscal year ending June 30, 1970, and \$20,000,000 for the fiscal year ending June 30, 1971, and such amounts as may be necessary for each of the two succeeding fiscal years".

Senator WILLIAMS. And so without further ado, Dr. Venable, president of the Association of State and Territorial Health Officers, comes to us from Georgia and I know that he has to get back to conferences downtown.

We give the forum to you and I know you will introduce your colleagues.

STATEMENT OF DR. JOHN VENABLE, PRESIDENT, ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS, GEORGIA; DR. JAMES PEAVY, PRESIDENT-ELECT, ASSOCIATION OF STATE AND TERRITORIAL OFFICERS, TEXAS; DR. WILSON SOWDER, STATE HEALTH OFFICER OF FLORIDA; DR. LESTER BRESLOW, STATE HEALTH OFFICER OF CALIFORNIA; AND DR. ROSCOE KANDLE, STATE HEALTH OFFICER OF NEW JERSEY

Dr. VENABLE. Thank you, Senator Williams. It is a privilege and a pleasure for us to be here today in support of this legislation. The Association of State and Territorial Health Officers, of which I am privileged now to serve as president, has a formal position in support of this legislation and we are happy individually to follow up that position of the 50 States and four Territories that are members of our organization.

I would say a few remarks in relation to one point before introducing the others of our group. That is the relationship that this legislation may have to comprehensive health planning, the Partnership for Health Act of the 89th Congress. This is just now under way in the States. We are not yet fully on top of all of the problems of this new program and there have been and will be a great many special needs.

People have tended to say, "Let 749 handle it." We believe that the problem to which this legislation is directed is of sufficient magnitude that at this point in time it certainly should continue to be separate. Perhaps later on when comprehensive planning is better organized, when we have had a little more experience with it, it may be or may not be, depending on the situation, that appropriations through that mechanism rather than separately would tie migrant health services more closely into a comprehensive health planning for the State and comprehensive health service. But certainly, now, we would support this as separate legislation.

I am happy to have with me this morning the health officers from four States in which the health of migrants is a major problem and in which major activity has occurred. If I may I would like to introduce to you all four before they speak. Next to me is Dr. Sowder of Florida, then Dr. Peavy of Texas, Dr. Kandle from New Jersey, and Dr. Breslow of California.

They will speak, if the Chair would permit, to this legislation and then they will remain in order to answer any questions you may have.

Thank you very much.

Senator WILLIAMS. Could you pause just for a moment?

Dr. VENABLE. Yes, sir.

Senator WILLIAMS. Our Migrant Health Program is still in its infancy, but it has been operating for 5 years. It was a small miracle that we ever got it passed, to tell you the truth, but it still is in its

infancy. Doctor, is it your thought—I think it is as you expressed it—that in its infancy it should be sheltered in a sense and not be lost in a still amorphous comprehensive health program which is not yet fully established?

Dr. VENABLE. In my judgment, it would be far better at the moment to keep the two programs separate, but I would want to comment also that comprehensive planning properly developed within the States will certainly work closely with the separate program of migrant health and begin to incorporate it into the comprehensive whole.

Senator WILLIAMS. But at this point, they shouldn't be lumped together?

Dr. VENABLE. That is right.

Senator WILLIAMS. After it is fully established and fully operative, then it would be good administration to include it?

Dr. VENABLE. That would be my judgment.

Senator WILLIAMS. But not at this point?

Dr. VENABLE. Yes, sir.

Senator WILLIAMS. We certainly thank you. By the way, how is the migrant health program working in Georgia?

Dr. VENABLE. We have a very small problem in Georgia. They seem to jump across us from Florida to South Carolina and back again.

Senator WILLIAMS. You know, there isn't a great deal of migrant worker harvesting in Georgia, is there?

Dr. VENABLE. Not much; in fact, very little.

Senator WILLIAMS. Who picks those peaches?

Dr. VENABLE. Well, peaches, of course, are a little bit out of their line of travel for the migrant crop. They are usually done with local labor. It is a concentrated activity, as you know, and in a very few weeks out of the season and I wouldn't say they don't have labor problems in that harvest, but it is usually done by local people.

Senator WILLIAMS. You don't have a real heavy concentration of migrant farmworkers?

Dr. VENABLE. No, sir. We are able to cope with what we do have through our local health activity which is rural in these areas and set up to handle rural situations and there are no serious problems in relation to residency and this sort of thing, so we do work it in our total program.

Senator WILLIAMS. I found when I was handling legislation that, if I had the support of Georgia, from the mayor of Atlanta to Herman Talmadge and Dick Russell, the legislation was in excellent company. I know that you have another engagement to keep, so I will ask no further questions. We do thank you very much for coming here today.

Dr. VENABLE. Thank you, Senator.

Senator WILLIAMS. Now, who is chairman of the board now that Dr. Venable has left? Who is chairman of the board?

Dr. PEAVY. I suppose I am, Senator; Dr. Peavy of Texas.

Senator WILLIAMS. Dr. James Peavy, you are the president-elect of the Association of State and Territorial Officers?

Dr. PEAVY. Yes.

Senator WILLIAMS. Where are you from in Texas, Doctor?

Dr. PEAVY. My home is in Austin, Tex. I am the commissioner of health in Texas.

Senator WILLIAMS. Do you ever get down Rio Grande way?

Dr. PEAVY. Oh, yes, sir. In fact, as you know, we just had a terrific problem in that area with all the flooding.

Senator WILLIAMS. We were down there.

Dr. PEAVY. Yes, I know. I believe I met you there, Senator.

Senator WILLIAMS. We are honored with your presence here and we know that you know what it is all about.

Dr. PEAVY. Thank you.

Senator WILLIAMS. The forum is yours.

Dr. PEAVY. The first one we would like, if we may, to testify is Dr. Wilson Sowder from Florida. If this is agreeable with you, Senator Williams, I will call on Dr. Sowder.

Senator WILLIAMS. It certainly is and from coast to coast, border to border, on our travels, I have commended Florida for its enlightened approach to the problems of these very poor people.

STATEMENT OF DR. WILSON SOWDER, STATE HEALTH OFFICER OF FLORIDA

Dr. SOWDER. We appreciate that, Senator, and I want to say for Florida that we feel that this is a very good law, a badly needed law, and it is doing a tremendous amount of good.

It in my judgment needs more money than we are presently getting. We need more money. We think the bill should not only be extended, but that more money should be put into the program. It is particularly important to Florida because out of the estimated million migrants, we get about 100,000 of them, about 10 percent.

Now, of course, we share those at certain parts of the year with other States. Some of those migrants are located and work in counties where they actually outnumber the resident population and it is a little difficult for the State to cope with the problems without Federal aid.

On the makeup of our migrants—some of these come from Georgia, the Negro and white natives, and many of them come from the South into the migrant stream—about 60 percent are Negro, about 17 percent from Dr. Peavy's State of Texas or else direct from Mexico.

They call them Texas Mexicans in Florida. Fifteen percent are Puerto Ricans and about 8 percent are what they call Anglos. They come down there in September and stay whether there is work or not until about April and then they go north into the migrant stream along up to your State of New Jersey and even farther on.

They are, in essence, the same type of people that the Congress is trying to help out in the urban areas, the poverty group.

They are a rural poverty group. They are people, however, who are doing useful work. They are essential to the agricultural economy and they are earning their way. So I think that they deserve the help that we are giving them and more.

Out of our 67 counties, 17 are in this program.

Senator WILLIAMS. Out of 67 counties?

Dr. SOWDER. Sixty-seven counties.

Senator WILLIAMS. How many are in the program?

Dr. SOWDER. Seventeen.

Senator WILLIAMS. These are the areas of high concentration of farm migrants?

Dr. SOWDER. Yes, sir.

Senator WILLIAMS. Dade County also has agriculture.

Dr. SOWDER. That is right; yes, sir.

In fact, it is one of the big ones. Palm Beach County is a big one. Then we have places like Collier County where they have 19,000 migrants at the peak of the season and about that many permanent residents. We have about five other counties to which we need to extend this program.

We did ask for about \$1.1 million this year in the central project which takes care of all but two counties. Two of our counties, Palm Beach and Dade, have separate projects. The others are lumped together.

We wanted this year about \$1,100,000 to run the program properly but there was only enough money for approximately \$650,000. So we endorse the program. We think it is badly needed. We think a lot of people would suffer unnecessarily if the program were cut out and I personally think it meets the requirement of a special type program in that it is geographically limited.

We have here a high-risk group with all their problems, so I am not quite so convinced as Dr. Venable that it will ever be a program that can be easily merged into, you might say, the generalized program.

This problem needs special treatment.

Senator WILLIAMS. We certainly appreciate that.

Dr. SOWDER. Thank you.

Senator WILLIAMS. You head up the State health program in Florida?

Dr. SOWDER. Yes, sir.

Senator WILLIAMS. How long have you been in this position?

Dr. SOWDER. A little over 22 years.

Senator WILLIAMS. You have survived many administrations, haven't you?

Dr. SOWDER. About eight or nine. I forget how many.

Dr. KANDLE. Don't push that.

Senator WILLIAMS. You must know what you are doing.

Dr. SOWDER. Maybe they don't know what I am doing.

Senator WILLIAMS. We are happy to share your view. As I indicated earlier to Dr. Venable, in its infancy this program should grow on its own foundation and not be lumped in with a lot of other very necessary programs for better health, and you put it very forcefully.

You indicated that we have been short in our numbers on dollar amounts for this program. Would you mind if I recall your testimony to Senator Holland and Senator Smathers?

Dr. SOWDER. I would be very happy for you to; yes, sir.

Senator WILLIAMS. Thank you, Doctor.

STATEMENT OF DR. JAMES PEAVY, PRESIDENT-ELECT, ASSOCIATION OF STATE AND TERRITORIAL OFFICERS, TEXAS

Dr. PEAVY. Senator Williams, let me again express to you our very deep appreciation for the opportunity of appearing before this committee.

In Texas, as you know, we have something over half of all the migrants in the country home-based in our State. This was a terrific problem with us prior to the enactment of the bill in 1962. I do want

all of the committee to know that we are grateful for the bill itself and for giving us the opportunity to provide some of the badly needed health care services in the State of Texas.

We had terrific public health problems prior to 1962. Health care was almost nonexistent for this type of person and this bill has been of tremendous help to us. At the present time we have 27 projects, one of which is statewide, and the remaining 26 are local projects in areas where the migrants are concentrated.

We do have a great need to extend the type of program that we have. We feel quite sure that if we had double the present amount of funds, we could use them in a very effective manner. The big problem that we have, of course, is health care.

Tuberculosis is a problem. We also have prenatal problems, in fact the whole gamut, and this bill allows us to provide health care. In about half of these 26 projects we do have a provision for hospitalization of the migrant worker himself.

I think everyone in our State from all the reports I get is tremendously grateful for the opportunity of providing health care to the migrants and we have nothing but good reports every week throughout our State where we have projects.

We are certainly grateful to you and we hope you will see fit and find the means of at least doubling the program and we feel that the whole Nation will benefit by this extension of the migrant health bill.

Again, we appreciate the opportunity very much for being here, Senator WILLIAMS. I will be glad to try to answer any questions that I can.

Senator WILLIAMS. Bringing health care to people who are on the road, who travel, and who have no permanent residence, presents a great problem to you men, doesn't it?

Dr. PEAVY. Yes, sir; it does.

Senator WILLIAMS. It is obviously a greater problem than serving people who are settled in a community. You almost have to find the people that you want to immunize or test for tuberculosis or whatever it is. It is a hard job.

Dr. PEAVY. Yes, sir; it certainly is. We have had some outbreaks. We had an outbreak prior to the enactment of this program in 1962. We had a big outbreak of diphtheria because the susceptible population were not immunized against diphtheria.

They migrated to the plains area and we had an outbreak as a result of that. Now with the financial means to give the necessary immunizations early, we think it goes a long way not only to help the migrant himself, but to help the entire population.

Senator WILLIAMS. But again you couldn't expect them to come to the community clinic. You almost have to go where they are.

Dr. PEAVY. Yes, sir; and it takes a health education program along with it, as you know. It's not just making the services available, you have to convince them that this is a necessary procedure.

Senator WILLIAMS. You have the cure for tuberculosis; do you not?

Dr. PEAVY. Yes, sir; we certainly do.

Senator WILLIAMS. I can remember as a kid delivering milk to my uncle up in the Adirondacks to Trudeau Sanitarium, and the treatment for tuberculosis then wasn't really treatment. Well, it was Trudeau's pioneering effort. It was a fresh air treatment.

Dr. PEAVY. Yes, sir.

Senator WILLIAMS. You know what Trudeau Sanitarium is today?

Dr. PEAVY. Yes, sir; I believe so.

Senator WILLIAMS. The headquarters for the American Management Association.

Dr. PEAVY. Yes, sir.

Senator WILLIAMS. Although doctors have found the answer to tuberculosis, the incidence of tuberculosis among migrants is very much higher than the general population.

Dr. PEAVY. That is right.

Senator WILLIAMS. You have to find them and treat them?

Dr. PEAVY. Yes, sir.

It is still a problem, of course, in our State because of the problems we have. In the particular area that is home base for the migrants we have sort of unusual problems and we still have not conquered tuberculosis, but I think we are making progress.

Chemotherapy that has been put into effect for tuberculosis has shortened hospitalization. Casefinding methods are better and I certainly think in the near future we can reach the goal of eradicating tuberculosis.

Senator WILLIAMS. How about polio? Dr. Kandle will recall in the State of New Jersey when the Salk vaccine came out there was a doctors' boycott on the roundup of people to come in and they wouldn't administer the Salk vaccine. They wanted to do it on a business-as-usual basis.

And what was the next? The wafer?

Dr. PEAVY. Oral vaccine.

Dr. KANDLE. Sugar.

Senator WILLIAMS. Yes, the oral vaccine. When that came on it became a public responsibility to show up on Sundays, every three Sundays, to get the vaccine. That is easy in a suburban community or a city community, where you have the people concentrated. But inoculation of migrants presents a far more difficult health problem.

Dr. PEAVY. Much more so. I remember, Senator, when I was director of the communicable diseases program in the prevaccine days we had as many as 250 paralytic polio cases reported in a week through the State of Texas.

This year throughout the year, we have had a total of seven cases. I think this is dramatic and shows what can be done in public health.

Senator WILLIAMS. You are reaching them?

Dr. PEAVY. Yes, sir.

Senator WILLIAMS. We appreciate, Doctor, your endorsement of what we are trying to do. It means so much more because you know more about what we are trying to do because you are on the firing line administering the program.

Dr. PEAVY. Thank you, sir.

Senator WILLIAMS. Who is next? Dr. Kandle?

STATEMENT OF DR. ROSCOE KANDLE, STATE HEALTH OFFICER OF NEW JERSEY

Dr. KANDLE. Yes.

Senator WILLIAMS. Dr. Kandle, I am honored indeed that you are in charge of my own good or bad health in the State of New Jersey, and you serve with great distinction.

I do want to say, Dr. Kandle, before you make your statement, that this committee can't perform the task alone. This health program, for example, would never have been passed without the help of Senator Holland of Florida, Senator Byrd, now deceased, of Virginia, and some of the other Senators who were with us, and we passed this bill without objection.

It was a unanimous vote, and I am grateful indeed to many other Senators who were there at the beginning. We have had a unanimity here in the Senate that has made this possible.

Dr. Kandle.

Dr. KANDLE. Thank you, sir. New Jersey has had Federal grant money for 5 years and in 1963, when we really got started, we were able to see 2,000 persons and they got a rather skimpy kind of care.

However, during that year, we were able to introduce this very vital factor that you have already spoken of, Senator; that is, the Outreach. Of course, having been brought up as a Calvinist, this is an easy term for me, and we were able to put the Outreach really into effect.

We really go out and see them, as you say, in the camps and in the fields as we need to, and we dealt then with the multiple and difficult problems of alcoholism, out-of-wedlock pregnancies, accidental injuries, mental retardation, or whatever.

I mean we see them all. And somehow or other, we had to begin to come to grips with their problems. We saw, for example, dysentery and hepatitis from bad sanitation. I remember particularly that we were struck by the great dental needs.

But what can you do with a little bit of money and small program to begin with? So at the first we said, well, we will only be able to help those who need, for example, the control of hemorrhage or elimination of pain, bone infection, dental infection. But even so, even with such limited and rigid criteria, we were able to look after some 200 people right at the beginning.

Now we have a reasonable range of medical services. We have the New Jersey State College of Medicine and Dentistry involved and the several departments of education and labor. We have students from the four university medical and dental schools, and best of all, we now have more than a dozen practicing dentists and physicians who are serving the migrant people just as they serve the rest of the people.

We think this was a tremendous breakthrough because now the agricultural migrants are getting the same kind of care and the same quality of care under the same kind of a system that the rest of the people get, including hospitalization and all the rest.

I don't know; I couldn't get an unduplicated count for the current year, but I know we served 10,000 people and, perhaps as importantly, we supervised 566 camps, and that is quite an undertaking.

One of the interesting things, and I think it shows that things are working well developmentally in this specialized program, and I do think it ought to be specialized, is that during the current fiscal year \$40,000 worth of services were provided under medicare.

We just didn't think we were going to see that many older people. But from among the families and groups who came into our program, this many are now part of a regular medical system.

I think New Jersey is doing its part. For example, we have a two-bill package of legislation that is before the current legislature. Parts 1 and 2 were approved by the assembly, by 38 to 3 and 36 to 3, last Monday.

They are now going before the senate in its last session. Governor Hughes thinks that there is going to be favorable action and he himself, in spite of his current infirmity, has been working very hard to see that these bills get through. If I may, I would at least like to call attention to and possibly enter into the record the newspaper accounts of the progress of these two bills.

Some of the provisions of these bills are new standards, increased penalties, and tax exemption for improvements in the living conditions and working conditions for the migratory agricultural workers. I think this is a rather imaginative kind of legislation.

Senator WILLIAMS. We will include those in the record.

(The newspaper clippings follow:)

BY AMBULANCE, IF NECESSARY—MIGRANT CAMP BILL GIVEN A CHANCE

(By Earl Josephson)

The bill tightening migrant labor camp regulations, now is given a good chance of clearing the legislature, even if Governor Richard J. Hughes has to take an ambulance ride to accomplish it.

It may take an extra meeting of the Senate next week to bring the bill to a vote if Republicans balk at special treatment for the measure, passed yesterday in the Assembly.

There is even an outside chance that Hughes might have to take a special ambulance trip from his Philadelphia hospital into Camden if the bill is one vote shy.

That is because Senate President Sido Ridolfi of Mercer believes he can't vote in the Senate while he is acting governor. Once Hughes is inside New Jersey, Ridolfi says he can vote.

ENOUGH VOTES

Ridolfi said Hughes would make the brief trip if necessary and if his physicians consent, but he expressed optimism that there will be enough votes, including some from Republicans.

The bill, opposed by the farm lobby, was approved 38-3 by the Assembly with support from seven Republicans. Thirty-one votes were needed.

Fifteen is the required vote in the Senate, where the Democrats have 17 members. One, Majority Leader John Waddington of Salem, opposes the bill.

It would give the state power to certify camps before they can open, increases fines and requires camp operators to keep an accurate register of laborers.

By the 1970 growing season, unless hardship is established, operators would have to—

Provide twice as much sleeping space as is required now.

Install flush toilets, unless privies are proven superior because of ground conditions.

Upgrade bathing and drinking water facilities.

A companion bill approved yesterday grants farmers a property tax exemption on the new water supply or sewerage facilities.

Assemblyman S. Howard Woodson Jr. of Mercer, the sponsor, told his colleagues the bill was "not revolutionary, only a first step."

WHO SHOULD PAY?

HELPING THE MIGRANTS

Although we have no reason to doubt the genuineness of Governor Hughes' humanitarian concerns, we suspect that his flair for dramatizing those concerns is not without its political aspects.

The sudden flare of interest in legislation for improvement of migrant farm labor housing is a case in point. Action on the bill which sailed through the Assembly this week—and for which the Governor threatens to call a special

session of the Senate, if necessary, to secure passage before the end of the year—is a case in point. It was no doubt triggered by the recent *deaths by fire of five children* of a farm worker in Salem County, and was timed to take advantage of the reaction to that event.

Nor does this strike us as entirely improper, despite the protest of at least one Republican assemblyman that votes for the bill were sought on the basis of “emotionalism.” Surely there is a proper place for emotion when one contemplates the conditions under which many migrant workers must live.

However, it does seem to us that the type of legislation that is offered does not go to the heart of the matter. In effect, it seeks to improve the living conditions of migrant workers by forcing additional expense upon the farmers. Now, agriculture in this state is, generally speaking, in a parlous economic condition. Farmers do not, for the most part, pay low wages and offer only minimal living accommodations for their hands simply because they are mean-hearted skinflints, but because they, in their turn, are at the mercy of buyers, processors and distributors who have the economic power to shave their profit margins to the bone.

Ultimately, the exploiter of farm labor is not the farmer, but the supermarket shopper, whose low food prices are, in effect, subsidized by the misery of farm labor.

Now, if the general public is to enjoy the effects of such a subsidy, it ought to help pay for it. If the state government, in all its majesty of social concern, wishes to enact an improvement in migrant living standards, why should not the state treasury pay for it? We might suggest such a proposal as strategically located migrant camps owned and run by the state.

True, this would constitute, in effect, a subsidy to state agriculture. But, as we have already pointed out, it is the general public which benefits, in the form of low food prices; and at present there is a subsidy being paid—and it is being paid by the laborers themselves, in the form of deprivation and misery.

HUGHES' PET PROJECT—ASSEMBLY OK'S MIGRANT LABOR REFORM BILL

Controversial migrant labor reform legislation that has become the pet project of Gov. Richard J. Hughes was approved *overwhelmingly* Monday by the Assembly.

The measure, approved 38-3 by the lower house, now faces a stiff Senate test before going to the governor for his signature.

The bill, the most important of a *two bill package*, was supported by seven Republicans who joined 31 Democrats. The three “no” votes came from Republicans.

Hughes, before entering University of Pennsylvania Hospital last week for eye surgery, urged fast approval of the measure and said he would continue to press for ratification despite his hospitalization.

The Senate has only one scheduled session left, and if the legislation is to pass then, the upper house must use emergency treatment requiring a three-fourths vote. But with only 24 of the 29 senators left after resignations, all but two are needed. Further, Majority Leader John Waddington, D-Salem, is reportedly against the bills.

However, Gov. Hughes has said he might call a special session of the Senate to act on the measure if needed.

The 1st measure *increases both civil and criminal penalties for violations*. The fine is boosted from \$200 to \$500 for each day of the civil violation, while the criminal fine is hiked from \$200 to \$1,000, and the prison term from 60 days to one year.

Under the measure, the owner of a migrant labor camp found in violation would be protected if he could prove the violation was caused by the tenant.

REQUIRE APPLICATION

Camps would have to apply for state Labor and Industry Department *certification* at least 60 days before opening, and the state must inspect within 45 days of the request or the camp may open without an inspection.

In addition, all new construction or major alterations would have to be approved by the state.

The measure doubles sleeping space requirements, requires a potable water supply, bathing facilities and flush toilets by Jan. 1, 1970. The bill, however, provides for exceptions in the case of hardship.

The 2d bill, approved 36-3, *allows farmers tax exemption for installation of toilet facilities and water supply equipment.*

Opponents of the package, including the New Jersey Farm Bureau, have lobbied heavily for defeat. Various religious leaders and the state AFL-CIO have urged approval of the measures.

The bill was moved by Assemblyman S. Howard Woodson, D-Mercer, who said "There is a growing awareness across the nation that there can no longer be any forgotten people."

He called the 20,000 migrant workers and their children "the backbone of our farm economy."

And in an appeal for Republican votes, he said that "partisan philosophies pale into insignificance when there is concern for human life."

He did not specifically refer to the death by fire in Salem County of the five children of a farm worker but Hughes did in a telegram sent to all Assemblymen.

Some Republicans objected to this. Assemblyman Alfred Beadleston of Monmouth called it "ghoulish" and complained the telegram appealed for passage, not on the merits of the bill, but on emotionalism.

Many Republicans voted for the bill but complained they had not had time to study it. They said there was no documentation and they had only minutes earlier received a preliminary report by the governor's task force.

Dr. KANDLE. Thank you, sir.

Senator WILLIAMS. I am proud indeed.

Well, it is not completed action, but——

Dr. KANDLE. It is very imperative.

Senator WILLIAMS. It is tentative action.

Dr. KANDLE. I would like to stress particularly that the plight of the migrant is clearly a national problem to a very considerable extent and, while we can do a good deal in a State program and we can improve things substantially through State planning, it won't solve the problem. It just cannot be solved by individual States.

That isn't the way the thing operates. For example, from our prejudiced point of view, we think that many of the children get a considerable part of their relatively high quality education during the short time that they are in New Jersey in the summer.

At the same time, we think that this getting into the stream and having the machinery that works in the stream is most important. We have been able to work closely with Florida. We now have machinery whereby we can identify people and what has been done for them and their problems, and we send them down to Dr. Sowder in Florida and he can keep the thing going during the wintertime.

This kind of arrangement and this kind of management of these families and groups throughout the year is immeasurably more effective because what we were doing episodically before wasn't getting us very far.

For example, a diabetic. What good does it do to get him squared away in New Jersey and then have him move on again unless the information is going to be transmitted, and his care continued.

Of course, it is a beginning process and really the machinery isn't greased yet, but it is beginning to work. So that we think there is a special need to continue and to increase the Federal stimulative and supportive funds so that this whole chain of services to the agricultural migrants can become truly effective.

Senator WILLIAMS. Thank you very much, Dr. Kandle.

In education of the children of migrant families, we are trying to evolve a system that will create a record—where he begins education—that will be his educational profile that he will carry with him as he travels throughout the States with his family.

In regular accepted medical care there are so many immunizations for so many diseases that when I go abroad I can't keep up with all of the things you have to do to fulfill health requirements for travel abroad. I would think that folks who travel within our own country, in the migrant farm stream, would have the same problem that I have when I go abroad, when I try to keep up with the various inoculations such as yellow fever, typhoid, and the others.

After they leave Florida, how do the migrants let the folks in South Carolina know that they have already had what South Carolina might want to give them in immunization shots? Is there any record that goes with them?

Dr. SOWDER. Yes, there is, and we are continually trying to perfect this record system, an interstate record of health. In fact, we are right at this time working in Florida and have a record which we hope will be acceptable—we have been using these interstate records for some time.

Of course, one of the big problems is to get the people to keep them and carry them. They lose them, you know. But we are now trying to perfect a common record so that it will be agreed to by all States involved.

Senator WILLIAMS. The perfection of that is something that you experts might discuss at your national conference.

Dr. KANDLE. But, Senator, don't forget that the one-shot thing is bad enough, but it is only part of the problem. You know, younger prenatal women are girls. After all, this process takes 9 months. They float up and down the eastern seaboard.

And we have chronic conditions. We start a kid on some therapy for a bad leg or a bad hip or something. We can't do much with him in the 2 or 3 weeks or 4 or 5 weeks we have him.

We can only get him started. Or maybe somebody else has started it. These chronic things are beginning to show up because we are doing a lot better than we used to do. In addition to the record system, as I said, we now have the machinery where we send the kids' names to where they say they are going to be.

Hopefully, Wilson Sowder will be able to identify them, and he does get a good many of them. It is beginning to pay off.

Senator WILLIAMS. It is hard to keep records of people who travel as migrant farmworkers travel. Recordkeeping is a pain in the neck to everybody, anyway. Right?

Dr. PEAVY. Yes, sir.

Senator WILLIAMS. And as they travel in the broken-down buses—some travel in trucks; some travel in their jalopies—it is a difficult thing to get people to keep certificates, the documents.

I would think possibly the document could be dignified with a jacket with a seal of Florida on it or something similar to that, and this would be a valued possession that would be honored as the passport.

Dr. PEAVY. Exactly.

Senator WILLIAMS. Officially honored.

Dr. PEAVY. Yes, sir.

Dr. SOWDER. Actually, I think there have been a lot more developments than I have been able to tell you about because I am at the bureaucratic level and I didn't realize I was going to get to talk to you today, but the people who are out at the firing line, who really know the

details of this program, if they were here, could give you a lot more satisfaction as to details.

We have in Florida every year a migrant labor meeting down in Palm Beach.

Senator WILLIAMS. That is West Palm Beach.

Dr. SOWDER. West Palm Beach, and people from all over the eastern seaboard interested in migrant labor talk over these common problems. Insofar as Florida is concerned, you don't have the fellow here that knows the most about it.

The ones who are actually working down at the working level could tell you more about how this record and interchange actually works and they are doing a lot of work on it, I assure you.

Senator WILLIAMS. Fred Blackwell just suggested that just as we are trying to develop and encourage the use of an educational record that follows a child as he travels with his family, that we might also include in the dignified jacket a health record. I would think that such a dignified recordkeeping jacket would be a valued family possession.

Dr. PEAVY. I think it is a real good idea.

Dr. KANDLE. Senator, may I make sure that the record shows that a great deal of the leadership for this program and the putting together of these several parts such as that meeting in Florida and so on, is done by the Public Health Service and a good deal of this record work is under their leadership, too?

This wouldn't work as it is working if we didn't have the kind of folks that we have in the Public Health Service. They are really a dedicated group of people who give themselves to the program. Their leadership and inspiration, and their putting together some of these communications that we have to deal with separately is an enormously important contribution to the program.

Senator WILLIAMS. This must be developed on a national scope.

Dr. KANDLE. It is a national problem.

Senator WILLIAMS. Because this is interstate labor. That is what we are talking about.

Dr. KANDLE. Right.

Senator WILLIAMS. With all the family problems associated with interstate labor.

Dr. SOWDER. We have a young physician sitting back here who is on an internship in Washington who is from Palm Beach, Dr. Logsdon. Maybe he could give us a little more detail.

Senator WILLIAMS. We would like to hear from him later.

From California, we have Dr. Breslow. Why don't you take over now?

STATEMENT OF DR. LESTER BRESLOW, STATE HEALTH OFFICER OF CALIFORNIA

Dr. BRESLOW. Thank you, Senator. California has an estimated 271,000 persons in migratory agricultural families. It is difficult to determine precisely the true regular residences of many of these people, but we find that a quite substantial proportion of them do have whatever can be called permanence in their residences outside of the State.

Until recent years, these people had inadequate, very inadequate, or no health services. This year with funds from the Migrant Health Act in California, we have health projects in eight counties.

These projects include preventive medical services, environmental sanitation services, because in many of these camps and places where the people live, there are quite inadequate water supplies, health education, and public health nursing services.

In 16 out of the 18 counties, in addition to these preventive services, we also include in the program general medical clinical services. The preventive services are immunizations, child health conferences, maternity services, and now also family planning.

This year we will have something more than 14,000 persons receiving their general medical care in these clinics. I would like to give you just a couple of stories briefly to illustrate the kinds of services the people are getting.

One case was an adolescent girl who came into a general medical clinic with a severe headache. The physician who was in the clinic that day arranged for her to be seen by an expert neurologist in one of the cities nearby who diagnosed the girl as having a brain tumor.

Fortunately, in this case surgery was effective and the girl recovered. That experience not only taught the family a great deal about medical care, saved the life of the girl, but also taught the people in that agricultural migrant community a great deal about the fact that when you do have symptoms, doctors can oftentimes do some good.

It teaches people how to use medical care and the value of it.

Senator WILLIAMS. We have been in California on our field trips and hearings. We saw clinics not only close to where the camps were and where the families lived, but actually in the camps.

Dr. BRESLOW. That is right.

That is typical in California. We have put these services right out where the people are living and working, and in general these clinics function during the evening hours during the harvest season, so that the people really have access to them.

We don't have any 8-to-5 schedule. The schedule, as a matter of fact, is typically from 5 p.m. to midnight.

Senator WILLIAMS. And you are getting the cooperation of the growers, the farmers?

Dr. BRESLOW. Absolutely. I would like to come back to that point. That is very important.

Just one other brief case to illustrate the kind of things that are happening. A Spanish-speaking mother brought in a child who had a relatively minor respiratory infection, but the physician who was seeing that child noticed that the mother herself appeared to be in severe pain and so he turned his attention to her and found that she was indeed suffering from a severe frontal sinusitis, which he was able to treat.

The mother didn't come there for her very severe pain. She came there to bring her child, but she learned from that experience that the doctors can also do something for adults. She brought in her husband subsequently who was found to be suffering from diabetes.

I mention these stories to illustrate the fact that these people simply have not had experience with medical care. They don't know what it means, what it can do. So besides actually providing service this is an important educational endeavor.

Senator WILLIAMS. Well, for those who have not been exposed to medical examination and care, there is some kind of fear of a clinic.

Dr. BRESLOW. That is right.

Senator WILLIAMS. We must break through this barrier of fear; isn't that right?

Dr. BRESLOW. That is correct. These people have had oftentimes rather unfortunate experiences with medical care. Some 60 percent of the people with whom these projects are dealing speak Spanish and oftentimes only have little English knowledge. They live, as you have noticed in your trips to California, quite a distance from towns. To get away from work, to find the means of transportation to go into physicians' offices, is a quite difficult thing for these people to do and when they get there, oftentimes the physicians' offices are already overcrowded with the people from the towns.

These programs have been organized throughout the areas of California where we do have a concentration of these migrant populations by local health departments, by county medical societies, and county hospitals.

These programs are all organized by the local people who adapt them to their own modes of operation.

Now, we find that there are still some problems that we haven't dealt with.

As you have remarked, we are not reaching all of the people, and those that we are reaching we are not providing sufficiently complete services. We find, for example, in surveys that have been made among preschool children that 15 percent are suffering from anemia.

Often this is due to nutritional deficiencies, sometimes associated with parasitic diseases. But we don't provide, as much as we should like to, adequate nutritional services in these projects.

Further, as someone else remarked earlier, we do not provide dental services, although one of the very great needs among these people is better dental care. The programs are well regarded locally.

At the outset a few years ago, there was some concern locally as to the significance of these projects, what they were aiming at. But now we do have substantial support not only from local officials, from medical societies, hospital groups, but the growers who are concerned with maintaining the camps and using these people in labor, and of course, the people themselves.

Although there is conflict on some other aspects of migrant labor we find substantially unanimous agreement on the desirability of this kind of health service which we find now should be not only continued, but expanded.

Senator WILLIAMS. We certainly are aware of that. We have been in California, we have been in Texas, and we have been in Florida.

We were most encouraged by what we saw in your States. I remember an elderly man who had a leg infection and he just was afraid to go to the clinic which was right down the road. Oh, it was an angry dog. We saw that dog. And he had a terrible infection but he was afraid to go 50 yards down to the clinic which was on the camp.

There was a young girl who was a volunteer at that same camp. She was a VISTA volunteer as I recall, and she just talked to him until she persuaded him to go down to the clinic, and it made all the difference.

He was cured and what were the words he used? He feels fine now, but he went even further than that; something about "they saved my life."

Mr. BLACKWELL. Yes.

Dr. KANDLE. The VISTA people have been magnificent, Senator. Senator WILLIAMS. I notice a group of young girls entering to witness this hearing. So we have a lot of future VISTA volunteers right here in the audience from the Ursuline Academy in Bethesda. You heard about these hearings, girls? You wanted to come over? Well, we welcome you. We are talking about better health for very poor people who have lived in very bad health, the families who harvest the crops and migrate from Florida, Texas, southern California, all the way up the country. These doctors are testifying today on the extension of the migrant health program which the Congress of the United States enacted in 1962. With that program we have been able to bring better health throughout the country to these very poor people.

This has been a very exciting hearing for me. Did you want to call another witness, Doctor?

Dr. SOWDER. I would like to very much.

Dr. Logsdon, would you mind? He is up here in Washington on one of these 2-year training programs. He was an assistant in Palm Beach County, Dr. Donald Logsdon.

I may have to run in a minute to catch a plane, Senator. It won't be because I am not enjoying this. I hope you will excuse me when I feel I have to leave.

Senator WILLIAMS. When you have to leave, we will certainly understand. Evidently, Dr. Logsdon, you have worked with some of the folks that do harvest the fruits and vegetables, particularly in the Florida area outside of Palm Beach?

STATEMENT OF DR. DONALD N. LOGSDON

Dr. LOGSDON. Yes.

Senator WILLIAMS. West Palm Beach?

Dr. LOGSDON. Yes, sir.

Senator WILLIAMS. We have been there and that is one of the hardest jobs that any man or woman could do, and, unfortunately, too many kids were working in that, too.

Dr. LOGSDON. You mean in the field harvesting crops?

Senator WILLIAMS. Yes, sir.

Dr. LOGSDON. Yes, sir. In Florida and Palm Beach County with the large agricultural industry, there is a demand for any kind of labor that is available when the crops are due to be harvested.

My experience was as a director of a migrant project in Palm Beach County for 3 years and working in the clinics as well as being administratively responsible for the project as funded by the migrant branch of the Public Health Service. It was operated also in conjunction with the State program in migrant health.

Senator WILLIAMS. Tell us how it works.

Dr. LOGSDON. Our program basically was oriented toward bringing services to the people, a wide range of medical care, by use of mobile medical clinics which we called a rural health clinic, and providing services for any of the migrant patients who came to this clinic in the field. We did not specialize the service.

In other words, if a mother came in with a child, the mother would also receive medical care as well as the child, and these services involved the full range of medical services as well as educational services

through sanitarians, and social services, and nutrition services. We tried to provide a comprehensive care program oriented toward the needs of the patients.

Senator WILLIAMS. And you used mobile units to go to the camps?

Dr. LOGSDON. Yes, sir.

Senator WILLIAMS. How about to the fields?

Dr. LOGSDON. We picked out areas where the migrants were available, where they were concentrated. It could be a labor camp; it could be a grocery store; it could be an intersection where there were concentrations of migrants, and these clinics were held in the evening hours and in the afternoons.

Senator WILLIAMS. The program works where there is money for the program?

Dr. LOGSDON. Yes, sir. If I may add, in my experience in Palm Beach County a pressing need that became more and more obvious was the need for funds for hospitalization of the migrants inasmuch as many of these people would delay going to a hospital emergency room or to the hospital until they were seriously, critically ill.

It was crisis oriented. We felt that if there were funds available for hospitalization and it would be possible to admit these patients earlier, it would be certainly helpful to the patients if they got care earlier. Frequently it would decrease the amount of care required in the hospital.

Senator WILLIAMS. Crisis oriented?

Dr. LOGSDON. Yes, sir.

Senator WILLIAMS. You describe it as we understood it, too. Until we passed a migrant health program, people were not treated until there was a crisis?

Dr. LOGSDON. Yes, sir.

Senator WILLIAMS. What we are trying to do is reduce the number of crises and what you are suggesting is that this can also be done not only in the mobile units with routine care, but making hospitals available in early stages of illness rather than wait until it is the true crisis; is that right?

Dr. LOGSDON. Yes, sir. Also in regard to illnesses that are not life threatening—in other words, a migrant may have a hernia or some other type of illness that is not an emergency—it is very difficult to get this corrected as the situation is now without funds to get him admitted on an elective basis. Of course, if the man receives this type of care he can usually return to work and become more productive.

Senator WILLIAMS. Going back to my recollection of some dark days in the State where Dr. Kandle and I come from in New Jersey, I can recall 7 years ago I think, that there were several women who were pregnant who never saw a doctor in the prenatal period, didn't see a doctor at the time of birth, and in fact the babies were born literally in the field.

Do you remember that, Dr. Kandle?

Dr. KANDLE. Yes, sir. It doesn't happen now, though, sir.

Senator WILLIAMS. That is right. So we are at last beginning to meet responsibility to human beings whom we all rely on.

Dr. KANDLE. Yes.

Senator WILLIAMS. For all the vegetables and all the fruits that we need, we rely on these farmworkers. I think the Nation has a responsibility and we are meeting it with the cooperation of you great men at the State level.

Well, this has been a most illuminating panel of true experts. As a legislator who will have the responsibility of taking this particular bill to the full committee here, and then to the floor of the Senate, I am going to really lean on you all the way.

Dr. KANDLE. We are with you.

Senator WILLIAMS. Thank you very much.

Dr. PEAVY. May I just express to you on behalf of all of us our sincere appreciation for the opportunity of appearing before you this morning.

I want you to know that we are quite grateful to you for everything that has been done in the past and we appreciate very much this opportunity to appear before you and present some of the accomplishments and also some of the needs.

Thank you very much for the opportunity.

Senator WILLIAMS. We appreciate that. It is our honor to have you here. Dr. Breslow, Fred Blackwell has a question.

Mr. BLACKWELL. Dr. Breslow, Senator Murphy's legislative assistant, Mr. Samuel Culbertson, who is present, has requested that you elaborate on a few points which he has submitted.

If you don't have the specific information for us this morning, you could just submit it from your office when you return. The first question is how much is California receiving in funds under the act?

Presumably fiscal 1967 is the year in question here. Secondly, what is needed for the upcoming fiscal year to meet the demonstrable needs in the State of California and could you answer that same question or make a projection over the next 3 years?

Dr. BRESLOW. I could answer the first two questions quite readily. For the current year, we are receiving from the Migrant Health Act fund \$1.2 million and we estimate that for the ensuing year, that is, the budget year 1968-69, we could very effectively use at least twice that much money in California.

Mr. BLACKWELL. \$2.4 million?

Dr. BRESLOW. That is correct.

Mr. BLACKWELL. For each of the next 2 years?

Dr. BRESLOW. Well, for the year 1968-69. I really am not able to answer the latter part of the second question; that is, for the ensuing years, but certainly it would be more than twice as much as we are getting for the current year.

Mr. BLACKWELL. In the beginning of the California project there was considerable appropriation of State funds added into this pool. Is that still the practice in California?

Dr. BRESLOW. Yes. The program in California started before the national program. In fact, I think in some sense it was a forerunner of it. The California Legislature appropriated \$75,000 for the same kinds of service that we have been describing here, plus some additional funds for administrative purposes. That \$75,000 continues in our program, but it is sufficient only at the present time to support projects in three of the counties. The Federal funds have helped immeasurably in carrying forward the program that is so much needed, and we would continue to have need for the very substantial Federal funds as well as, of course, keeping the State appropriation.

Mr. BLACKWELL. So California's contribution is \$75,000 each fiscal year?

Dr. BRESLOW. That is for services. The actual appropriation, I think, is about \$105,000, the difference being for the basic administrative staff.

Senator WILLIAMS. I am glad you suggested these questions, Mr. Culbertson. Senator Murphy from California has been a fighting ally with us on this subcommittee.

Dr. BRESLOW. We are very well aware of Senator Murphy's support and appreciate it. We hope that he will continue to support this program as he has in the past.

Mr. BLACKWELL. Dr. Breslow, one other question.

This may have been our misunderstanding of the figures you gave previously, but it was thought that you gave these data on numbers: That there are 271,000 migrants in the State of California.

Yet only 14,000 were served or reached by the clinics.

Dr. BRESLOW. I want to make that very clear. The 14,000 were people who received relatively complete general medical care on a substantially year-round basis.

This does not include the tens of thousands among the 271,000 who received what we call preventive medical services such as child health supervision, immunization, prenatal care for the pregnant woman, family planning.

These services go to many, many more than the 14,000 and, of course, the entire group benefits from the sanitation program which perhaps doesn't receive the attention in hearings like this which it really deserves because to have a safe water supply is perhaps the very basis of public health. Nor does it include the public health nursing and health education services which reach many, many of these 271,000. I want to make quite clear that the 14,000 who were served by the general medical clinics are only one small portion of the program.

I wanted to bring that to your attention, though, to indicate that that many people depend on this program utterly for their full medical care.

Mr. BLACKWELL. Would you care to estimate the percentage of the 271,000 that are in need of medical services, in the layman's sense of the term, not sanitation kind of services?

Dr. BRESLOW. Well, all of them are, of course, in need of medical care just like all of us. The whole population in the most general sense is in need of medical care, but I would say without having any hard data on this matter that several times as many as the 14,000 now being served by general medical clinics in the fields could well be served by the same type of service.

Mr. BLACKWELL. Is it your opinion that the persons not being served by your clinics are getting medical care through regular doctors' offices or are they doing without them?

Dr. BRESLOW. The typical thing for such people who do not have general medical clinics in their camps or where they are working is to wait until they are in a seriously critical situation and then they may find the means to get into a public hospital in the county seat that may be many miles away so they do get medical care in extremis, so to speak, but they don't get the kind of medical care that we would want all Americans to have.

Further, many of these people are not able to take advantage of the so-called mainstream of medical care. Some of them do not

technically qualify for welfare benefits. Some of them are not categorically linked.

Many of them are Spanish speaking. It is a real difficulty for many of these people to get the kind of medical care that this program is bringing to them.

Senator WILLIAMS. That is because of the language barrier?

Dr. BRESLOW. Yes. When such a family goes to a typical doctor's office or even to many of our public clinics, they do not find there people who can effectively communicate with them.

Senator WILLIAMS. I will tell you this is a problem.

Dr. BRESLOW. It really is and that is why we feel that it is so important in these projects, as we have endeavored, I think quite successfully to do, to be certain that in every project there is on the staff at least one person, often several, who can effectively communicate with them in their own language, to find out what their problems are and help them to do the things that are being recommended.

Otherwise, you are not accomplishing very much.

Senator WILLIAMS. We are, I hope, on the threshold of passing a bill that will encourage bilingual education. Senator Yarborough, of Texas, has been the leader in this effort, and if we pass the bill, it will include this bilingual education. I don't know how far it will reach into the adult population, but it certainly will reach the youngsters.

Do you know what staphylococcus infection is?

Dr. BRESLOW. Oh, yes.

Senator WILLIAMS. It can be a little painful, can't it?

Dr. BRESLOW. Not only painful; it can be fatal.

Senator WILLIAMS. I had one of those infections when I was campaigning in 1964 and I had to keep going, but it really was a painful process.

I would stop in a hospital in Millville, I would stop in a hospital in Newark, whenever it really got to the point where I couldn't stand it any longer, and, invariably, I would get a Spanish-speaking intern.

The more I said "ouch" the more good he thought he was doing. It was an experience. I am glad it is over because I didn't know it could be fatal. I know it was painful, but I didn't know it could be fatal.

Do you mind one more inquiry?

Mr. BLACKWELL. Dr. Breslow just raised the importance of the sanitarian and it might be well for the record to have this discussed by the entire panel beginning with you, Dr. Breslow.

This goes to the migrant camp. The treatment under State law varies considerably throughout the country. In one State, it is a housing code proposition. In another, it is a sanitation code.

I believe this is the case in Florida. I know that that is the concept under which inspections of camps are made in the State of New York. In other States, they seem to be merged, the housing and sanitation code.

I don't know the facts currently in Florida, but when the subcommittee made its first field trip into the State of Florida, I believe there were at the most three sanitarians to conduct the inspections for the entire State of Florida. In interviewing one of the inspectors, he indicated, and it was quite understandable, that he would maybe make a repeat visit to a camp two and a half years later with no way of knowing what is happening meanwhile.

Of course with the fiscal problems of States being rather strained financially, there is common understaffing of the sanitation inspectors. What is the opinion of the panel?

Would it be a proper function of this program to lay even greater emphasis on providing more sanitarians to go into camps; should he be tied directly with the State inspection agency in an advisory capacity and submit his report to the State agency, calling attention to the hazards in the camp?

For example, the kerosene stove might be treated as a sanitation hazard because when a person is burned, then it is a medical problem. This, I believe, is the treatment of the kerosene stove in the State of New York.

Starting with Dr. Breslow: What would be your reaction to increasing the sanitarian manpower available in the camps to head off some of the illness and injuries that wind up in your clinics and cost more by the time they get there?

Dr. BRESLOW. We think this is a very important aspect of the program and that is why in all of these 18 counties which I mentioned, we do include the sanitation personnel usually linked with the health department, regular sanitation service, to go out into the camps.

We feel that it is not much use to send doctors and nurses out there if people are going to be drinking water that is going to cause dysentery or not able to care for their food in a way that will prevent diseases. We regard sanitation personnel as an essential element of the program.

We also feel that, although we want to take full advantage of all Federal, State, and local legislation with regard to maintaining a sanitary environment and adequate housing, the best codes in the world no matter who writes them or tries to enforce them will not accomplish what they are aimed at unless there is some competence right where the action is in getting done what needs to be done. While we do place substantial weight on these codes and try to get them enforced, in our minds it is much more important to have competent personnel go right out to these camps and show the people and the growers how they can achieve good water supply and the other elements of sanitation.

Mr. BLACKWELL. Are your sanitarians equipped and trained to provide health education to the workers?

Dr. BRESLOW. We try to have all of our personnel at least minimally equipped to discuss whatever people are interested in about health, whether it is well water, or immunization, or headache, or whatever.

They are not physicians or nurses, but they are trained. We try to make all of our personnel somewhat competent in health education. We also employ, however, because of the very great need, people who are specifically qualified in health education, people who have had graduate training in it.

Mr. BLACKWELL. How many sanitarians do you have for the 18-county area and is that number adequate?

Dr. BRESLOW. I am sorry I can't answer that question. I would be able to find it and send it to you if you would like.

Mr. BLACKWELL. We would be most grateful to have that information, Dr. Breslow.

(The information follows:)

STATE OF CALIFORNIA DEPARTMENT OF PUBLIC HEALTH,
Berkeley, Calif., December 14, 1967.

SENATOR HARRISON WILLIAMS,

Chairman, Subcommittee on Migratory Labor, Committee on Labor and Public Welfare, New Senate Office Building, Washington, D.C.

DEAR SENATOR WILLIAMS: This letter answers specific questions that arose at the hearing of the Subcommittee on December 7 in relation to your bill extending the health services authorization and appropriation for migratory farm workers.

During 1966-67, fourteen California counties with federally funded health programs for migratory workers had sanitation components utilizing 11.32 man years of 14.83 man years funded. A shortage of registered sanitarians made it impossible to fill all of the budget positions. However, this did represent an increase of 3.32 man years over 1965-66.

A planned program of activities which would provide full environmental services for farm workers in California would require approximately 65.4 man years. Of this total, 21.8 man years would be at the professional level providing administrative, supervisory and specialized services; the remaining 43.6 man years would be for sanitation aid positions for the provision of direct services to the farm worker population in California. With this number of personnel it is calculated that the level of environmental health for farm workers in California could be elevated to that provided the rest of the population.

The presently budgeted sanitation components are devoted to the development of sound programs providing direct services to migrants living in rural settings. This program involves inspectional activities in both the living and working environments of the farm worker group. Even though the present level of environmental protection is not high enough to cover all adverse environmental factors, it does give minimum coverage to approximately 82% of the migrant population in rural California which, when contrasted to last year's 60% coverage, represents a substantial improvement. In 10 out of the 14 counties mentioned above, the objective attainment during the past year in sanitation activities was 70% or greater. In all counties except one, inability to staff sanitarian positions appeared to be the reason for low objective attainment.

The following represents a summary of the more measureable aspects of the present California program:

1. *Working environment.*—During the past year project counties reported that compliance with the Food Crop Growing and Harvesting Sanitation Law was satisfactory on the part of California's agricultural community. It was noted that in over 75% of the fields where required for farm workers, facilities with toilets were present, and in over 40% of these the required hand washing facilities were also present. Drinking from the common container remains an educational challenge, as do some occupational health hazards.

2. *Living environment.*—Housing for migrant farm workers remains a major problem. Over the past two years the flash peak housing program of the Migrant Program Branch of the Office of Economic Opportunity in California has achieved a level of success by providing living units with a peak capacity to house approximately 8,500 migrant farm workers. In many instances this is the first time that occupants have had the experience of using a refrigerator, range, toilet and bathing facilities inside a dwelling place. Future problems remain, however, due to the fact that a net capacity to house 4,745 migrant farm workers will be lost in 1968 with the removal of 1,249 housing units constructed many years by the Farm Security Administration. The sanitation component in the county projects where such adverse changes in the housing situation may take place are directly involved in assisting in the development of adequate housing facilities.

We should be happy to supply further information if this would be of assistance to the committee.

Yours most sincerely,

LESTER BRESLOW, M.D.,
Director of Public Health.

Mr. BLACKWELL. Dr. Kandle, we are familiar with the camp inspection procedures in your State. How would the sanitarian fit in?

Dr. KANDLE. It wouldn't have occurred to me to separate them. I mean that is the way I have been brought up. That is the way we operate. We just wouldn't think of trying to deal with this population without dealing with their environment at the same time we dealt with them and their bodies.

Mr. BLACKWELL. Do you see a need for a greater number of sanitarians under this program, assuming of course the appropriation goes through?

Dr. KANDLE. We carried a good part of this under our own State moneys because we could get some moneys for sanitarians and we take people from other places and stick them on the migrant program in the summer because we don't have money, for example, to pay for hospitalization and so forth.

So you sort of switch the money around to meet the kinds of needs you have.

Obviously, we have to have more staff than we now have. I am sure you are familiar with some of our vicissitudes and this legislation that Governor Hughes is pushing so hard will immeasurably strengthen our hand because these people aren't just advisory; they are enforcement people.

We had an unhappy event a couple of weeks ago when we lost five children.

Mr. BLACKWELL. If it is feasible, can you have your office submit later for the record something on the number of sanitarians?

Dr. KANDLE. Yes, I am happy to do it, but I have a reservation. I don't like to try to count the bodies because that isn't the way we operate this program. I mean if you ask me how many are specifically at any moment—

Mr. BLACKWELL. If you have any reservation, Doctor, then it is not feasible. The request is withdrawn.

Dr. KANDLE. I will submit the data, but I mean if I said there were five, that would be improper, because at the height of the season we might have 25 guys working. The other part is, as I think Dr. Breslow has brought out, that many of these are now being integrated, particularly down in the Cumberland County.

The Board of Chosen Freeholders made that application themselves and are running this program through the county health department.

Boy, for New Jersey that is something. I mean this is a real step ahead.

Mr. BLACKWELL. Dr. Peavy?

Senator WILLIAMS. What you are saying then is your people are generalists rather than specialists.

Dr. KANDLE. Yes, and I am not unwilling obviously to provide all the data, but I want to make sure it is clearly understood that this is a generalist kind of program.

Dr. PEAVY. I think you are exactly correct in that the environmental hazards certainly are a major part of this program, something we all must take into consideration. In Texas, of the 27 projects, the 27th one being statewide, each one of the 26 have sanitarians available in the area.

Many of these are attached to local health departments and we use the local health department sanitarians. I might mention also we have a unique situation in that we have three counties in which the medical societies themselves are sponsoring the project. They are so interested in the total program that they are sponsoring it themselves. But in each one of these 26 areas, we do have provisions for sanitation and sanitation activities.

Most of them have a sanitarian attached to the local project. By and large, staffs are composed of nurses, and sanitarians, and health educators in each one of the given areas.

In the State project, we broke the list down into regions where we have a concentration of migrant workers, and in each one of our State projects, we have a full-time sanitarian, we have a health educator, and two nurses.

This is to cover the entire area, and of course, this supplements the existing local sanitarians in a given area. So, environmental health is a very important phase of this.

I remember going into migrant health camps before this bill was passed and in many areas you would maybe have two water spigots to supply the whole camp and sanitation hazards were just tremendous in these areas.

I think we have made a lot of progress but we need to go still further.

It is certainly not up to the level we would like to see it and that is one reason we are pleading with you. If you could double the funds, I am sure this would be money that is very well spent because of not only the health of our migrants in Texas, but the entire Nation.

Mr. BLACKWELL. Dr. Logsdon.

Dr. LOGSDON. In Florida, the projects that are operating do have sanitarians as part of those projects and with equal emphasis on their activity with the medical services so that in Florida certainly the number is greatly expanded since you were last there.

There are men at the State level who do migrant housing inspection also, responsible for it, but most of it is done through the county projects. In our experience, and particularly in my own, the problem is not so much for more sanitarians.

As a matter of fact, we had difficulty finding qualified men to fill the positions in the State, so we have started training what we call sanitarian aides, sanitation aides, and these men work with the sanitarians. They do not require the same extensive training but are able to do a lot of the tasks that sanitarians previously did.

Another problem was that under the statutes in the State of Florida, the violators of the code were tried in the criminal court. Many times we needed legal assistance to know which direction to go in a particular violation if the person did not respond to the usual educational efforts about improving the housing. This was one of the recommendations that came out of the project in Palm Beach County, that we receive legal assistance in order to know how to handle offenders or violators of the code relating to migrant housing.

Senator WILLIAMS. Gentlemen, we are deeply grateful. The record is absolutely perfect from where I sit. This has been absolutely perfect testimony in support of a very noble effort.

Dr. LOGSDON. Thank you.

Senator WILLIAMS. We will recess for 5 minutes while we get our slide projection equipment in operation.

(A brief recess was taken.)

Senator WILLIAMS. Dr. Radebaugh, we certainly are grateful that you have made the long, hard journey here from your position as associate professor in the school of medicine at the University of Rochester. As you are also director of a migrant health project in Monroe County, you certainly come with full knowledge of the problems we face. I know you are familiar with our legislation. You have worked under the program and we welcome you here. Our legislation has already begun to solve some of the problems but now we want to go another 5 years and see if we can substantially reduce

the incidence of those conditions that lead to very bad health for migratory families.

I know that you missed the interesting testimony earlier this morning because you were delayed in the air; and, I wish the weather had been better and you could have been here to join them. We had a panel of the heads of State health programs from Florida, California, Texas, and New Jersey.

I know that you have a presentation that we have been looking forward to for some time.

**STATEMENT OF DR. JOHN RADEBAUGH, ASSISTANT PROFESSOR,
SCHOOL OF MEDICINE, UNIVERSITY OF ROCHESTER, ROCHESTER,
N.Y., PROJECT DIRECTOR OF MIGRANT HEALTH PROGRAMS,
MONROE COUNTY, N.Y.**

Dr. RADEBAUGH. Thank you, Senator Williams.

Senator WILLIAMS. I will say that Senator Kennedy of New York did want to be here to welcome you personally, but he has returned to New York City for the funeral of Cardinal Spellman. I think one of the Senator's representatives will be over to say hello.

Of course, Senator Kennedy knows the story you are going to tell first hand because he went to these areas. Were you with him when he went to the areas that you will later discuss?

Dr. RADEBAUGH. Yes.

Senator WILLIAMS. OK.

Dr. RADEBAUGH. I would like to preface these remarks with just a note about a group of people in Central New York State who have been active in the migrant field for about 4 years, and during the past 2 years on almost a full-time basis.

"The modern locus of poverty is even more the rural than the urban slum," commented John Kenneth Galbraith in his book, *The Affluent Society*.

Many of those who make up these slums are the seasonal farm-workers who travel north and south and ebb and flow with the crops. They are isolated in areas with few social services, few financial resources, and often are away from the scrutiny of the public.

These rural communities, in contrast to urban communities, have little flexibility in attempting to help the seasonal worker. For when a rural community is inundated by a transient population such as the migrant farmer, it cannot tax its already overtaxed resources to accommodate his needs.

One of these needs is health care and one of those least able to provide this care is the general physician located in this rural area. Already overburdened with his own practice, he finds it almost impossible in many situations to offer care except in extreme emergency for the incoming seasonal farmworker. Let me give you some recent examples of conditions which have been encountered in New York State.

Mr. Carter, a worker with BEAM (Basic Education for Adult Migrants), in Wayne County, was called one evening by Mr. Roy, a migrant who was quite concerned about a sick friend. Mr. Roy had tried unsuccessfully to seek medical attention for his friend and now turned to Mr. Carter for help.

Mr. Carter found this man to be quite ill with a temperature of 103°. He helped him into the back seat of his car and headed toward the nearest hospital. There the migrant worker was denied medical care. Mr. Carter then went to another hospital. Medical care was not obtained there.

He went to still another hospital and they would not see this man. A doctor on the street near the hospital was also too busy to examine the sick man and gave the excuse that he was hurrying for an appointment.

Twelve hours and 100 miles later, the semiconscious man was admitted to a Veterans' Hospital in Syracuse, N.Y. The attending doctor told Mr. Carter that if 2 more hours had passed this man would have died.

Mr. Post, director of Area I of BEAM, noted that his area had more unsolved health problems than any other area in the central portion of the State of New York. He pointed out a lack of clinics, hospitals, and dental facilities throughout the area.

There was a temporary clinic conducted by the State health department during the summer, but it closed down 2 months prior to the time that the seasonal farmworkers left the area. The nearest location to most of these seasonal farmworkers was Sodus, N.Y., with only two practicing physicians—both of whom required an appointment before seeing any patient. Mr. Post recounted the following incident:

A woman and a child fell from a truck one evening, and I couldn't get a doctor. After traveling around and telephoning for help, I finally took the woman and child into Sodus. By this time, the child was unconscious. Someone is going to have to bring medical service into this area of Wayne County.

In Genesee County, Reverend James Proctor, a migrant minister, attempted to find emergency medical care for a mother, daughter, and an adult woman at one of the seasonal camps. He took them into the local health department who referred them to the emergency ward of a nearby hospital.

A physician in the emergency ward said that these patients could qualify for medicaid; and, thus, he would not treat them. The migrant minister took these people back to the camp and called six doctors in the area before he was finally able to obtain care for them 2 days later.

His comments:

If these people had tried to seek care on their own, they would have been unable to find it. It is only because I knew the physicians in the area that I was finally able to get an appointment.

Reverend Proctor recounted:

Three weeks ago, I had a similar situation develop, of a person with a severe tooth infection. It took me five days before I was able to get emergency care for this patient in a dentist's office.

The difficulties of the seasonal worker are compounded occasionally by language barriers, by cultural barriers, and by lack of transportation. I think these are well known to this committee.

Another more vivid example was encountered in Monroe County when Mr. James Alford was found dead in the outhouse at the Perzik Camp on August 8, 1966.

The report reads as follows:

This adult Negro male with no medical history was found expired this morning in the outdoor toilet about 6:30 a.m. by Willie Oliver, also a resident of the camp.

According to Mr. James Hill, camp boss, the deceased arrived in the Monroe County area from Gifford, Florida, on July 15, 1966, and has been working at the camp since this time.

He is a big eater, smokes about five packs of cigarettes per week, and does not drink. He has had no medical history or attendance but has complained of a constant cold since coming from Florida; and according to his roommates, the deceased coughed continually all night long. Apparently, some time early this morning he got up to go to the bathroom. It is a walk of some 85 feet from the dormitory to the bathroom (actually an outhouse).

On following the path, spots of blood can be seen in the sand along the way as well as a fruit juice can filled with reddish-brown substance next to the deceased's bed. The deceased was found lying supine on the bathroom floor. There is blood on the toilet seat and on the floor of the toilet. A foamy, bright-red substance is emitting from the oral and nasal cavities. The body was removed by car 160 and lodged in the Monroe County Morgue at 10:35 a.m. State police request an autopsy be performed.

An autopsy was not performed, but the patient was signed out as having tuberculosis. His death is an example of (1) the lack of medical care available even in a county with a migrant health program; (2) the danger which a person with active tuberculosis presents to his fellow workers.

Senator WILLIAMS. Tuberculosis is a highly contagious disease?

Dr. RADEBAUGH. Yes.

Under existing health laws, he would not be allowed to work in a kitchen. Yet, why would he be allowed to work in the field handling the same food without adequate medical screening?

In Steuben County, N.Y., Father Timothy Weider tells of Mrs. Robinson, a seasonal worker, who sought medical care for her sick baby in 1966. Without transportation, she walked 10 miles in a fruitless attempt to find a physician. Her baby died in her arms.

Another family was unable to return South in the winter of 1967 and lived in a corner in Steuben County. We have a picture of that. I think we can show that.

(Slide.) In the winter of 1967, unable to find transportation for medical care, the mother delivered a baby in this corner. The outside temperature was 15° below zero—yet the baby survived.

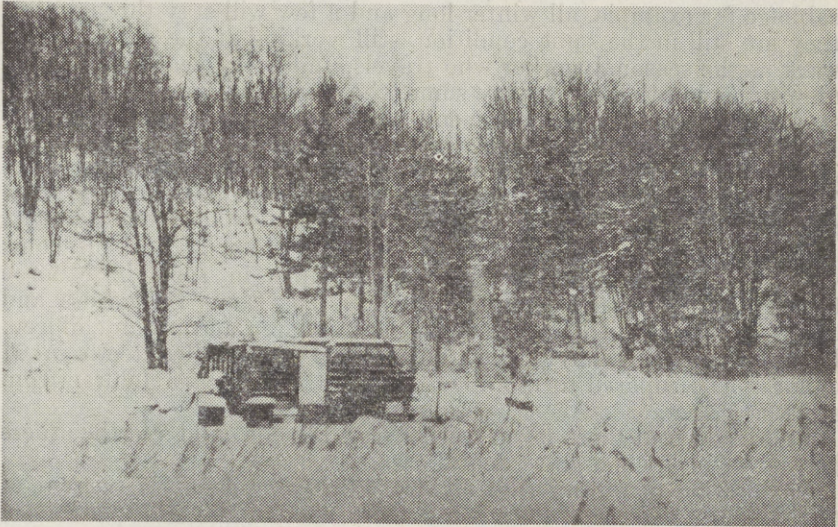


Senator WILLIAMS. Doctor, will you pause? I have to take 10 minutes to go to the Senate floor for a vote. You don't have any particular time problem now; do you?

Dr. RADEBAUGH. No, sir.

(A brief recess was taken.)

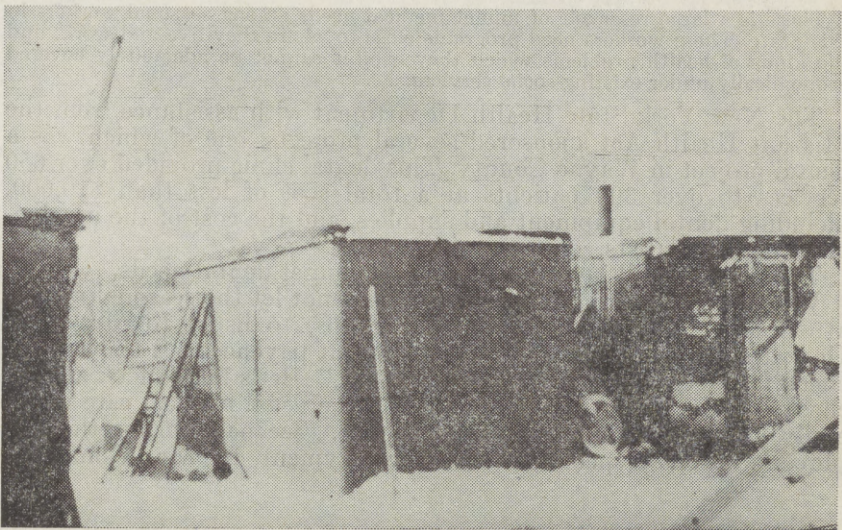
Senator WILLIAMS. All right.



Dr. RADEBAUGH. (Slide.) This again is the corner crib where in the winter of 1967 the baby was born, and an outside temperature of about 15° below zero. Some of the neighbors of this family were living in equally primitive conditions. Take a look at the next slide.

(Slide.) Truck bodies.

And here is another slide with this make-shift-type arrangement for housing.



Senator WILLIAMS. Why is it that these families are there? The harvest is over.

Dr. RADEBAUGH. The harvest is over.

Senator WILLIAMS. Why do they remain through the winter?

Dr. RADEBAUGH. Some of the families are unable to get back South and will shift for themselves in the area of their last farmwork. Others will find temporary positions repairing boxes or working in cabbage for example, all winter long and a few will stay through, but they are still in the same condition, still working at the same type of work as the seasonal worker who travels, and every year in this community, as in others, there are some who come and finally settle, who stay on in these camps, and eventually become permanent residents.

Father Weider stated that medical or dental care was almost impossible to obtain in this county of about 1,900 seasonal workers. Most of the people could not afford medical or dental care nor knew how to apply for medical assistance.

Dental problems are even more neglected than medical problems with the seasonal farmworkers. For example, in 1966, in Monroe County in an organized dental program, Dr. Louis Gangarosa and other dentists studied a series of migrant children and urban children. In the migrant children, they only found seven filled teeth in 68 children as compared to 173 filled teeth in the 97 urban children from a poverty area.

I may add that these seven teeth were all in one child and the others had never been exposed to dental care.

In addition in the migrant children, they found only 7 percent of the children had filled or missing teeth compared to 57 percent of the urban children. This showed almost total lack of dental care to which the migrant children had been exposed. This was even more evident in the adult population, many of whom have never see an dentist except for an emergency dental extraction.

Dr. Arthur Baker, deputy commissioner of health for the State of New York, has a deep interest in the medical problems of the seasonal worker in New York State.

To quote Dr. Baker:

There is a large reservoir of unmet medical needs among seasonal workers in this State. These workers need programs close to where they live and work, and the kinds of health problems which they exhibit cannot be adequately covered economically under existing social services.

The New York State Health Department with assistance from the Migrant Health Act sponsored several projects, one of which was a dental project in Wayne County. This dental clinic provided over 650 services to over 300 patients at a total cost of less than \$10,000, including dental equipment and supplies, and the cost of the involvement of the dentists.

This was a small investment to cover unmet dental needs.

Why is the investment necessary? Why not let the seasonal worker attempt to use existing services? Perhaps, to listen to Mr. J. C. Gonzales, who commented about his recent paycheck, "I showed the check for 20 cents which I got for 2 weeks,"—let's take a look at that check—(slide) one can understand why the usual medical care is not easily attainable for the seasonal worker. (See page 35 for the employer's letter respecting the wage payment to Mr. Gonzales.)

CURTICE - BURNS, INC.

LINCOLN ROCHESTER TRUST CO.
ROCHESTER, N. Y.

ROCHESTER, N. Y.

50-17
223

CHECK NO. 0100831

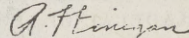
PLANT	EMP. NO.	S. S. NO.	DATE
05	1645	582 03 8073	8 04 67

\$.20	AMOUNT \$.20
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PAYROLL ACCOUNT #2

PAY TO
THE ORDER OF

J C GONZALES


 AUTHORIZED SIGNATURE

⑈ 100831 ⑈ ⑈ 0223 ⑈ 00171 ⑈ 000 069 5 ⑈

Senator WILLIAMS. That was from Curtice-Burns, Inc.?

Dr. RADEBAUGH. That is right. This is a large packing company in western New York State and hires Puerto Rican workers. This Puerto Rican worker arrived and was idle for the first week.

The second week that he was there, he had seven and a half hours work or the equivalent of seven and a half hours of work. His total pay during that time was absolutely 20 cents. Let's take a look at this pay stub and we can see what happens.

(Another slide.) For his board, they took out \$10 of that pay and the total taken out together was \$10.50, leaving him after his final deductions 20 cents.

CURTICE - BURNS, INC.

THIS IS YOUR EARNINGS RECORD

CHECK NO. 0100831

PLT	EMP NO.	SOCIAL SECURITY NO.	RATE	EXEM.	HOURS	O.T. HRS.	EARNINGS	O.T. EARNINGS	GROSS EARN.	NET PAY	
05	1645	XXXXXXXXXXXX	1 500		007 5		11 25		11 25	20	
FED. TAX	F.I.C.A.	STATE TAX	DBC	HOSP.	PENSION	PAY SAV.	COMM. CHEST	BOARD	TOTAL OTHER DED.	DATE	
	49		6					10 00	10 50	7 30 67	
OTHER DEDUCTIONS					AMOUNT	OTHER DEDUCTIONS					AMOUNT
PUERTO RICO INS					50						

Senator WILLIAMS. What is that; is that a Puerto Rico I-N-S?

Mr. BLACKWELL. Puerto Rico Insurance.

Dr. RADEBAUGH. That is right.

Mr. BLACKWELL. The pay slip is dated July 30, 1967. The board deduction is \$10. The total deduction is \$10.50. Is that the \$10 plus this 50 cents?

Dr. RADEBAUGH. Yes.

Mr. BLACKWELL. Well, gross earnings \$11.25, seven and a half hours?

Senator WILLIAMS. I will say this: They keep good records.

Dr. RADEBAUGH. Yes, much better than many areas.

Senator WILLIAMS. I notice a social security number. Where is the deduction for social security?

Mr. BLACKWELL. Is his social security this \$0.49?

Dr. RADEBAUGH. Yes.

Senator WILLIAMS. Point out social security.

Mr. BLACKWELL. 49 cents. Is this rate \$1.50 an hour?

Dr. RADEBAUGH. Yes.

Mr. BLACKWELL. The wage rate is \$1.50 an hour and he worked seven and a half hours.

What is DBC?

Dr. RADEBAUGH. I don't know.

Mr. BLACKWELL. But the net pay story is still 20 cents.

Senator WILLIAMS. And that is for a full week's work?

Dr. RADEBAUGH. Yes.

Mr. BLACKWELL. Seven and a half hours?

Dr. RADEBAUGH. This is all he got during 2 weeks that he was in that camp. He came with 40 workers and these 40 workers were told that when they arrived from Puerto Rico they would have a 40-hour week. The first week there was not enough for them to do and none of them worked.

In the second week, most of them were able to get about this period of time working. These are contract workers, also.

Senator WILLIAMS. They are working under contract?

Dr. RADEBAUGH. Yes.

Senator WILLIAMS. They gave them really a guaranteed period of work?

Dr. RADEBAUGH. That is right.

Though the contract workers supposedly have advantages, in this situation they were not able to enforce this.

Senator WILLIAMS. That was July of this year?

Dr. RADEBAUGH. Yes, sir. I mention this only as an extreme example but it can be duplicated in a number of situations each season and illustrates the uncertainty of employment for the seasonal workers.

But it also illustrates his often inability to buy the usual health services.

Senator WILLIAMS. I wonder if he was required to pay tax on that 20 cents.

Dr. RADEBAUGH. I don't really know.

Senator WILLIAMS. What kind of company is this? That record-keeping is meticulous in every detail.

Dr. RADEBAUGH. This is a large packing company and by law they have to keep this. They have a number of employees.

Senator WILLIAMS. What kind of housing do they supply?

Dr. RADEBAUGH. This housing is somewhat crowded, but really is better than the average.

Senator WILLIAMS. And the majority of the workers are Puerto Ricans?

Dr. RADEBAUGH. Yes, sir.

Senator WILLIAMS. What is the crop that they are harvesting?

Dr. RADEBAUGH. They will handle tomatoes, and apples, and beans.

Senator WILLIAMS. And they stay in the fall?

Dr. RADEBAUGH. Yes, that is right.

Senator WILLIAMS. This period was the peak of the crop really for tomatoes.

Dr. RADEBAUGH. Yes.

Senator WILLIAMS. And he lost a week?

Dr. RADEBAUGH. That is right. I think one of the problems was somebody must have miscalculated their need for workers at that

particular time or it may be that it is standard practice in some areas—I am not sure—have more workers than you need.

Senator WILLIAMS. That used to be an economic theory, that it is good to have a pool of unemployed. I thought we discredited that, but maybe it still exists in certain areas. It costs more to go through the bookkeeping here than this poor fellow made. Isn't that amazing?

Mr. BLACKWELL. What county is this?

Dr. RADEBAUGH. This is Monroe County or actually it is just over the border in Livingston.

Senator WILLIAMS. Rochester is in Monroe County?

Dr. RADEBAUGH. Yes.

Senator WILLIAMS. It appears to me, as Fred Blackwell suggested, something ought to be done to check this transaction.

Dr. RADEBAUGH. I think it is quite obvious.

(The material referred to previously follows:)

CURTICE-BURNS, INC.,
Rochester, N.Y., December 7, 1967.

Hon. HARRISON WILLIAMS,
Senate Office Building, Washington, D.C.

DEAR SENATOR WILLIAMS: I have received a call this afternoon from Mr. John Heiney, Executive Vice President of the National Council of Agricultural Employers in reference to your Senate Subcommittee hearing in Washington this morning.

His call informed us about Dr. John Radebaugh's testimony before your committee. Dr. Radebaugh made reference to a Curtice-Burns check payable to a J. C. Gonzales net amount approximately twenty cents. Our firm operates five plants within a twenty mile radius of one another. Quite often a worker will work at more than one plant during a particular week. This is what happened in Mr. Gonzales' case. I am enclosing a photo copy of his returned check in the amount of \$89.94 covering the same period (week ending July 30, 1967) as the check you saw this morning.

All I am attempting to do here is to set the record straight with your committee. We have been using Puerto Rican workers since 1951 and a great number of our workers have been with us, seasonally, since that time.

We have good facilities and working conditions and whenever it is necessary, we provide medical treatment including transportation for our workers.

Thank you.

Sincerely yours,

R. A. MYERS, Personnel Director.

2/E 7/30/67 - Dist. Ctr. Reg. Earnings Gross Earnings net pay
84.00 96.00 89.94

CURTICE - BURNS, INC.
LINCOLN ROCHESTER TRUST CO.
ROCHESTER, N. Y.

ROCHESTER, N. Y.

CHECK NO. 0100245

PLANT	EMP. NO.	S.S. NO.	DATE	AMOUNT
01	0241	582 03	8073	89.94

PAY TO THE ORDER OF J C GONZALES

AUG 8 1967

PAYROLL ACCOUNT #2

50-17

0000008994

DECEMBER 14, 1967.

MR. FRED BLACKWELL,
*Counsel, Senate Subcommittee on Migratory Labor, Senate Office Building,
 Washington, D.C.*

DEAR MR. BLACKWELL: The Curtice-Burns Company denies that Mr. J. C. Gonzales received a check for twenty-cents while in their employ. Accordingly, I have put together an exhibit with Mr. J. C. Gonzales statement of the circumstances. Further inquiry may be advisable if there seems to be continued doubt.

JOHN RADEBAUGH, M.D.

CURTICE-BURNS, INC., SEPTEMBER 22, 1967—DISCUSSION WITH J. C. GONZALES

I am J. C. Gonzales. I was working in the warehouse this week where I got the check for \$.20 where I worked for 7½ hours. We are seven in the family. I got five children, my wife, and me. That's seven altogether. So after that day after that week when I got the check for \$.20, Mr. Colon came around to the camp; and I showed the check for \$.20 which I got for two weeks. He did not say a word to me. He did not say anything to the company either. When we come down here to Curtice-Burns, it was told us down in Puerto Rico we get 160 hours a month or 40 hours a week; and when we came here to Curtice-Burns, they denied to us the 40 hours a week. The past 1st month, 2nd month, and 3rd month the promise was broken down. After a month and a half, I was making around \$100.00 a week, working three shifts and making \$100.00 a week. Sometimes I work around 24 hours. That's the only way I can make some money here. I am short 12½ hours this week. I went straight out to the main office, and I reported it. The office says we will get paid the next week.

(To obtain full information on this issue the following information was sent to Curtice-Burns:)

DECEMBER 21, 1967.

MR. R. A. MYERS,
Personnel Director, Curtice-Burns, Inc., Rochester, N.Y.

DEAR MR. MYERS: Senator Williams has referred your December 7 letter and enclosures to me with instructions to obtain for inclusion in the record all facts and materials necessary to reflect accurately the pay transaction between Mr. J. C. Gonzales and Curtice-Burns, Inc., which transaction was raised by the testimony and exhibits presented by Dr. John Radebaugh in his recent appearance before the Subcommittee.

Subsequent to your December 7 letter, Dr. Radebaugh, by cover letter of December 14, submitted the enclosed September 22, 1967, statement of Mr. J. C. Gonzales. Contents of the Gonzales statement, as well as the procedure described below, were discussed with Mr. John Heiney, with whom we have held two discussions on the pay transaction.

You will notice that the statement of Mr. Gonzales broadens the calendar period in question, by alleging among other things, non-compliance with the guaranteed work period during the "1st month, 2nd month, and 3rd month" of his employment. In view of these allegations by Mr. Gonzales, apparently directed at the entire period of employment, it is suggested that you provide copies of Curtice-Burns, Inc. statements of Mr. Gonzales' earnings and pay checks for each of the thirteen weeks that Mr. Gonzales worked with you this year.

On receipt of this material the following procedure will be followed to clarify this matter in the hearing record:

1. Your letter and enclosures of December 7 will be included in the hearing record at the page where the Gonzales pay transaction was first mentioned by Dr. Radebaugh.

2. At the page in the record where the Gonzales pay transaction is last mentioned, Dr. Radebaugh's December 14 letter and the Gonzales statement will be included in the record, followed immediately by the above described earnings record and pay checks.

In addition to these procedures, it has occurred to us that another definitive method to establish your company's contention regarding the pay transaction would be to have a representative of the Puerto Rican Labor Department, after examination of the Gonzales pay roll records, submit a statement to the effect that all pay transactions were in accordance with the contract provisions. We will,

of course, also include in the record any such statement made available to the Subcommittee.

You may rest assured that hearing records of this Subcommittee have always been compiled with meticulous care for fairness, and we assure you that you will have full opportunity to have included in the record material that truly reflects the facts of the Gonzales pay transaction.

Sincerely,

FREDERICK R. BLACKWELL, *Counsel.*

Senator WILLIAMS. Isn't Justice Keating from Rochester?

Dr. RADEBAUGH. Yes, sir.

Senator WILLIAMS. When he sat here as a Senator, he was very helpful. However, we are interrupting you.

Dr. RADEBAUGH. That is all right.

However society in attempting to bargain itself out of responsibility for health services, often incurs a greater hidden debt, as shown by the following example. Each State has a sanitary code and New York State has a sanitary code. I quote from chapter 1, part 15.6, for farm labor camps:

Where a stove or other source of heat is provided, it shall be installed in such a manner as to avoid both a fire hazard and a dangerous concentration of fumes or gas. Use of portable kerosene heaters shall not be permitted.

On October 20, 1967, Mrs. Caroline Cooks was looking over the shoulder of her husband who was filling their portable kerosene heater. They lived in a building with six rooms without central heating in Steuben County of New York State. There were other seasonal workers living in some of the other rooms.

Mr. Cooks had requested heat from the owner of the camp in which he was living. The camp owner merely laughed and said, "You've got a wife, haven't you; let her keep you warm."

Mr. Cooks was finally able to borrow a portable kerosene heater, the type which is shown on this slide. We will take a look at this next slide.



(Slide.) This is taken from another migrant camp fire which occurred in 1967 in Wayland, N.Y., in which a man was burned to death. Here is the same type of heater, no outside venting, an extreme fire hazard. This heater exploded.

Mr. BLACKWELL. Doctor, this is not the Cooks' heater? This is an example of the same type?

Dr. RADEBAUGH. It is an example of the same type. The heater exploded, and Mr. Cooks received some flash burns of his face and one hand. His wife received severe burns of the body and face and was rushed to the hospital with 65 percent second- and third-degree burns.

She was placed on the danger list at the Strong Memorial Hospital and was treated in the intensive care unit with three special nurses. Estimates were that she would be in the intensive care unit for 4 or 5 weeks and then in the hospital for another 6 months.

The costs in the intensive care unit for your interest are \$250 per day or \$7,500 for 4 weeks' period of time.

The total estimated cost, \$21,000 for the 7-month period of time.

The cost of this would be covered by the local community and the State, a cost which this rural poverty-stricken community could ill afford.

I will mention by paraphrase that conditions in this community are part of Appalachia and the infant death rate, to give you an example, is the highest in the State of New York.

Yet, with an adequate health program which included sanitary inspection, such as those under the Migrant Health Act, this accident could have been prevented. The Migrant Health Act provides for such preventive programs, thus saving the Government thousands of dollars.

Senator WILLIAMS. Will you pause there just a moment?

You said, "Yet, with an adequate health program which included sanitary inspections, this accident could have been prevented."

But earlier you said there was a code.

Dr. RADEBAUGH. That is right.

Senator WILLIAMS. That code does prohibit dangerous stoves, so the problem is that there hasn't been adequate inspection. Is that what you are saying?

Dr. RADEBAUGH. Yes; this is true. One of the reasons given is that the State itself is unable to afford adequate inspectors.

Senator WILLIAMS. Well, that is hard for me to understand. Isn't New York State considered, I think, to use the word, the wealthiest State in the Nation?

Dr. RADEBAUGH. Yes; it is.

Senator WILLIAMS. Yet you say the State can't afford something as simple as inspecting or saying to your grower, "You fix up or get out of business"?

It is almost that simple.

Dr. RADEBAUGH. Yes, it is, and it is a basic problem I think in the migrant camp situation. Those who do inspect, for reasons that may be clear to some, do not enforce the regulations in many situations.

Perhaps it is because the community itself doesn't support them. In other counties in the same State inspections are enforced considerably.

Mr. BLACKWELL. The inspection authority in New York is composed of the county and the State levels?

Dr. RADEBAUGH. In the counties in which there is a county health department, it is at a county level. In counties such as Steuben County, in which there is no county health department, it is at a State level.

Senator WILLIAMS. And this was at what level?

Dr. RADEBAUGH. State level.

Senator WILLIAMS. If I were Governor of the State of New York I wouldn't go up there. I would stay away from that place.

Dr. RADEBAUGH. There are problems easily seen in a number of areas. The inspection group in September saw similar situations of inadequate enforcement.

Senator WILLIAMS. The harvesting season goes into the cold of winter. Apples are harvested into October; aren't they?

Dr. RADEBAUGH. Yes. Potatoes and cabbages, which are big crops in this area, are also.

Senator WILLIAMS. Housing is one of the whole range of problems that the committee is concerned about and responsible for. However, in terms of the legislation presently being considered, you tie this tragedy to the sanitary and the inspection code and the failure to make the grower live up to the code and the sanitary conditions?

Dr. RADEBAUGH. Yes.

Senator WILLIAMS. That is a health problem.

Dr. RADEBAUGH. It is a health problem. It is as basic as the health problem of treating somebody with tonsillitis, or somebody with an infectious disease, or somebody with a chronic illness, and in this particular population it presents a far greater problem than it does to the ordinary person living in an established community.

Mr. BLACKWELL. Dr. Radebaugh, isn't there a health problem involved in the kerosene heater that probably affects far more people than the heater explosion? This heater just doesn't provide enough heat, and in the camp we visited in the Rochester hearings, the occupants there stated, I believe, that eight or 11 people had become seriously ill just a week or so before from a cold snap.

When the temperature drops, this doesn't provide anything near the amount of heat that is needed to keep infants, or an adult with perhaps low resistance, warm enough to ward off diseases; so this type of heater should be condemned per se.

Dr. RADEBAUGH. Yes, this kind certainly.

Mr. BLACKWELL. It was rather nippy when we were there and it was just September.

Dr. RADEBAUGH. I agree that this type of a heater is illegal and the State health code further states that the building should be capable of being heated to 68° F. after October 1 and obviously this could not possibly do that.

I think that the Migrant Health Act can have a great effect on situations such as this because wherever there are health programs people are aware of some of these problems and the effect that they have on health, and the Migrant Health Act in some States has provided sanitary supervision.

In other States, because of the health program, there has been a close liaison with sanitary inspectors so that things have improved in those particular areas.

Senator WILLIAMS. Our earlier testimony this morning from the heads of State health departments confined your views. A measuring activity is required and the regular health officers are given a broader scope.

Mr. BLACKWELL. Before you leave this incident of Mrs. Cooks, you speak of certain costs in terms of estimates with regard to future care. Will she actually receive this care, or is there a question about whether she is going to be left scarred and maimed for life?

Dr. RADEBAUGH. No. Actually, the irony of this situation is that Mrs. Cooks died 1 week after admittance to the hospital, so in this situation, the State did not incur these costs.

Mr. BLACKWELL. She died from these injuries?

Dr. RADEBAUGH. From these burns, yes. They were severe enough and she did not survive past a week.

However, for those who do survive any burn, it is a very expensive type of medical care. The hidden savings, I would like to emphasize, is if there were adequate preventive measures to insure adequate heating devices. The country, the State, and the community would save far more money if it invested it in an adequate inspection procedure.

In closing, I would like to mention that the Migrant Health Act was created also to prevent such problems as we encountered a few years ago in a patient who was referred to Florida.

This was a boy who we saw in one of our clinics who had an inguinal hernia and we recommended that it be repaired.

However, before this could be done, the family moved back to Florida and we sent a letter to the health department in that area asking that further medical care be obtained. Let's take a look at that letter.

(The letter referred to follows:)

UNIVERSITY OF ROCHESTER SCHOOL OF MEDICINE & DENTISTRY,
DEPARTMENT OF PREVENTIVE MEDICINE,
COMMUNITY HEALTH REHABILITATION UNIT,
Rochester, N.Y., September 14, 1965.

FLORIDA STATE HEALTH DEPARTMENT, MIGRANT HEALTH DIVISION,
Jacksonville, Fla.

GENTLEMEN: *Kenneth Cain*, whose parents are Mr. & Mrs. Willie Cain, Box 207, Hastings, Florida, was seen by me in the Brockport Day Care Center, Brockport, New York, on 8/12/65. A diagnosis of a (right indirect inguinal hernia) was made at that time and recommendations were started for referral to the Surgical Outpatient Department at Strong Memorial Hospital, since *surgical correction was recommended*. The family moved, however, to Florida before this appointment could be kept and said that they would seek medical care upon their return. I am writing to you hoping that such arrangements can be made. We have been conducting a health program in this area and are interested in the followup care of patients seen here. [*I wonder whether a return note could be sent to us regarding disposition of this particular child*].

Sincerely yours,

JOHN F. RADEBAUGH, M.D.

St. Augustine, Fla.

Sorry, at the present time we have no referral agencies that could help this family.

ST. JOHNS COUNTY HEALTH DEPARTMENT,
J. C. LORANGER, M.D.

This is the letter which we sent to Florida asking for further surgical care for this boy, this patient. The reply which we received in 1965 was, "Sorry, at the present time, we have no referral agencies that could help this family."

I would like to follow this up by saying the State of Florida now through the Migrant Health Act has corrected this situation in this particular county and such a patient would not have the same problem in 1967.

Mr. BLACKWELL. This is September 14, 1965?

Dr. RADEBAUGH. Yes.

Mr. BLACKWELL. And the difficulty that made it impossible to help the man has been corrected in the Florida system?

Dr. RADEBAUGH. Yes, sir. The State of Florida has used the Migrant Health Act and Federal funds to assist in many of these counties and St. Johns County in which this patient was residing has been a recipient of some of those funds.

Senator WILLIAMS. This is the sort of situation that we are beginning to meet? Is that what you are saying?

Dr. RADEBAUGH. Yes. I visited Florida just 2 weeks ago at a conference with some migrant health directors and was pleased to hear what was happening in that State with these funds which have been available.

This county I know from talking with people there would not have this problem at the present time because they now have improved services available for the seasonal worker.

It is evident to us that the Migrant Health Act should be extended, that it should be increased so that the spotty distribution of some of the programs is alleviated and more programs are available in more States.

The distribution of health care now and the programs which are geared to try to help the seasonal worker are small and few and many of them poorly funded. I believe that this large group of people traveling over many miles of country should have the benefits of some Federal supervision in their health care, some coordination in their health care, so that they can receive services that would be available to the ordinary citizen who lives in one area through most of his life.

Let Congress take positive action in extending the Migrant Health Act and let Congress take action in increasing the funding for a very necessary group of people so that perhaps the reply could come back, as did this worker in a letter to one of our nurses in November 1967:

I will never forget how good you were with us, cause this is our first time we have been treated like humans.

Senator WILLIAMS. When was that statement made?

Dr. RADEBAUGH. In November of this year, 1967.

Senator WILLIAMS. And that was a woman who came to your—

Dr. RADEBAUGH. This is a woman seen in one of our clinics, and she wrote this.

Senator WILLIAMS. In Monroe County?

Dr. RADEBAUGH. Yes. She returned to Florida and wrote this complimentary letter back to one of the nurses in the program.

Senator WILLIAMS. Well, all the testimony this morning makes me feel derelict in my duty. I don't think we are doing enough in this area. What does the first of the year provide?

Mr. BLACKWELL. \$13 million, which, according to the information of the subcommittee, coincides exactly with applications now on hand in the migrant health unit which have been examined according to the personnel there and are approvable applications.

I understand also that this does not represent in any sense of the word the amount needed to meet the sound applications that could be submitted throughout the country.

Senator WILLIAMS. Or should be encouraged to be submitted. How about Wayne County? Do they have a program as you have in Monroe County?

Dr. RADEBAUGH. No. Wayne County has had one clinic for children in the summer funded through the State health department.

This clinic finishes in early September. Yet many of those people stay around for 2 more months or so and there is no facility at all for them during that time.

Senator WILLIAMS. This just proof of the fact that the money we put in would be sufficient to meet present applications. I wonder if Wayne has made application?

Dr. Radebaugh. No.

Senator WILLIAMS. That is the whole point.

Dr. RADEBAUGH. Actually I have tried to point out areas in which there is no migrant health program or funding and areas which are in dire need of some help. These are communities in rural areas. All of them are within 50 miles of Rochester.

Senator WILLIAMS. Doctor, certainly we are motivated by the humanitarian desire to bring better health to these very poor and transient people, but beyond that, aren't there also other reasons for helping the field hand who had never been treated by a doctor and died of tuberculosis?

Dr. RADEBAUGH. Yes.

Senator WILLIAMS. Tuberculosis is a contagious disease; isn't it?

Dr. RADEBAUGH. Yes.

Senator WILLIAMS. In the general consumer interest, shouldn't it be important to bring better health to these farmworkers?

Dr. RADEBAUGH. Yes, it should; and I believe that these people should have examinations just as restaurant workers and other people who are working with food.

Senator WILLIAMS. We would be doing this even if there weren't a health hazard for all of us who are consumers. We would be doing it, anyway, but that is an additional point.

Mr. BLACKWELL. Doctor, do you know whether there is a requirement for an examination of the worker who goes into the food processing part of the operation?

Dr. RADEBAUGH. There is for the Puerto Rican workers under the contract arrangement. I am not certain about the noncontract workers.

Mr. BLACKWELL. They are examined though in Puerto Rico before they arrive?

Dr. RADEBAUGH. Yes, sir.

Mr. BLACKWELL. And that is an examination for the field hand or any worker coming in under contract?

Dr. RADEBAUGH. Yes, sir.

Mr. BLACKWELL. Do you know if workers in a plant processing applesauce are required to submit to a health examination?

Dr. RADEBAUGH. I am not certain about that. I know that most of the processors in western New York State are using noncontract labor,

that is, they are not under the Puerto Rican contract and I do not believe that in that situation they do have to have physical examinations.

Mr. BLACKWELL. You have been working with this migrant project rather full time for about 3 years now?

Dr. RADEBAUGH. Yes.

Mr. BLACKWELL. Is it your opinion, Doctor, from your experience in working with these people, that the typical migrant worker and family either receives medical care from one of the migrant projects, or does without?

If he doesn't get it from you, do you have any reason to believe that he gets it elsewhere?

Dr. RADEBAUGH. The better paid workers on some of the better paid farms are able to seek care from physicians in the area. Those who are the average find it very difficult to have the funds or find the funds for medical care.

In our own State medicaid, which should help them, is quite difficult for them to even apply for in some of these rural communities.

We know in some counties that they are turned down or given such difficulties in making the application that many of them just can't get through the redtape or the involved procedures of signing up for medicaid, so the better paid workers can get medical care just as the better paid people elsewhere can, but I think the majority must rely on a program in their area that is close to them in order to get care, and in New York State in most of the areas there are no such programs.

There are only about five in the State which are an attempt to bring care to the people and the rest of the seasonal workers must try to get local facilities if they can.

Mr. BLACKWELL. In reference to Mr. Carter who was rejected by three hospitals and finally accepted by the Veterans' Administration hospital, what was his illness?

Dr. RADEBAUGH. That man's illness?

Mr. BLACKWELL. Yes.

Dr. RADEBAUGH. This was an infectious disease, but I don't know the final details of that.

Mr. BLACKWELL. For my own help in case I am ever in a medical situation without my credit cards and a little cash how much fever must I be running to be admitted on an emergency basis?

This man had 103 degrees. How high does it have to go before someone injects himself into the situation and says, "This man just has to have some care"?

Could you advise me on what I can do to get in if I ever have that trouble?

Dr. RADEBAUGH. I advise you to stay out of a few counties and pick your areas quite carefully.

Mr. BLACKWELL. In the situation of the tuberculosis victim—we will call him victim—as a layman, it strikes me that this man had what we used to call galluping consumption.

What was this individual's age?

Dr. RADEBAUGH. He was in his late twenties, I believe 28 or 29, somewhere in that area.

Mr. BLACKWELL. Twenty-eight or twenty-nine?

Dr. RADEBAUGH. Yes.

Mr. BLACKWELL. A young man. Couldn't this sputum that was found in the fruit can beside his bed have been analyzed to determine definitely?

Dr. RADEBAUGH. Yes; it could have.

Mr. BLACKWELL. Shouldn't that have been analyzed to determine whether in fact there had been tuberculosis in this camp so that precautions and examinations of the other people in a situation like that could be probably ordered by some official?

Dr. RADEBAUGH. Yes; I think as one looks at this, someone should have taken more interest in trying to find out the exact cause of the situation. I will say that we heard about the death a few days later, and in cooperation with the public health services the health department tuberculin tested everybody in that camp and also did X-rays on people in that camp.

Senator WILLIAMS. Are you familiar with the Tine test?

Dr. RADEBAUGH. Yes.

Senator WILLIAMS. That is for tuberculosis?

Dr. RADEBAUGH. Yes.

Senator WILLIAMS. And it is instantaneously applied. I remember a little documentary film out in a strawberry field. We had about, let's say, 75 workers who were tested in a matter of within an hour.

Dr. RADEBAUGH. Yes.

Senator WILLIAMS. It is not a hospital examination or an X-ray, the whole business.

Dr. RADEBAUGH. No; it is a very simple test and it could be applied in this area of migrant health quite readily.

Senator WILLIAMS. Where the people live?

Dr. RADEBAUGH. Yes.

Senator WILLIAMS. As we found out, we applied it in the field.

Dr. RADEBAUGH. Yes.

Mr. BLACKWELL. On the corner birth, that was in 1966?

Dr. RADEBAUGH. Yes.

Mr. BLACKWELL. And the temperature outside was 15°?

Dr. RADEBAUGH. Below zero.

Mr. BLACKWELL. Below zero?

Dr. RADEBAUGH. Yes.

Mr. BLACKWELL. What month was that?

Dr. RADEBAUGH. This was in the winter. I don't know the exact month. This is from Father Weider. I have talked with him and know him very well.

Mr. BLACKWELL. Do you know what transpired after the birth? Was there any effort made to get the mother or maybe at least the baby into a better shelter?

Dr. RADEBAUGH. No. I think this actually goes back to the first slide.

Mr. BLACKWELL. It would be ironic if that was December 25.

You really don't know whether the family stayed there?

Dr. RADEBAUGH. No.

Mr. BLACKWELL. Were there other children in this family?

Dr. RADEBAUGH. Yes. I only mentioned Father Weider because he is an area director from the catholic diocese under Bishop Fulton Sheen, and he has been sent to this area to try to see what can be done to improve some of the conditions.

The plea that he makes, and I talked with him yesterday before coming here, is that there ought to be some type of medical care in this area. We have begun.

Mr. BLACKWELL. What county is this?

Dr. RADEBAUGH. This is Steuben County.

Mr. BLACKWELL. Way up?

Dr. RADEBAUGH. Way in the southern tier. It is in part of Appalachia actually. And his point is that the physicians there are too busy and too involved and work such long hours with their own patients that they just don't have time when this new group of people come in each summer.

Senator WILLIAMS. That raises something in my mind. You know, there is a total shortage of doctors in rural areas.

Dr. RADEBAUGH. Yes, there is.

Senator WILLIAMS. I have known millionaires who can afford a doctor, and they are up just outside of Saranak Lake and they are both local, and there just aren't enough doctors even though you have the money.

Dr. RADEBAUGH. Yes, I agree; and I think the group that suffers the most when you have a situation like this are those who do the traveling like the seasonal farmworkers.

Senator WILLIAMS. Obviously if the people with money can't get doctors, people without money will be the last ones that will be cared for. I know that the University of Rochester had a medical school of prominence. How many students do you have in attendance?

Dr. RADEBAUGH. There are 72 and they are planning to go up in the next 3 or 4 years to 96.

Senator WILLIAMS. How many applicants do you get every year?

Dr. RADEBAUGH. I don't really know. I would say it is about 6 or 7 to 1 that is accepted.

Senator WILLIAMS. That is the way it runs.

Dr. RADEBAUGH. And it is obvious this is a sideline that the medical schools are going to have to expand to keep up with the population demands.

Senator WILLIAMS. If Senator Yarborough were here, we would be here from now until 2 on that one subject. He has a passion for this. I do, too.

Dr. RADEBAUGH. I think the profession is beginning to wake up at this point and trying to correct some of the doldrums that have gone on the past 10 years.

Senator WILLIAMS. Plus the rural practice isn't attractive, is it?

Dr. RADEBAUGH. It isn't except where there is a group practice.

We have noticed around our area where a group of two or three or four physicians will combine into some type of a facility and they can attract people much better than just by practicing alone.

Mr. BLACKWELL. Do you know the size of the family living in that corner? How many kids were in that?

Dr. RADEBAUGH. No, I don't.

Mr. BLACKWELL. Will you try to get that for us?

Dr. RADEBAUGH. I can try to get more detail from Father Weider.

Senator WILLIAMS. Are those slides also on your charts?

Dr. RADEBAUGH. I have a few charts which I brought with me if you would like to see some of that material.

Senator WILLIAMS. Normally we don't pictorialize our hearings, but this is worth going to the expense of putting it pictorially in the record if we could work that out.

You are going to give us the negatives of all these?

Dr. RADEBAUGH. Yes.

Senator WILLIAMS. And we have had the slides. You have additional pictorial material and that will be included in the record, too, without objection.

Dr. RADEBAUGH. I would like to add just one further comment.

Mr. Marion Folsom was invited to this session and he wishes to express his regret for not coming, but I would like to quote from a book which some of you may be familiar with called "Health is a Community Affair."

Senator WILLIAMS. He is the former Secretary?

Dr. RADEBAUGH. He is former Secretary of Health, Education, and Welfare, or Health and Welfare at that time, and he is the chairman of a committee which made a survey throughout the country. Among the recommendations of this committee is this:

Every resident of the Nation, whether he lives in New York, the West Virginia hills, the bayous of Louisiana, or the plains, mountain, or coastal areas of the country, should be able to learn about and attain services necessary for the health of himself, his family, and his neighbors.

Communities must make health services available, accessible, and acceptable to all of their residents.

I would like to include that.

Senator WILLIAMS. Say that last part again.

Dr. RADEBAUGH (reading):

Communities must make health services available, accessible, and acceptable to all of their residents.

Senator WILLIAMS. He brings it down to community responsibility. However, in this particular area of interstate families, we want to have, along with our interstate responsibility in many fields, the Federal Government in partnership with the community to do exactly what former Secretary Marion Folsom said.

Where is he now? Is he up your way?

Dr. RADEBAUGH. Yes; he is living in Rochester and is still very active in health affairs.

Senator WILLIAMS. We were pleased when he accepted our invitation to testify, but I gather a conflict developed.

Dr. RADEBAUGH. He felt that on short notice, he wasn't really prepared to testify at this point.

Senator WILLIAMS. But he certainly philosophically supports what we are doing.

Dr. RADEBAUGH. Yes. His interest I think stems from a year or so of some knowledge of what has been going on. He has also made inspections similar to ones which your committee made in September in upstate New York.

Senator WILLIAMS. Oh, he has?

Dr. RADEBAUGH. Yes.

Senator WILLIAMS. You are associate professor at the University of Rochester?

Dr. RADEBAUGH. I am assistant professor of pediatrics.

Senator WILLIAMS. Which is higher.

Dr. RADEBAUGH. Assistant is lower. Associate is higher.

Senator WILLIAMS. We have you listed as an associate. Well, I move that you become an associate. All New Yorkers vote aye. Alright.

Mr. Blackwell has an amendment to my motion. He wants you to be a full professor.

You are certainly entitled to it. What is your particular discipline within the medical profession?

Dr. RADEBAUGH. I am a pediatrician by background. However, in these project programs, I am becoming a general physician again.

Senator WILLIAMS. A great deal of your time is put into this program for migrant families?

Dr. RADEBAUGH. Yes. In fact, I think there should be people in the medical profession who take this as a full-time program. I think the only way to really improve some of the conditions is to have a few people who can take this as a full-time occupation, not something as part time or something that would take just a few hours a week or something of that sort.

In fact, to put it even stronger, I think this is one of the big public health problems in the country, trying to provide medical care for these traveling seasonal workers.

Senator WILLIAMS. I suggested earlier to our first panel that we are trying to develop an educational profile of the kids that they can carry with them as they go so that in a new school the teachers there will know at what level they should be placed, and Fred Blackwell suggested that a medical code file might be part of the family document and put in a form that they would feel is a possession that would be worthy of making sure they don't lose because living in those busses up there in Wayne County it is easy to misplace your possessions.

Dr. RADEBAUGH. That is right; yes.

Senator WILLIAMS. I touched on this with our friend from Florida, the State health director, Dr. Sowder. A lot of migrants start from Florida. They might well start with a nice packet with the seal of the State of Florida. This packet would be a rather valuable family possession including the very necessary documents concerning both their education and health.

Dr. RADEBAUGH. I think this would be well worthwhile. The migrant health branch has been discussing this and I believe this spring they are going to try to implement this with something definite, a type of record which will be agreed upon by people on the east coast perhaps to use.

Senator WILLIAMS. This is the Public Health Service?

Dr. RADEBAUGH. Yes, that is right, of the Public Health Service.

Senator WILLIAMS. Miss Johnston, have you been working on that?

STATEMENT OF HELEN JOHNSTON, CHIEF, MIGRANT HEALTH BRANCH, PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Miss JOHNSTON. We have a second meeting of the group made up of project people. The scheduled second meeting will be held early in the spring to try to get some agreement on what to do and how to do this.

Senator WILLIAMS. And then you move into a project next year probably on a demonstration or pilot basis?

Miss JOHNSTON. We hope there will be 115 projects at least moving into the use of this system that we are working out.

Senator WILLIAMS. Fine.

This has been most productive. This is the third straight day I have been sitting in this chair. I sat here yesterday and the day before on problems of older people and we have had a magnificent hearing this morning.

I feel as though I have partial ownership of this chair.

Thank you very much, Dr. Radebaugh. We are grateful to you.

We will reconvene next Wednesday.

(Whereupon, at 12:52 p.m. the hearing recessed, to reconvene Wednesday, December 13, 1967.)

MIGRANT HEALTH SERVICES

WEDNESDAY, DECEMBER 13, 1967

U.S. SENATE,
SUBCOMMITTEE ON MIGRATORY LABOR OF THE
SENATE LABOR AND PUBLIC WELFARE COMMITTEE,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to recess, in room 4232, New Senate Office Building, Hon. Harrison A. Williams, Jr. (chairman of the subcommittee) presiding.

Present: Senator Williams.

Committee staff present: Frederick R. Blackwell, counsel; Boren Chertkov, associate counsel; and Eugene Mittelman, minority counsel.

Senator WILLIAMS. We are honored to begin the second day of hearings on the Migrant Health Act with the statement of Dr. William Stewart, Surgeon General.

You are in charge of the health of the Nation, are you not, Doctor?

STATEMENT OF DR. WILLIAM H. STEWART, SURGEON GENERAL PUBLIC HEALTH SERVICE, WASHINGTON, D.C.

Dr. STEWART. I have a great deal of it under my care.

Senator WILLIAMS. How do you assess the health of the Nation right now at this hour?

Dr. STEWART. Well, in general our Nation is rather healthy, but we have a long way to go. Many of the indices are better in other nations than they are in our own in a few things like infant mortality, where we now are 13th of 15 of the nations of the world.

Senator WILLIAMS. Is that right?

Dr. STEWART. And there are other indices where we could improve the situation. While I can say that we are a healthy nation, we have work to do.

Senator WILLIAMS. We are dealing here with a group of people we all rely on, farmworkers, and one of the great anomalies of life is that they harvest our crops and yet they have been some of the people who have been less cared for in regular health care, is that right?

Dr. STEWART. This is very true.

Senator WILLIAMS. Well, we have been working on this subcommittee for almost a decade to try to develop programs to improve the situation with the cooperation of the Public Health Service. I think we have made a stride forward, but we have a long way to go.

Dr. STEWART. I think this is true.

Senator WILLIAMS. Of course, you know far more about this than I do, as you were intimately associated with the health care of farmworkers long before this subcommittee was interested, in 1966.

We are honored to have you here.

Dr. STEWART. Thank you, Mr. Chairman.

It is true that in 1951 and 1952 I tramped some of the migrant camps in California and I worked in some of the camps in southern Georgia, so I have had some insight into it for some periods of years. I am very pleased at this opportunity, Mr. Chairman, to support extension of the Migrant Health Act. The leadership that you and members of the subcommittee and full committee have provided in this field has brought medical care to great numbers of Americans who might not otherwise have known any of the benefits of modern medicine.

Until passage of the act in 1962, health care for migrants was virtually nonexistent. Today, thanks to extension of the act in 1965 and your continued support, major gains have been made in bringing health services to this group who, in spite of their vital role in a major national industry, remain the last to receive health benefits most Americans take for granted.

The migrant farmworker and his family are not only poor, but geographically and socially isolated, lacking in knowledge about health services, and often afraid to encroach on a possibly hostile community.

The Migrant Health Act of 1962, as extended in 1965, started to change this picture. The core provision of the act is the family health service clinic. Here the human treatment given helps to overcome the barriers of strangeness and fear, at the same time that the medical treatment relieves physical pain. The clinics are held at times and places where they can be conveniently used by workers and families without loss of time from work. They teach the people, themselves, better methods of personal and family health care as well as caring for their immediate needs.

Because of the limitations of family clinic facilities and staff, supplementary arrangements are needed for emergency care between clinic sessions, and for specialized services beyond what the clinics can offer. These supplementary arrangements have been used as the primary method of extending care to migrants in areas where the number or the dispersion of migrants, shortages of health manpower, or other problems have made family clinics impractical.

At present, family health service clinics are operating seasonally or year round at more than 200 locations. More than 800 private physicians are serving migrants through these clinics or through other systematic arrangements.

In addition to medical treatment for the illnesses or injuries the workers or family members bring to the physician, projects provide immunizations, prenatal care, well child supervision, and health education. They support this personal health care by inspections of the camps and other migrant housing to identify defects and obtain their correction.

Rather than simply wait for the migrant to seek medical care, nurses, aides, and other community workers seek out the worker and his family, helping him to understand that these services are truly for him, and advising him of better ways to protect his own health.

Experiences in many localities have shown that gradually the people gained confidence in these healthworkers who were seeking them out and listening to their problems. They came more and more readily

to accept the preventive services the nurses and physicians offered. They accepted and applied the health teaching. They carried the personal health records that were issued to them in one location and presented them at the next work location so that continuity of health services could be better assured.

From a scant handful of counties in which systematic efforts to provide migrants personal health care were made a half-dozen years ago, the number has now grown to more than 300. These counties are in the service area of 115 single or multicountry projects, three-fourths sponsored by State or local health departments, and one-fourth by local migrant councils, medical societies, hospitals, governing bodies, interfaith church groups, or medical schools.

The typical project places major emphasis on general medical care offered by private medical practitioners in family health service clinics, outpatient departments of hospitals, or their own offices. Often a project relies on some combination of these three approaches to providing general medical care.

The facilities of the clinics are sometimes primitive. An example might be a four-walled unit in a migrant labor camp that customarily houses one or two workers or a migrant family. Or facilities may be improvised in a church basement or an empty school building. A few projects use mobile units which move from one location to another on a regular schedule.

Some of these projects provide dental services under similar conditions. The need for such services is made evident by the fact that most migrant children and adults require remedial dental care.

All projects employ nurses who are the "welcome wagon" for migrant health services as the people come into the project area. The nurses also work in the medical clinics and sometimes hold "sick call" or nursing clinics.

Another common denominator of service is sanitation. Probably no project area yet has housing that fully meets existing standards for sanitation and safety. Some of the illness and accidents seen in the family health service clinics can be directly traced to poor living and working conditions and the lack of adequate places for children to play. The best means of prevention is through the employment of sanitarians and sanitation aides who work both with property owners and occupants to bring about improvement.

A final common denominator is health education—an effort that at the optimum is planned and shared by all project staff members from the clerk-receptionist in a clinic to the physician, nurse, dentist, sanitarian, and aides. In some cases, migrants or ex-migrants themselves have been employed as liaison representatives between the professional workers and the migrants to help in the educational effort. Considerable effort has been expended by central branch staff in developing films and other health education aids for migrants, and in working with local projects on health education problems.

Hospitalization was added to the scope of services under the provisions of the 1965 extension of the Migrant Health Act. Funds became available for the first time for this purpose during 1967. At present 55 projects providing inpatient hospital care along with other services are operating in 25 States. These projects have agreements with more than 160 hospitals.

In the latest 12-month period for which summarized project data are available, migrants made 125,000 visits to physicians, and 18,000

visits to dentists. In addition, nurses made 215,000 visits to migrant households and sanitarians made almost the same number of visits to living or work sites.

The benefits become more apparent from case histories sent in by projects. A crippled teenager, never before able to go to school, was identified and brought under care by one of the projects. Now fitted with a prosthesis, she is attending a special school and has learned to read and write. Teenage girls recruited as volunteer aides to work in a migrant clinic have sometimes chosen health careers. Two attended college with assistance from their community—one to prepare herself as a social worker and the other as a nurse.

Communities and individuals have invested of their own time, facilities, equipment, funds, and other items essential to the provision of project services. The projects have served to bring migrants under the benefits of other programs such as the maternal and infant care program of the Children's Bureau for "high-risk" mothers and children, the Lions Club program for providing glasses for persons with visual defects, and the services of vocational rehabilitation.

One adult worker saved her sight—and perhaps her life—as the result of a visit to a night clinic. Here the physician examining her believed she might have a tumor. The specialist to whom she was referred confirmed his diagnosis. Within 24 hours she was hospitalized in another State. One of the project aides helped her keep in touch with her crew during her month-long hospitalization. With the month over, she was able to return to her crew, alive, well, and able to work.

Many other cases are less dramatic, but also relieve pain, reduce handicapping, long-term disability, and help to make the lives and earning opportunities of migrants a little better.

Still there is much to be done. Grant-assisted projects are reaching only about one-third of the Nation's migrants, and these for only part of the year. Nearly 40 percent of the counties with seasonal migratory workers still have no grant-assisted project services. Medical visits and dental visits made by migrants are only about one-fifth and one twenty-fifth of the national per capita average. These utilization rates are no indicator of need, since infant and maternal mortality in migrant-impact counties are about 125 percent of the national average. Deaths from influenza and pneumonia, tuberculosis and other infectious diseases, diseases of early infancy, and accidents are from 150 to 400 percent of the rates for the Nation as a whole.

As indicated earlier, many services and facilities are forced to operate at a relatively primitive level. Equipment, supplies, clinic facilities, better trained personnel, and expansion of services are greatly needed in many areas if the caliber of health services available to the general population is ever to be approached.

Without continued and expanded financial and technical assistance, much of the current effort would be lost. The President's National Advisory Commission on Rural Poverty has recommended extension of the Migrant Health Act with sufficient funds to expand the program in terms of geographic coverage and services offered. We recommend extension of the act for 2 years, or through fiscal year 1970. By that time, we expect the States to begin providing health services to migrants as part of their continuing operations authorized and supported by the partnership for health. Migrants are only part of a much larger group of rural poor whose health services are deficient.

The Migrant Health Act has and will continue to serve a vital role in developing and stimulating health services to a group whose needs have long been virtually ignored. But we believe that the ultimate mechanism for dealing with the health needs of migrants is the partnership for health legislation adopted by the last Congress and renewed by this Congress just last month.

The momentum behind migrant health programs—and the added stimulus that will be provided by this legislation—will help the States adequately plan service programs so that the special needs of migrants can be met within the framework of health services for all the people.

The advantages of a separate health program to migrant families have been great. But the time will come—and very shortly—when migrant families will be far better served by a recognition on the part of the States and communities that for all their unique problems and needs, migrant families are much like the rest of the population. They must have access to medical services at a price they can afford to pay. By the end of fiscal year 1970, we expect the States to be dealing with migrant health problems as part of a larger program of overcoming rural health deficiencies.

In short, we believe that this separate program of assistance to migrant families is helping to overcome the inequalities in health care between them and the rest of the population, but that in the long run, true equality in health care will be realized only when their needs are not treated separately by the States.

One further amendment we recommend. Because this program is growing rapidly and maximum flexibility in funding is vital if we are to respond to the needs of the project developers, we recommend that specific dollar authorizations not be written into the law, and that you substitute the phrase “and such sums as may be necessary” for the ceilings now proposed in S. 2688.

In closing, Mr. Chairman, I call your attention to the fact that even with extensive mechanization in agriculture, there is no immediate end to the need for migratory labor presently in prospect. As long as the people move, and as long as they have needs, all Americans—as consumers of the products they help to produce and harvest—must help to provide them access to the services enjoyed by the rest of us who represent to them “the other American” of the American dream.

Mr. Chairman, I will be very happy to answer any questions.

Senator WILLIAMS. That is a very strong and helpful statement for those of us who are advocates of this bill. I think that all members of the committee are advocates of continuing this program.

Frankly, I didn't realize that we had reached as many farm families who migrate as you indicate. You said a third have been reached with the health program.

Dr. STEWART. Approximately 30 percent, that is correct, Mr. Chairman.

Mr. CHAIRMAN, I have not been on my best behavior and I should introduce an old friend of yours, Miss Helen Johnston, who is sitting here at the table with me.

Senator WILLIAMS. She was with us last week and she is always with us whenever there is work in this field. Does she help you at all?

Dr. STEWART. Does she help me?

Senator WILLIAMS. Yes.

Dr. STEWART. She teaches me everything I know.

Senator WILLIAMS. She has been a longstanding friend of this committee. We have friends all over the country. Helen Johnston is always there.

We welcome you. Do you have anything to say, by the way?

Miss JOHNSTON. I think Dr. Stewart has said it.

Senator WILLIAMS. Do you have the statistical breakdown of the States and the hospitals that are included in the new program?

Just what States are involved in the hospital part of this program?

You said that 160 hospitals participate.

Dr. STEWART. That is correct.

Senator WILLIAMS. Do you have that figure broken down?

Dr. STEWART. I can give you a distribution of where those hospitals are. It is 100 hospitals that we do have contracts with.

Senator WILLIAMS. That wouldn't be an unusual burden for you administratively to give us?

Dr. STEWART. Not at all. I wouldn't be surprised it is in this book somewhere.

(The information requested follows:)

States in which migrant health projects have agreements with hospitals

State:	Number of cooperating hospitals	State—Continued	Number of cooperating hospitals
Arizona.....	4	Nevada.....	1
Arkansas.....	1	New Mexico.....	1
California.....	1	New Jersey.....	9
Delaware.....	5	North Carolina.....	6
Florida.....	17	Ohio.....	16
Illinois.....	7	Oregon.....	18
Indiana.....	1	South Carolina.....	2
Iowa.....	7	Texas.....	18
Kansas.....	12	Virginia.....	1
Kentucky.....	1	Washington.....	2
Michigan.....	21	West Virginia.....	3
Minnesota.....	3	Wisconsin.....	4
Missouri.....	3		

25 States—164 cooperating hospitals.

Senator WILLIAMS. The bill before us provides for a 5-year extension of the migrant health program.

Dr. STEWART. This I understand. We are recommending a 2-year extension, Mr. Chairman.

Senator WILLIAMS. We are going to keep going for 5 years, anyway, are we not?

Dr. STEWART. I would imagine so.

Senator WILLIAMS. I think 5 years probably is a conservative figure. That program which we know is going to continue might well survive the political demise of some of us. You know what I mean.

Dr. STEWART. Yes, sir.

Senator WILLIAMS. Because there are going to be elections between now and then, so maybe it would be conservative to make it a 5-year program, and then we could be insured against a change along the line.

Dr. STEWART. There is no question in my mind, Mr. Chairman, that the need requires a major effort through one form or another. The needs are great although we have made progress.

Senator WILLIAMS. On a needs basis it should be extended for at least 5 years?

Dr. STEWART. I think there is no question that the need will continue for a variety of mechanisms.

Senator WILLIAMS. I certainly support your comment on the last page of your statement that we authorize such sums as may be necessary. The practical fact around here is we can't get away with that. We have to put the dollar figure in. So we have done it for 3 years and then for the last 2 years we used your phrase, but it is not an accepted way of legislating, as you know.

Dr. STEWART. Yes; we are aware of that.

Senator WILLIAMS. To some degree we have to be practical and conservative. Fred Blackwell lives 15 hours a day with all of the complex problems of migrant farm families and is the staff director of committee. I think he has some questions to ask you, Dr. Stewart.

Mr. BLACKWELL. Dr. Stewart, will you be submitting estimates of need for the first 2 years of extension that you have recommended?

Dr. STEWART. We will be very happy to supply the committee with our estimates of what it looks to be needed for the 2 years that we are recommending.

Mr. BLACKWELL. Could you also submit estimates on the 3 years beyond that?

Dr. STEWART. Yes; we could, I think.

Mr. BLACKWELL. As the chairman has pointed out, the practice in this committee is to indicate ceilings at least in the immediately foreseeable years, and your estimates would be very helpful to the subcommittee and the full committee.

Dr. STEWART. We will be glad to give you the Department's estimates.

Mr. BLACKWELL. Thank you.

Doctor, in regard to overall need which you have not touched upon in your testimony, the most reliable data indicates that the migrant farm family population throughout the country is at least 1 million. Would you comment on the amount or the dollar formula for determining adequate medical care for this population?

Dr. STEWART. Well, you have a population of a million, which includes the women and children in this group who move with their employment, who do not have any location that they call home, although they have a home base. They may spend a year in three of four locations and then many different camps within those locations. They have more disease and more death. They have the disease patterns of 30 years ago. They do not have the means to deal with these. They are required to live in an environment which enhances the infectious diseases rather than protects against them, and they are also a population which by their movement and by their not having roots and by their seasonal employment do not fit into all of the methods we have of trying to provide various forms of care or prevention, and what we are providing is probably somewhere in the order of, oh, 20 percent of what goes to an individual who is living normally in a city as an average worker. The expenditures for health under our program for the Nation as a whole, including local and State contributions, is around \$12 per capita for the one million migrants. If you narrow that down to health expenditures per capita for migrants residing temporarily in areas that are actually served it is about \$20.

If you get it to the person actually served, the amount gets up to around \$35 per person actually served with a medical dental or nursing service.

In the population as a whole the amount ranges, depending on the age of the individuals, somewhere between \$125 and \$200 per capita, so even though there are some problems in comparison here they are of such extremes that the need is quite apparent. We have had trouble in the hospitalization program because even though we have had 160 hospitals cooperating because in order to spread the money we pay only 60 percent of the cost to the hospitals.

I don't know what the hospitals do about the rest of it, but this I am sure works a hardship on some hospitals.

Then there are environmental areas which need correction, which will take some time and effort, particularly the housing and the sanitation, the supply of water, et cetera, so it is a neglected population. They do not have the means of taking care of themselves.

Mr. BLACKWELL. Experience to date indicates that the per capita expenditure for the migrant farm individual is about \$12 per capita compared to the national average of \$100 to \$200 per capita?

Dr. STEWART. Yes; that is about it if you assume that there is nothing else providing medical services for the migrant other than the program we are talking about and the 40-percent contribution from the communities. There are some other sources of funds, but they are very small and so it doesn't really change the conclusion one arrives at.

Mr. BLACKWELL. In your prepared statement you mentioned that about two-thirds of the migrant population was currently not within reach of the existing projects.

Dr. STEWART. That is right.

Mr. BLACKWELL. Do you have an estimate of the cost of reaching that two-thirds with roughly the same amount of care that exists throughout the other programs? Of course, the present amount of care is not up to what you might call adequate care.

Dr. STEWART. Well, if you were going to expand the present project system so that it covered all the migrants at the level that we are now covering those that are covered, you would have to have in the order of \$20 million to \$25 million rather than the present \$8 million that we have. This is a minimal kind of coverage. It does a lot of good, but it is not comparable to what a nonmigrant citizen gets.

Mr. BLACKWELL. To make the level of care in the existing projects of Florida, for example, available nationally, you would have to go immediately to about \$20 million? Is that your estimate?

Dr. STEWART. That would be my estimate which I would like to leave open for correction later on. Some of it depends on where the uncovered people are. It may be that they are in areas where resources are even scarcer than the ones that are already providing services. I would think the projects now are going where there are resources to work with.

With respect to some of them, in many areas it doesn't make any difference how much money you have. There is nothing to put together to provide a service for the migrants. So it may be more difficult. I think one of the things we must understand—and I am sure you do—is that the project grants that we have act as an impetus to organization. The project sponsors organize resources. They provide extra funds for payment of these services. They provide people who work

in a sense as the advocate for the migrant, such as the nurse who works with the migrants, the camps, and so forth, the sanitary aide who works with the grower on improving the plants.

When it gets into the payment for the actual hospital service, or the physicians' service, or the drugs, we will—I think—in the long run have to find ways of developing adapting to migrants methods we have in this country for paying for services for other people. At the present time, this method for needy people is through Title XIX of the Social Security Act. Title XIX has a lot of problems as far as being used adequately for migrant labor, and it may be that as time goes on this will have to be fitted together with other mechanisms, but I can't believe that we will ever reach the level of payment for real hospital service, physicians' services, drugs, the medical care of the migrants, through the project system.

Now, I don't want to say that the project system is not necessary, because it adds to this the real true health component, the preventive services, the seeking out, the advocacy for the migrant, the thing that makes service come about. This is long range I am talking about, but I think this is the area that we hope, over time, to begin to work together on this with the States in developing this.

Senator WILLIAMS. Doctor, we are now working with the project system. This is in a sense opening the door to regular health care for people who prior to this met only closed doors for better health.

Are you suggesting a future regularization of care in terms of perhaps insurance like Blue Cross-Blue Shield.

Dr. STEWART. I think that to really bring up the level of health services—I am talking about personal health services now to the migrants—eventually to the level that is comparable to that for the employed person in an industrial town, will require some form of prepayment program or tax-supported program or others. The project system has brought attention. It has developed the program. It has opened doors. It has added that component which would not be there even if you did have the prepayment system, that is, the public health component, the advocate for the migrant, the health education, the immunization, all of these things which may have to continue as a project, but to really bring up the care to the level that is acceptable, and that the average American in this country receives, is going to take, in addition to the projects, other mechanisms. This is longer range. It is going to be more difficult. We have some mechanisms which have problems with them, but we haven't had a great deal of experience yet with the implementation of the Title XIX section of the Social Security Act and we will have to see. The same thing is true of the rural farm worker.

Mr. BLACKWELL. Doctor, the State of California has been one of the most forward-looking States in establishing programs for migrant farm families, and also for the general populace. In recent years California has enacted the Medi-Cal program and continues to give medical care to all of their people. Isn't there an economic effect or offset that occurs when such a State also has a migrant health program?

For example, doesn't every instance of care extended to the migrant farm family in California result in an economic advantage to the State of California law under its Medi-Cal program?

Dr. STEWART. It is possible that the payment of hospital and physician services under this program is an offset against what would

have been paid out of Medi-Cal. I am not familiar with the details of eligibility in the Medi-Cal program and whether the migrant worker would be eligible or not. This I just don't know. But it is possible, quite possible, that you have a choice here of paying it out of this program or paying it out of another program in California.

Senator WILLIAMS. Gene Mittelman has a question, I believe.

Mr. MITTELMAN. Dr. Stewart, in your discussion with Mr. Blackwell on the disparity between expenditures for migrant workers and those for all other citizens in America, you seem to have assumed that given the same level of per capita expenditures the same level of health might be achieved.

Isn't it true that because of the conditions under which migrant workers are forced to live and work they are actually more susceptible to various types of diseases and injuries than the general populace in the country, so that actually to bring them to the same standard of health more expenditures per capita would be required?

Dr. STEWART. Yes. I thought Mr. Blackwell was talking about the payment of personal health services, hospitalization, and physicians' services. What you are talking about is how do we improve the environment of living and working so it has an impact on how often one gets sick and what diseases one has. I would agree with you entirely that, as long as the environmental situation is as it is in many places, there will always be an increased prevalence of disease and mortality among the migrant workers. These things go hand in hand.

Mr. MITTELMAN. The point that I was trying to emphasize is that the disparity is actually greater when you view it in terms of actual levels of health because migrants require proportionately more expenditures on personal health services to bring them to the same level of health as other citizens.

Dr. STEWART. That is true. The increased prevalence of the respiratory diseases, the increased prevalence of diarrhea disease, which is in every area, is probably a function of environmental living rather than a function of whether one is more susceptible to disease or something like that.

Mr. MITTELMAN. Thank you, Doctor.

Senator WILLIAMS. Doctor, we are grateful indeed. I only apologize for taking so much of your time from your other duties, but you have been most helpful to our committee in our deliberations on this bill. It is still our hope that we can in the closing hours of this session report this bill out.

Dr. STEWART. Thank you, Mr. Chairman. It has been my pleasure.

Senator WILLIAMS. You are a frequent visitor before this committee and we are always grateful to you.

Dr. STEWART. Thank you, sir.

Senator WILLIAMS. And for your "Girl Friday," Helen Johnston.

Thank you, Helen.

Miss JOHNSTON. Thank you.

Senator WILLIAMS. Our next witness is Dr. C. L. Brumback, project director, Palm Beach County Health Department, which is located in West Palm Beach, Fla.

When people hear the name Palm Beach, they think of the luxury on the waterfront. Those of us who have been to West Palm Beach know that that is one of the thriving agricultural parts of our country. That is where you work out in the field.

**STATEMENTS OF DR. C. L. BRUMBACK, PROJECT DIRECTOR,
PALM BEACH COUNTY HEALTH DEPARTMENT, WEST PALM
BEACH, FLA.; AND LEONARD E. WHITE, VICE PRESIDENT,
FLAVOR PICT CO-OP, INC., DELRAY BEACH, FLA.**

Dr. BRUMBACK. Thank you, Senator Williams. This is Mr. Leonard White here with me.

Senator WILLIAMS. Yes; I was just going to suggest that Mr. White come up at the same time so we have a double-barreled Florida here all at once. Thank you.

Dr. BRUMBACK. This is a real privilege for us to be here, Senator Williams, and we both appreciate the opportunity of speaking in support of the extension of the Migrant Health Act and also hopefully increasing its potential through more adequate funding.

Senator Williams, I have a prepared statement. However, I will summarize this in the interest of time, with your permission.

(The prepared statement of Dr. Brumback follows:)

**PREPARED STATEMENT OF CLARENCE L. BRUMBACK, M.D., DIRECTOR, PALM
BEACH COUNTY HEALTH DEPARTMENT, WEST PALM BEACH, FLA.**

Palm Beach County continues to require agricultural workers in large numbers despite some tendency toward mechanization, the effects of which have been largely offset by the development of new acreage for agricultural use. Information obtained from the Farm Labor Office, Florida State Employment Service, showed a population of nearly 30,000 domestic migrant agricultural workers and dependents in the county at the peak of last season. Figures for Florida showed approximately 100,000 migrant workers and dependents in the State during January, 1967. These figures do not include foreign workers. Information obtained for the season ten years ago indicated that migrant populations in the State and Palm Beach County were at approximately the same levels as at the present time. No great change in total requirements for agricultural migrants is anticipated in the foreseeable future.

The tremendous health needs of agricultural migrants in Palm Beach County were recognized many years ago. However, attempts to meet these needs had been sporadic and limited until approximately 12 years ago. At that time a series of studies and service programs were initiated with the help of Children's Bureau grants. These special projects added much to our knowledge of the migrants' health problems and the most effective ways of solving them.¹ Furthermore, they substantiated the necessity of a Federal, State, and local partnership in the development of health services equivalent to those available to the resident population.

Our early experience showed that traditional public health services, inadequate to meet needs of residents, were totally unable to cope with problems of agricultural migrants, especially if the latter constituted a sizeable number of people. The situation was further complicated by the mobility of the migrant population, lack of qualification for local welfare services, their distance from health centers, and the fact that their work made it difficult for them to attend clinics at regularly scheduled times. Obtaining continuity of care was most difficult in the absence of interstate or intercounty referral systems. Lack of health knowledge and unwillingness of migrants to accept traditional services was as great a problem as lack of understanding or motivation on the part of the professional workers.

In Palm Beach County, Federal project funds were combined with State and local money to provide the means for developing special services available at such times and places that migrants could take advantage of them. The services themselves were designed to take the migrants' cultural background and attitudes into consideration for increased acceptability.

Referral mechanisms were developed in cooperation with other agencies so that continuity of care was promoted as migrants moved from one geographic area

¹ Koos, E. L., "They Follow the Sun", Florida State Board of Health Monograph, 1957. Browning, R. H., and Northcutt, T. J., "On the Season", Florida State Board of Health Monograph, 1961.

to another. Services were generalized so that they encompassed needs of the total family group. In this way needs of adults and children could be met in a single visit.

With passage of the Migrant Health Act in 1962, funds became available for development of migrant projects throughout the United States. The many projects which are now in operation have greatly increased our knowledge of migrant health problems and how to deal with them most effectively. Furthermore, these various projects reinforce each other so that migrants may now move from one project area to another along their various streams, and services started in one place may be continued in other locations on the way. Exchange of experience by professional workers has further added to effectiveness of these programs. One of the greatest "spin-off" values derived from these projects has been the strengthening of total public health services through reinforcement of existing programs, and acquisition of knowledge which is especially applicable toward meeting health needs of the poor.

In addition to improvement in the provision of personal health services, significant advances have been made in environmental health. Although State laws and regulations now provide standards for migrant housing and sanitation, such standards could not have been achieved without assistance from the Migrant Health Act. Palm Beach County has 136 farm labor camps with a total capacity of 26,959 individuals. In addition, there are 395 rooming houses with over 5,000 units and 1,300 other dwellings used by migrants. Upgrading these facilities, educating owners, operators, and occupants in principles of environmental health, and developing field sanitation programs could not be accomplished without augmentation of health department staff and facilities.

The Palm Beach County Migrant Health Project has now been in operation over 11 years. In the beginning a disproportionately large expenditure of effort was required to obtain minimum improvements. Health services conveyed to the migrant's doorstep might not be utilized because of ignorance, or fear. Improvement of housing and sanitation was a very slow process with inadequate laws or staff.

Now, migrants travel long distances to attend clinics. They seem eager to obtain information about health. The existence of other projects along the travel routes facilitates the exchange of information on patients. Acceptance of migrants by the communities has improved, largely due to greater involvement in service projects.

The volume of services now being provided to agricultural migrants in Florida is partly reflected by figures obtained from annual reports for the 1966-1967 season. Selected figures are as follows:

Clinic visits.....	43, 236
Field visits (nursing).....	13, 678
Sanitation visits.....	10, 875
Completed referrals (to other counties or States using the migrant health services referral system).....	1, 763

Comparisons with previous years show a marked increase in the various services.

Even though the volume of health services now being provided is great, large numbers of migrants are not adequately being reached. Far too many medical conditions are in advanced stages before they are discovered; there are too many unnecessary deaths. Migrants are learning where to turn for help in treating illness, but we are only making a beginning in teaching the value of preventive measures and positive health. We have a long way to go before the environment in which the migrants live and work is brought up to acceptable standards, and it will take continued efforts to maintain these levels.

When illness is discovered which requires medical care or hospitalization, often for prolonged periods, we remain greatly handicapped in Florida. The funds available for hospitalization are completely inadequate, as are those for payment of physicians. As a result, obtaining treatment; except for emergencies, is often difficult. Hospitals and physicians do continue to provide treatment in many cases without reimbursement, but again migrants are without resources available to the resident population.

Partly as a result of the Migrant Health Act, the State and various counties have increased their efforts in behalf of migrants. However, the task exceeds local capabilities in those areas which continue to have large migrant populations. The intercounty and interstate character of these problems argues strongly in favor of continuation of migrant health programs as special services, at least until other resources become available.

An increase in funds available through the Migrant Health Act is strongly urged. Existing projects are limited in their ability to reach people needing service, or by their inability to provide a full range of medical care. Other areas would like to develop migrant projects, but are unable to do so because of inadequate funds.

Senator WILLIAMS. Certainly.

Dr. BRUMBACK. Since my home county, Palm Beach County, Fla., requires a very large number of agricultural farmworkers, we naturally have been impressed with the tremendous health needs of these people and their families.

When I first came in contact with this problem over 17 years ago, it soon became obvious that major assistance from the Federal Government was needed. Local resources were just not available for more than token support and many of the problems crossed State lines. Local health services are not adequate to meet the needs of the resident population. When 30,000 migrant workers and their family members in one county are added to this resident population——

Senator WILLIAMS. What was that figure?

Dr. BRUMBACK. 30,000 workers and family members, which is a current estimate which I think is quite conservative, and these people have a disproportionately large number of problems.

It is impossible to do more than say that migrants are welcome to attend clinics if they can afford to lose a day's pay, make a 40- to 50-mile round trip, and return as often as necessary to obtain the fragmented services typically provided in most communities.

One would have to assume that the migrants are tremendously motivated to obtain health care and this was certainly not the case a few years ago.

The Palm Beach County migrant project has been in operation over 11 years. The early efforts were assisted by grants from the Children's Bureau, and through these studies and demonstrations we learned about the migrants' health problems, how they attempted to meet these problems, and the factors affecting their attempts at solution.

We learned a number of things which could be done to improve migrant health—the use of intermediary people for education and interpretation, the effectiveness of a multidisciplinary team, the family clinic concept in lieu of the traditional fragmented approach, the importance of providing services at a time and at a place most convenient to the migrant families and, most important, making the services acceptable to these people.

After over 11 years of these projects in Palm Beach County, we are now seeing the payoff of these services. Whereas formerly the services brought to the migrants' doorstep might be refused, now they will travel miles to attend clinics, and we can see the benefits in reduced illness, better nutrition, and much improved general health.

Of course, since 1962, local efforts have been reinforced by other projects. During this past year in Palm Beach County over 11,000 migrants received some type of personal health service—maternity care, immunizations, treatment of illness or injury, planned parenthood service, well child examinations, et cetera.

In addition, most of the 30,000 migrants were affected by environmental health services, improvement of housing and sanitation, and an unknown number received health information through various media.

Figures for the State of Florida obtained from annual reports for the 1966-67 season showed that there were over 43,000 clinic visits, over 13,000 nursing field visits, nearly 11,000 sanitation visits, and 1,763 completed referrals to other counties or other States.

I have some figures on the average per capita cost of personal health services in Palm Beach County. I was unable to get them for the State as a whole. But if we base this per capita information on the total number of the migrant estimated population in the county, we have a figure of \$11.16 per migrant.

If we base this on the number reached, actually reached by services, the figure is \$23.33. Of this the Public Health Service provided \$13.40 of the cost of the service for the migrants reached and \$6.66 based on the total population.

The sanitation services or environmental health services cost approximately \$2.60 per individual served, of which \$1.76 are grant funds.

Although the volume of service rendered taxed the staff to capacity, nearly 19,000 migrants in Palm Beach County received no known personal health services. In many cases the services rendered were inadequate to meet the needs. Lack of sufficient funds to pay for hospitalization or physician services has created an increasingly serious problem in obtaining adequate diagnosis or treatment. Sometimes treatment is delayed until emergency care must be given.

We estimate that our budget of \$334,813, including \$200,268 of Federal money, would have to be at least doubled to provide minimum acceptable care. I am not talking about adequate or optimum, but minimum acceptable care. Much of the increase would be used for hospitalization and physician payments. The balance would be used to augment medical servicing, nutrition, education, sanitation, and social services.

More emphasis could be given to prevention of illness and disability and promotion of positive health, and I think this sometimes is lost when we talk about hospitalization and treatment for illness and injury, already present. We really haven't gotten into a program of prevention in positive health as we should with these people.

To summarize, agricultural migrants are still not receiving anywhere near the same amount of health care available to the resident population. A major portion have not been reached at all by these services. Now, this is in a county that has been providing services through special programs for over 11 years. A good beginning has been made, but much more needs to be done. The interstate character of the problems justifies a continuing partnership of Federal, State, and local agencies in working toward its solution.

The urgency and unusual character of this need requires the special attention which is given through the Migrant Health Act. If we are not to lose what we have gained through these projects, it is imperative that the act not only be extended, but that sufficient funds be authorized and appropriated to provide the needed health services to our agricultural migrants.

Thank you very much, and I will be glad to answer any questions.

Senator WILLIAMS. That is a very helpful statement, I will say on behalf of the committee, Dr. Brumback. We had Dr. Wilson Sowder with us last week. He directs the State health program in Florida?

Dr. BRUMBACK. Yes, that is correct, Senator Williams.

Senator WILLIAMS. And I imagine you work with the State health department.

Dr. BRUMBACK. Very closely.

Senator WILLIAMS. When it comes to applications for funds under our national program, and since you are associated with a county program you coordinate your programs with the State health department?

Dr. BRUMBACK. Yes, we do, Senator Williams. However, we continue to have a separate program. We have had a program first financed by the Children's Bureau and then from 1962 until 1966 shared by the Children's Bureau with the Public Health Service and we are at present receiving funds from the Public Health Service. We do work through the State board of health, but we have a separate program.

Senator WILLIAMS. As I interpret your statement, you feel as though you made a good beginning in Palm Beach. It is Palm Beach County?

Dr. BRUMBACK. Yes, sir.

Senator WILLIAMS. You still have a long way to go and probably in terms of resources you need even today twice as much as the resources that are available?

Dr. BRUMBACK. Yes, this is true, and if this support were lost, although there would be a residual, I am sure, that would carry on, there isn't any question but what the program would be damaged tremendously. We simply would not be able to continue to support anything like the amount of services that we have and we can't see anything in the foreseeable future that would change this.

Senator WILLIAMS. Paul Rogers is the Congressman from that area.

Dr. BRUMBACK. Yes, sir; that is correct.

Senator WILLIAMS. He is in a sense our counterpart on the House side, and I know that you have made your feeling known to Congressman Rogers.

Dr. BRUMBACK. Yes, very much so, Senator Williams.

Senator WILLIAMS. Well, we have had very good cooperation with the House side, through Congressman Rogers particularly.

Dr. BRUMBACK. Yes; he is vitally interested.

Senator WILLIAMS. As a matter of fact, the whole program has gained such general acceptance that this committee has no controversy at all. Obviously you folks who are on the firing line are doing the work and have made the program work and it is known to be effective. It is our job to provide funds so that you can continue working in this area of dedication to people who some years back were almost wholly excluded from regular medical care.

Do you have any questions, Mr. Blackwell?

Mr. BLACKWELL. Dr. Brumback, the State contributes about a third to the program, on a statewide basis? Is that about right?

Dr. BRUMBACK. Well, actually this is predominantly local contributions. The difference between our total amount expended and the amount contributed by the Public Health Service is primarily the local contribution, Mr. Blackwell. The State contributes.

Mr. BLACKWELL. Local and State contribution would be equivalent to what? Would it be as much as a third?

Dr. BRUMBACK. Our total budget at the present time is \$334,000, of which \$200,000 is Federal money, so there is a balance of a little over \$134,000 which is primarily local.

Mr. BLACKWELL. So in your particular project the local contribution is slightly in excess of the State?

Dr. BRUMBACK. Yes, it is.

Mr. BLACKWELL. What was the per capita expenditure for persons reached in your project?

Dr. BRUMBACK. The per capita expenditure for personal health services for the migrants reached was \$23.33 according to our calculation.

Mr. BLACKWELL. And you characterize that, I believe, as minimum health care?

Dr. BRUMBACK. Well, actually when it is realized that this includes hospitalization, preventive care, clinic service, home nursing visits, and all types of health care for a period of 1 year, this is certainly very submarginal as far as trying to deal effectively with the health needs.

Mr. BLACKWELL. What would be the statewide cost of extending the \$100,000 in the State of Florida to the level of care that you have in your project? Would that be \$2.3 million? Is that the arithmetic?

Dr. BRUMBACK. I should guess that the State would want to at least double the amount expended at the present time, the same as we would.

Mr. BLACKWELL. Are you speaking of per capita, doubling per capita, or doubling total project cost?

Dr. BRUMBACK. I am talking about the total project money in order to supply minimal services to these people, because there are still a number who are not being reached, and those who are being reached are not being adequately reached. I think this is extremely conservative, Mr. Blackwell.

Mr. BLACKWELL. You are characterizing it as conservative, because the figure to double would not, on a statewide basis, result in the \$23 per capita expenditure in your project? Is that what you have in mind?

Dr. BRUMBACK. That is correct.

Mr. BLACKWELL. So, if your standard of care were used as the norm statewide, it would be roughly double again.

Dr. BRUMBACK. We don't consider ours optimum at all. We are not providing adequate care. We are not reaching half of the migrant population, so certainly our services are not yet adequate.

Mr. BLACKWELL. Dr. Brumback, I would guess that there is an increasing number of hospitalizations of migrant farm workers subsequent to the establishment of your program, that is, more people are reached, and more people learn about it; there are more illnesses and conditions discovered requiring hospitalization. Is that a sound guess?

Dr. BRUMBACK. Yes, it is. However, also we are cutting down on hospitalization now by being able to reach these people outside the hospital through outpatient clinics, through health education, through better environmental sanitation programs. We are cutting down on the need for hospitalization, and this we can document.

Mr. MITTELMAN. Just a few questions, Dr. Brumback.

Do you have any estimate of the amount of your budget that is spent on preventive, as opposed to remedial services?

Dr. BRUMBACK. I didn't bring figures on this. It would take a while to dig these out. Actually, I would say that we are spending a relatively small part of our budget, unfortunately, on preventive services. Most of the migrants that we see already have defects that require correction. They have illness and injury, and most of our time is spent in diagnosing and treating these things. A relatively smaller part is

spent on preventive work, promotion of positive health, and doing the job that we would like to do. If we did a better job along these lines it would require more immediate expenditures. I think in the long run certainly we would save money.

Mr. MITTELMAN. If you receive more money either from Federal, State, or local sources, would you spend it primarily on more remedial care, or do you think that you could make a more substantial effort in the preventive care area?

Dr. BRUMBACK. I think we can make a substantial effort in preventive services and promotion of positive health. We certainly would set this up as an objective, to expend quite a bit more effort in these directions; that is, toward prevention and promotion of positive health, better nutrition, better general health, better sanitation, and so forth.

Mr. MITTELMAN. Have you made any studies or estimates of the effectiveness of the money spent on preventive care, whether it really produces any significant results at all?

Dr. BRUMBACK. Yes, we have, and we can demonstrate that there has been a marked reduction in illness, particularly certain types, the diarrheal diseases, illness due to poor environmental health. There has been a reduction in preventable disease, and actually we are just beginning now, we feel, to receive the full benefit of programs that have been in effect now for over 11 years.

Mr. MITTELMAN. Thank you.

Mr. BLACKWELL. Doctor, just one final question in the same category. Do you have any findings on reduction of loss of time from work?

Dr. BRUMBACK. Yes. I think Mr. White will speak to this specifically from his point of view; that is, the farmer's point of view, Mr. Blackwell.

Senator WILLIAMS. Fine. Would you stand by while we hear from Mr. Leonard White, vice president of Flavor-Pict Co-Op., Inc., Delray Beach. Mr. White?

STATEMENT OF LEONARD WHITE, VICE PRESIDENT, FLAVOR-PICT CO-OP., INC., DELRAY BEACH, FLA.

Mr. WHITE. Yes, sir, it is Flavor Pict Co-Op. It is actually a family cooperative, but we are still farming as a family, incorporated, in order to market our products in volume.

Senator WILLIAMS. Do you grow mostly citrus?

Mr. WHITE. No, sir; our main item is tomatoes. We shipped about 27 million pounds out of Palm Beach and Martin Counties last year, of the one item. We produce some other vegetables, but our main crop is tomatoes.

Senator WILLIAMS. So it is not citrus at all? Your operation is vegetables?

Mr. WHITE. That is correct.

Senator WILLIAMS. How about strawberries? Do you have any fruits?

Mr. WHITE. We were in the strawberry business several years ago, but due to a few problems we finally decided to get out of it.

Senator WILLIAMS. I think you were wise. We have spent a little time down in strawberry country. I think you made the wise decision. That is rough business, isn't it?

Mr. WHITE. Yes, it is.

Senator WILLIAMS. We have some city boys up here sitting at this committee table, but we have spent a lot of time in the field, and Fred Blackwell and I particularly spent a lot of time in strawberries in Florida, and we concluded that if people can afford to lose that amount of money in strawberries, they would be well advised to get out.

Mr. WHITE. I think if they could afford to lose it, they wouldn't be farming.

It is a pleasure to be here.

Senator WILLIAMS. You mentioned you do a big business in tomatoes. What is the name of the tomato that you grow?

Mr. WHITE. We have the Flavor-Pict registered trademark which you probably have seen on tomatoes.

Senator WILLIAMS. What breed of tomato do you grow?

Mr. WHITE. We grow a trellis or a stake crop, a trellis-grown tomato, which is pruned by hand and only a crown fruit is harvested. It is not the bruised type tomato, that you see a lot of, grown for processing or green harvest. This is a vine-ripened fresh tomato shipped in cardboard cartons, in one- or two-layer cartons, to keep the quality standards where they need to be for fresh consumption.

Senator WILLIAMS. A Florida-developed tomato?

Mr. WHITE. Yes, the varieties that we use were developed by the experiment stations and the university in Florida, and I have worked very closely with experiment stations and these varieties were tried on our farms before they were released.

In the last 10 years we have upgraded our quality and varieties by, I would say, a change of varieties about three times in the last 10 years, and it has added a lot to the quality I think that you receive in the northern markets in the wintertime.

Senator WILLIAMS. Tomatoes are an annual planting. You have a planting each year, don't you?

Mr. WHITE. We plant each year, that is correct.

Senator WILLIAMS. I get a little provincial here. I come from New Jersey, and we have an extension service, and we have Rutgers University. Have you ever heard of the Rutgers tomato?

Mr. WHITE. Yes, I have heard of it, but it doesn't grow well in Florida.

Senator WILLIAMS. It is a good tomato for some parts of the country.

Mr. WHITE. That is why it was grown in New Jersey.

Senator WILLIAMS. Forgive the interruption. We are honored to have you come all the way here to aid us in our deliberations.

Mr. WHITE. I have an outline here of some few remarks. I may deviate from them just a little.

For the background, I am a farmer and I spend most of my time on the farm, about 12, 14 hours a day. The Migrant Health Act needs to be extended from my point of view, if we are to make any progress for the underprivileged migrant agricultural worker and because of his residential requirement for one thing and the transient nature of his occupation, it sometimes doesn't let him stay in one county maybe more than 2 or 3 months or sometimes even a few weeks. The migrant usually lives in a rural labor camp, or in our case, most of our migrants on the farm have housing furnished by the farmer.

Due to this, he does not have access to the programs designed to meet the needs of the local residents. And in addition to the labor that is housed on the farms, we have our day-haul crews which we are all familiar with, and I believe this is where most of our problem arises.

A day-haul crew is usually recognized by either the name of the crew leader or its locality where it stays, but the individuals within the crew are seldom recognized or most people don't even know they exist.

His education is usually neglected and he doesn't realize what medical attention he requires. The community in which he lives is often not aware of his existence or his needs until an epidemic or disaster brings some kind of attention to the general public.

The hospitals and county governments do not usually provide for migrant care in their budgets. The whole community does not usually feel that the migrant is a problem because of nonresidence and therefore excludes him from local assistance from some degree.

Most clinics and doctors are located in cities or in highly populated areas that are usually foreign to the migrant laborer. Due to his rural residence and the nature of his work, it is usually not possible for him to get to town or to a doctor or a hospital during the working hours because he doesn't want to lose the time or the pay that it takes, a sacrifice on his part, in order to get himself to the medical services that he needs.

The family clinics that we have available in the camps now I think have been the best thing that has happened. With the immunization of small children a lot of times other diseases are discovered, enough ahead of time to save great losses both to the farmer in the loss of the use of his labor, loss of time to the hospitals, and to the general public as a whole.

Senator WILLIAMS. Do you have a clinic on your farm?

Mr. WHITE. We have a clinic in the proximity of the farm. It is not on the farm. At times we have had clinics set up where the county health department would conduct clinics in the camp. Now we have it more or less in a permanent location. Since the laborer has learned what it is and that it is there to help him, he can go to it.

I think much time is saved by this, to keep from moving a clinic all the time. The laborer finally has learned to go to it and to trust the people, and we have seen a difference.

Senator WILLIAMS. I imagine you have several farms. As an average, how far would your migrant employees have to go to this clinic?

Mr. WHITE. The location of this clinic from the largest farm we have is approximately 4 to 5 miles.

Senator WILLIAMS. Do these migrants all have transportation?

Mr. WHITE. No, sir. The people that live on the farm or the family units usually have transportation. The singles do not. We have bus transportation for them to the fields. However, for the singles we conduct an inspection of the labor camp each morning. I have kept absentee records on labor for the past 12 years, and I maintain this record for 5 years on each employee. If the employee doesn't move his timecard in the morning, we check it to see what was the cause of his absence. If he was sick, we usually put a "S" on the card. If he was just plain absent, we mark it that.

This helped in a number of ways. It was designed to keep track of a large number of laborers, at the same time find out which ones had a habit of missing weekends and missing certain days of the week, but at the same time it was useful in finding out where the laborer was that had a health problem. The chronic illness is discovered very quickly by this method.

Senator WILLIAMS. You have a timecard on each employee?

Mr. WHITE. We have a timecard system on all the employees that live on the farms.

On the day-haul crews we don't have this service, and this is where the problem still remains, in identifying the particular workers and getting the service to these crews. This is still the major problem.

Senator WILLIAMS. That complicates the social security withholding, doesn't it?

Mr. WHITE. We have tried to help the social security situation with the crew leaders on a contract basis where they have the responsibility to see that social security is deducted, and we usually follow it up to see that it is done. It is pretty well worked out now, at least on our farm.

Senator WILLIAMS. How are your crew leaders now? Would you consider them reliable and responsible leaders of their group of workers?

Mr. WHITE. I would like to answer it this way. Crew leaders in general are one thing. Crew leaders on our farm are something else. We have had several years to develop a record whereby our crew leaders are reliable. We run a man-hour estimate every Friday of the total number of man-hours that will be used on the farm in the next 7 days, and I divide that figure by the number of hours for each worker, and the laborer knows this and we have pretty well steady employment the whole time that they are with us.

Due to this crew leaders are not looking for work part of the time. So, over a period of time there is some competition by crew leaders trying to work for us. I have a list and this is one reason I don't have a shortage of labor, and if I get a crew leader that gets lax in his job, let's say, and doesn't perform satisfactorily, I might dismiss him for a year and let him work in the community and find out what it is like, and he finds out how well he had it. It straightens him out.

All farmers might not be able to do this, but it works very well for us.

Another thing, the total amount of migrant labor in south Florida has not really changed in the last 10 years. We have approximately the same number of migrant laborers in the county that we had 10 years ago, and it is asking too much to tax a local community to pay the bills for people that move into the county overnight, with problems that we have no part of, we don't know anything about, and it reflects back on our local taxes and we have an influx that is tremendous in our county. A few counties in the country provide most of the fresh vegetables for the Nation in the middle of the winter.

I think this is one of the things that needs to be brought out. We have a nation to feed, and because of the climate and other conditions there are certain areas of the United States where these people will congregate in the winter months.

I think this creates a greater problem as far as epidemics or diseases and things that can be carried from other sections of the country are concerned, where a community may not be as strong as it would be if they stayed in the same place all the time.

Another thing that I think ought to be said here from the farmers' point of view is we hear a lot of talk about mechanics taking over agriculture. In the fresh produce or vegetable production we have a long way to go. The processors in the United States have finally developed machinery that will harvest tomatoes that are completely

ripe for processing, for instance, because processed fruit will be preserved, canned, dried, or frozen by some other means immediately after it is taken from the field, and in order to use these same methods for fresh produce, it would require development of new varieties.

For instance, on a tomato it would take one probably with a little tougher skin that would stand more bruising and handling by machinery.

Not only that, in the business I am in, of vine-ripened tomatoes, we pick the field maybe 60 or 70 times in the course of a winter. We don't have a machine yet, and I know of no one being developed, that would be able to separate the color from the immature fruit and the ripe fruit on the vine. These things are going to take several years to develop.

We are in the process now with the university of developing varieties that will lend themselves to mechanical harvesting. We have trials on the farm now. But this will take longer even than the 5-year extension that we hope will be provided here before we can see a difference.

I see no reduction in the need for the total amount of migrant labor in the next 5 years or it is not visible to me from where I sit as a farmer. That may begin to appear, but I think in a county like I live in, where we produce such a mass of vegetables for the Nation's winter consumption and there are so many varieties, so many machines would have to be developed that the engineering staffs at the present time through the universities and private concerns are not available to complete this program.

Senator WILLIAMS. How about the citrus crop? There you have a situation where you don't have to worry as much about bruising, but you still have to worry about the selection of the ripe from the unripe.

Mr. WHITE. Citrus usually matures at a more uniform rate on the tree. If the tree blooms uniformly, you have a uniform ripeness. They go by the test on a solid within the fruit to determine whether the tree is ready to harvest, and they harvest the whole tree at one time. The problem with citrus is that a lot of the older groves were not planted in such a fashion that machines would get in to harvest these rows.

The new ones are being laid out in sort of a hedge type or in rows where the new type machinery will adapt themselves to mechanical harvesting, and I think mechanical harvesting in citrus will take place at a much more rapid rate than it will in vegetables because you are dealing with a particular kind of fruit and citrus is almost the same whether it is in California or Florida or wherever it is. The problem is about the same.

This is about all I have on my report. I will be glad to answer any more questions.

Senator WILLIAMS. You have said a lot of things that have been most helpful to us, and you did indicate your support for the 5-year extension of the migrant health program that the subcommittee is now considering.

Mr. WHITE. That is correct. I think that 5 years we may find will not even be long enough.

Mr. BLACKWELL. Mr. White, did your records in fact show a decline in absenteeism from the fields after the Project Health Care was initiated with your work force?

Mr. WHITE. Definitely it has caused a decline in our particular situation. We are near enough to the clinics so that the families that had chronic problems that needed to be, let's say, straightened out, got the assistance in time, I think, to help us, even to the point where the recordkeeping system now doesn't seem as important as it used to.

There are days now when I even fail to check the camp to see whether they are all working or not. I go by the time cards in the rack.

At one time it was serious enough that I had to check it every day. Now I do not do that, and I believe that we have accomplished quite a lot with the amount of funds that we have. I can definitely see the difference.

Mr. BLACKWELL. You are not giving specific percentages of decline, but if you used to have to check the camp and you no longer consider that a necessity, that implies a dramatic decline in absenteeism.

Mr. WHITE. I look at it from this viewpoint; that it has probably maybe caused a 30- or 40-percent difference in ours. At the same time we have caused families to become aware of medical assistance and a lot of them now have even decided to seek medical aid from a doctor or professional in town on their own.

Those that have transportation eventually go to a doctor and change over. I think maybe this will be the answer in future years when compensation becomes great enough to agricultural workers where they can afford to do it.

Mr. BLACKWELL. Worker attitude is of course subjective and difficult to evaluate. Do you have impressions of better attitudes on the part of the worker that would make him either a better worker or a more satisfactory person to have in your business operation because of the migrant health project?

Mr. WHITE. Definitely, we do. The first experience I had with the attitude change was several years ago when the Asian flu became a serious problem. In our packinghouse we employ approximately 170 workers, and I can recall one afternoon when 80 of those people fell out with the flu.

We took immediate steps to try to remedy or prevent, and we finally supplied medicine and doctor care for particularly the packinghouse crew and the key workers in order to prevent such a thing happening in the future. We haven't done this in the last 2 or 3 years because we have the other program in effect, but when the workers know that you are trying to help, it changes their attitude, and when the farmer helps to support the program, they will get hold of it a lot quicker than they would if it is ignored. We have encouraged it.

Mr. BLACKWELL. Eighty of your workers contracted the flu out of a crew of 170?

Mr. WHITE. That is correct.

Mr. BLACKWELL. That has a rather ominous economic implication. If you had a serious epidemic during a critical time of your processing and picking it would mean dollars out of your pocket, wouldn't it, if your workers weren't there to move the crop?

Mr. WHITE. That is correct. In a fresh vegetable crop you only have a matter of hours or at the most a day or two to stay within the maturity limits of the harvest on the particular crop when it needs to be harvested, and it is a loss if it is not properly harvested and refrigerated and shipped in that length of time, and with a major epidemic like this, it can really put you in a tight spot.

Mr. BLACKWELL. So even the loss of a week's harvest time due to a major epidemic would have a serious economic impact on your crop, wouldn't it?

Mr. WHITE. Definitely it would.

Mr. BLACKWELL. How many members are in your co-op, Mr. White?

Mr. WHITE. There are five at the present time.

Mr. BLACKWELL. And all of them are using the pooled camp facilities and the day-haul?

Mr. WHITE. The way we are set up, as I explained earlier, we are a family co-op, which is my father-in-law, myself, two brothers-in-law, and another member of the family. We farm as one total unit. We turn our production over to the cooperative and it operates this one major unit. We farm in two counties and three major farms, and this is consolidating our management and our sales force and also our labor.

I have been responsible for the labor and the production in the co-op for, well, since its existence.

Mr. BLACKWELL. What is the peak labor force of the five members?

Mr. WHITE. We have a peak force of from a thousand to 1,400, depending on the year and the yield. Usually 1,200 would be a good average. At the present time we have about 500 or a little better employed.

Mr. BLACKWELL. How long have you been farming tomatoes in Palm Beach County?

Mr. WHITE. We started in Palm Beach County in 1953.

Senator WILLIAMS. This committee sponsored legislation providing for a minimum wage for farmworkers on the larger farms. You are clearly under the minimum wage, aren't you?

Mr. WHITE. No, sir; we are not.

Senator WILLIAMS. You are not, with that number of workers?

Mr. WHITE. We are under the minimum wage, I guess, for agricultural workers, if that is what you are speaking of, yes.

Senator WILLIAMS. Yes.

Mr. WHITE. I think all the farmers pretty well pay that because when a large one has to pay the scale, the small ones have to follow or they do not get the labor.

Senator WILLIAMS. Even though they are not under the legal jurisdiction of the minimum wage legislation as a practical matter, they will have to follow you?

Mr. WHITE. The economics would dictate that.

I believe the one thing I would like to comment on is the minimum wage for agricultural workers as it is listed doesn't cover everything that it costs the farmer. We supply our labor with their housing, their electricity, their gas, and all the utilities, and even the transportation to work in addition to this wage in most cases, with the exception of day-haul crews which do not get all of these same benefits.

You add all this up, and it takes the farmer quite a lot more than what appears on a payroll sheet.

Senator WILLIAMS. The minimum wage is still at a dollar an hour, as I recall but in February it goes to \$1.15. I imagine your workers make a lot more than that, anyway.

Mr. WHITE. We work on an hourly base. Our own minimum is a dollar. Many make more than that, and of course the packers make more.

Senator WILLIAMS. Because not only do they have the floor of the minimum wage. They have the piece rate?

Mr. WHITE. We do not work piece rates, but we remember that if the dollar is the minimum, it is only your lower or less producing worker that is going to make a dollar. If a man is worth more than a dollar, definitely you are going to pay him more than a dollar. This is true in any industry, I think.

Senator WILLIAMS. This is December. Are you harvesting anything right now?

Mr. WHITE. Yes; we are harvesting in fact quite a lot of tomatoes right now. We are harvesting about 10,000 or 12,000 20-pound cartons of tomatoes today at the present time, which is a little more than we usually do in the first of December.

February, March, and April are our heavy months.

Senator WILLIAMS. I am advised that you and Dr. Brumback are good friends and closely associated.

Mr. WHITE. Yes, sir.

Senator WILLIAMS. And you worked this appearance here in Washington before this committee out together; is that right?

Mr. WHITE. That is correct.

Senator WILLIAMS. Well, we are grateful, indeed, to both of you. Do you farm in two counties?

Mr. WHITE. We farm in two counties.

Senator WILLIAMS. We know that Palm Beach County has a good working health program. How about the other county?

Mr. WHITE. The other county that I farm in is Martin County, which is on the north boundary of Palm Beach County, but the laborers that we have in that particular county do not receive the services or are not available to them as they are in Palm Beach County. I am not sure what the extent of the program is in Martin County, but we are located in a rural area that does not have access to the clinics in this particular county.

Senator WILLIAMS. Wouldn't it be in the interest of growers in your position to stimulate Martin County to start these health programs?

Mr. WHITE. It would be of interest to us. However, you probably know that most farmers are so busy tending to their own business that the majority of them do not give labor the attention that it needs.

I have been labor-minded since I have been in this business. I suppose that is why I am here today. I think, if they were approached, and maybe it should be my responsibility to try to help with this, that it would be in the best interests of all of us to try to promote this program, to get it to those workers that are not receiving it now.

Senator WILLIAMS. Are you a member of any farm association?

Mr. WHITE. Yes; I am a member of the farm bureau, and other local associations.

Senator WILLIAMS. You are a member of the farm bureau?

Mr. WHITE. Yes, sir.

Senator WILLIAMS. I don't know if they have taken an official position on the extension of the Migrant Health Act. Have they?

Mr. BLACKWELL. They have no position. Mr. White, you are speaking as a grower, as an individual, and not for the farm bureau?

Mr. WHITE. I am speaking strictly as an individual grower right now.

Senator WILLIAMS. Well, you certainly have a most enlightened labor policy. That is obvious from what we know and what you said here today. Sometimes we wish we could get a positive position from the farm bureau organization. We haven't been successful to date, have we Mr. Blackwell?

Mr. BLACKWELL. No, sir.

Senator WILLIAMS. They did support the housing bill for migrant workers. Mr. White, see if you can't get the farm bureau to think your way on health matters.

Mr. WHITE. All right; I will try.

Senator WILLIAMS. Anything else, Mr. Blackwell?

Mr. BLACKWELL. No.

Senator WILLIAMS. At this point I will insert in the record the prepared statement of Leonard E. White. We are grateful, indeed.

Mr. WHITE. Thank you.

(The prepared statement of Mr. White follows:)

PREPARED STATEMENT OF LEONARD E. WHITE, VICE PRESIDENT, FLAVOR PICT CO-OP, INC., DELRAY BEACH, FLA.

The Migrant Health Act needs to be extended if we are to make any progress for the underprivileged migrant agricultural worker who usually does not meet residence requirements where he lives. The transient nature of his occupation usually leaves him unknown and often unaccepted in society.

Because the migrant usually lives in a rural area in a labor camp, or housing furnished by the farmer, he often does not have access to local programs designed to meet the needs of local residents.

His education is usually neglected and he does not realize what medical attention he requires. The community in which he lives is not often aware of his existence or needs until an epidemic or disaster of some kind brings attention to the general public.

Hospitals and county governments do not provide for migrant care in their budgets. The local community does not usually feel that the migrant is their problem because of non-residence and therefore excludes him from local assistance.

Most clinics and doctors are located in cities or highly populated areas and in surroundings foreign to the migrant laborer. Further, because of his work schedule, loss of time and pay, he does not seek medical aid when it is needed. To provide the minimum of care for these people we should make clinics available in large labor camps, or other rural areas where the migrant can be taught what he needs to know about his own personal health as well as having medical assistance available possibly after work hours or at least accessible to him.

Much progress has been made since our local mobile clinics have been operating in rural areas. Many cases that could cause epidemics or serious health hazards are discovered sooner than they would if neglected, saving much time and grief to the migrant as well as losses to the farmer, the local hospitals, etc.

The total amount of migrant labor used in South Florida has not decreased in the past 10 years. The size and scope of the problems still remains before us. It is too much to tax a local community to pay the bills that they might not have any control over. The problem is interstate and national in scope.

There has been and still is a lot of talk of mechanization taking over the agricultural industry, which would replace the migrant. With mechanization advancing in the past ten years, it still has not relieved the need or visibly reduced the number of migrant laborers needed to harvest our crops. Our population is growing requiring more food. In the next four or five years it does not appear that varieties of vegetables will be developed fast enough to lend themselves to mechanical harvesting as fast as some would think. Some particular crops such as beans can be harvested mechanically for fresh market, others for processing may be harvested mechanically and this is being done. In Florida where the nation's large supply of fresh vegetables, for winter consumption is grown, a different problem exists. Most vegetables for fresh market must be harvested by hand until such time as the machinery and varieties are developed to change over. This takes several years at a minimum and very likely later than the extension of the Migrant Health Act would last. Any decrease in migrant labor needs is yet to be seen, and it does not appear to be as soon as most would like to think.

Senator WILLIAMS. The witness list indicates that the next three witnesses have much in common, all coming from the health care area and farmwork. Possibly we ought to create a little panel of Mr. Jose Gonzales, Dr. Virgil Gianelli, and Dr. Robert Locey.

Why don't you one by one identify yourselves and the position from which you speak.

STATEMENTS OF JOSE L. GONZALES, DIRECTOR, LAREDO-WEBB COUNTY HEALTH DEPARTMENT, LAREDO, TEX.; DR. VIRGIL GIANELLI, PROJECT DIRECTOR, SAN JOAQUIN COUNTY MEDICAL SOCIETY, STOCKTON, CALIF.; AND DR. ROBERT P. LOCEY, DIRECTOR, MIGRANT HEALTH PROGRAM, TRICOUNTY ASSOCIATED HEALTH DEPARTMENT, ST. JOSEPH, MICH.

Dr. LOCEY. Dr. Robert P. Locey, from the southwestern corner of Michigan.

Dr. GIANELLI. I am Dr. Virgil Gianelli.

Senator WILLIAMS. That is St. Joseph, Mich.?

Dr. LOCEY. That is St. Joseph.

Dr. GIANELLI. And I am from California. I am a physician in private practice, also project director for our local project, and president-elect of my society.

Mr. GONZALES. I am Jose Gonzales, acting administrator of the Laredo-Webb County Health Department, and project director of the Laredo migrant program.

Senator WILLIAMS. You share that activity in common, do you not? You are all project directors in this field?

Dr. GIANELLI. Right.

Whom do you wish to have first, Mr. Chairman?

Senator WILLIAMS. Why don't you start, Dr. Gianelli?

Dr. GIANELLI. Thank you.

This morning I wish to outline for you experimental programs undertaken by the San Joaquin Medical Society as they relate to medical care of migrant agricultural workers.

For the sake of orientation, the society comprises four counties in central California, of which San Joaquin is ranked as the fourth richest agriculturally in the Nation with a 1966 farm income of \$252,862,843. During 1965, farm employment ranged from 11,750 in the winter to 24,475 in the fall at the peak of the tomato harvest. The volume of farm workers depends heavily on migrants who come to San Joaquin County during the major harvest activity. As near as we can determine, the migrant population is between 12,000 and 14,000 with the major influx of out-of-State workers from Texas, Oklahoma, Arkansas, and New Mexico entering California at the South and following the crops northward through Oregon and Washington.

In 1954, the San Joaquin Medical Society, in an attempt to bring the benefits of modern medical care to all people, established the foundation for medical care, which embraced the principles of prepayment, fee schedule, claims review and quality control. It was then that our agricultural committee began meeting with representatives of organized agriculture in an attempt to meet the health needs of the worker. This activity continued for 6 years without bearing fruit.

With a feeling of frustration, we engaged in a radically different approach in 1960 when members of the society voluntarily staffed a clinic for migrant agricultural workers in proximity to a soup line and used clothing depot. Three years later it was apparent that we were reaching too few people by waiting for those who were forced to us through hunger or nakedness.

At this time, we inaugurated the policy of going to the people in the fields and their camps on the riverbanks, using the trunk compartment of automobiles as dispensaries.

To the question "Why don't you go to the county hospital?", the answer was, "We don't belong there. They don't like us, but we know that you like us because you have come to us when you did not have to do so." To the confession, "We are bringing you very poor medical care," the answer was, "We know that, but at least someone is at last trying to do something."

While out among the people, we observed the activity of the local public health nurses and sanitarians. It was a normal evolutionary development that when we wrote a program seeking to bring comprehensive medical care to these people that it should be a joint effort of the San Joaquin Medical Society and the San Joaquin local health district. We submitted a budget of \$315,000 this year and received grants from the following sources:

1. Initial grant from California State Department of Public Health, \$76,322.
2. U.S. Public Health Service, \$60,901.
3. California State Department of Public Health, another grant of \$25,000.

There are two migrant housing facilities in the county: one situated in the northeast portion adjacent to the county dump, Harney Lane Camp, containing 100 units. The other is in the south-central portion adjacent to the county hospital, Matthews Road Camp, with 144 units. Two fixed clinics were operated at the camps Monday through Friday from 7 p.m. until all patients were seen.

The Harney Lane Clinic operated for 6½-months; The Matthews Road Clinic, with 44 occupied units for 6 months, and with 144 occupied units for 4 months.

Obviously, the great majority of the migrant workers are living elsewhere and it was for this reason that we became interested in the mobile clinic concept.

A mobile clinic traveled 5 nights a week to outlying areas with particularly high farmworker populations, for a period of 4 months. We missed the cherry harvest, with a peak employment of 9,300. Our statistics cover a period to November 1, 1967. These variable intervals were necessitated by delays in construction and lack of funds.

Senator WILLIAMS. What does that mean exactly, Dr. Gianelli, when you say that you missed the cherry harvest?

Dr. GIANELLI. The cherry harvest occurs in May. The people come into the area about March and April. They come in early. If I may digress, if you have the time, the people that are going to pick cherries come into the area much earlier than the harvest season. I asked one woman why she was so far in advance of the harvest season and she said, "My husband and I cannot afford to miss the picking of cherries because it represents a large part or the largest part of our annual income."

I said, "Where are you from?" She said she was from the Bakersfield area. I said, "Why didn't you step into the farm employment office and find out when the cherries were ripening in San Joaquin County?" The reply was the only information they had available is for their own immediate use.

She said, "It is necessary for us to come up here ahead of time because there is such a competition that we have to line up the grower well in advance or somebody else will get the job."

I said, "Economically, what does this mean to you?" She said, "Well, in the Bakersfield area my husband and I, working full days at the best, the best day we had, was \$9 earnings for both of us, whereas in cherries the two of us working together can earn \$50 a day." So this year we were not funded early enough to man our clinics during cherry season; 2,693 patients were served with 7,129 visits in 379 sessions; 201 patients were referred to the offices of specialists in private practice, 93 to dentists, and 239 to private clinical laboratory and X-ray departments. There were 98 women given prenatal care and 183 took advantage of family planning and other gynecological services such as Papinicolau smears. They were served by Board-certified or Board-eligible gynecologists.

Children not only were treated for acute illnesses but also were seen for counseling, well-baby checkups, immunizations, and tuberculin skin testing.

While on the subject of tuberculosis, it should be noted that skin testing was a routine for adults also and those who reacted positively had chest X-rays. We found only one case of active tuberculosis. One adult whose skin test converted is receiving treatment. Seven children who had positive skin tests are undergoing treatment. We think this demonstrates that tuberculosis among migrant agricultural families is not the problem that it has been among the single migrant workers.

Four children were seen suffering from malnutrition, and 15 children and six adults with anemia.

Since our request for private hospitalization was disallowed because of lack of funds, patients were hospitalized at the county hospital. There were 36 such, of which 12 were maternity and five were newborn. There were 31 additional patients whom referring physicians felt should be hospitalized but who were not accepted by the county hospital because of the lack of continuity of care; that is, physicians in training overruled the judgment of senior physicians who had been following the patients, and the other reason is the elective procedures, as now there is a residence requirement in the county for what is termed or thought to be an elective procedure, and this elective procedure is a bugaboo in California at the moment, and I am sorry that Senator Murphy is not here with you this morning.

If I can make myself clear on that, for example, a gynecologist might see a woman and decide that she has an ovarian tumor. To this man with experience this could very well represent a cancer. To him this is an emergency procedure. But a house officer at the county hospital can examine the woman and decide that she has a benign cyst which can be taken out in some other county and so the woman is turned away, so that we feel that hospitalization is a very important part of our program because without it it is difficult to keep the morale of the physicians participating at the proper level.

From the foregoing, it is evident that we saw approximately 20 percent of the migrant farmworkers in our area. In anticipation of the question, "Why can't these people be seen under title XIX?" there are several points for consideration. As I have intimated above, these people are so thoroughly alienated from the rest of society that they will not seek out the medical services that are available. Secondly, they are not sophisticated enough to seek care for minor ailments, and least of all, for preventative care. Thirdly, during the major peak harvest period, their income makes them ineligible, according to regulations, for categorical aids.

In practice, we have found that it is necessary for bilingual health aides and nurses to contact the people during the daytime, ferreting out those who are ill, urging them to attend the clinics, double-checking to ascertain that they have done this, making the appointments for specialist referrals and checking to see that the patients go to the physicians' offices.

We should not assume that upon entering a community these people will follow the usual custom of contacting a physician for a routine physical checkup and making arrangements for emergency care if it should arise. Moreover, they are reluctant to take time off during the peak harvest season. As one cherrypicker remarked to me when asked why he worked while ill, "During the 3 to 4 weeks of the cherry harvest, I earn a large part of my annual income." Experience has taught us that the medical needs of these people cannot be met in the usual manner. The clinic, operated in the midst of the migrant agricultural workers, is tailored to their needs. This concept has been acceptable to the physicians. At no time did we suffer from a lack of competent professional involvement. The major physician criticism was the inability to follow through with hospital care when it was indicated. If funds are available, suggested improvements have already been tabulated for the coming season.

Another major area of deficiency is dental care. Because of limited funds, we restricted this to those in need of emergency treatment. We would like to greatly enlarge dental coverage. Of 150 dentists canvassed, 56 agreed to participate under the program.

Government funds are dispensed through the aforementioned foundation. The clinic physicians are paid on an hourly basis. The claims of those seen in private offices on fee-for-service basis are all reviewed by physicians and dentists.

Drugs usually are dispensed by the clinic doctor, but since the formulary is limited, arrangements were made to have prescriptions filled in private pharmacies. These claims were reviewed by a committee of the San Joaquin Pharmaceutical Association. Prescriptions written in private offices are also handled in this manner.

Until 1965, we had braceros in California who were furnished well-integrated medical care by international agreement. This was good. However, our own people have had to obtain their medical services on a "catch as catch can" basis. Their chief protection has depended on a thin line of committed people with meager economic resources upon which depends the awful responsibility of ultimately defending the honor of a nation before God and before humanity.

Some additional facts have been discerned. Medicine is a pluralistic discipline. No one scheme of action will serve all the people. With regard to migrant agricultural workers, close cooperation between

the county medical society and the local health district has proved fruitful. We feel that these organizations should work out their unique problems together on the local level.

It has been said that these patients will not use private facilities, but 496 of the 2,693 did just that. As of this moment, we have received followup reports concerning 60 percent of this group and more are expected within the next few weeks.

We are developing statistics that hopefully will be used to develop prepayment plans for the health care of agricultural workers. In the meanwhile, we have publicly stated that we believe it is the duty of Government to give assistance when the private sector cannot or will not cooperate. Migrant health funds are in essence a farm subsidy whereby the farmer receives healthier, happier, and more productive personnel and the physician is allowed to live with his conscience.

We feel that health education occurs whenever an aide, nurse, or physician, sees a patient. We do not believe that scheduling a health education lecture and movie in the evening, when these people are available, but when the children are fussing and the parents are tired after a day of hard labor, accomplishes its objective.

Our critics have said, "This program seems to work in your area, but it won't work in ours." We have no secret formula, but we would remind you that these people have been dehumanized as evidenced by such terms as "Wino," "Fruit-bum," "Okie," "Arkie," and "Spic." They can be rehumanized by the interest and love of their fellow man.

There is just one point in it that I would like to call to your attention that you might miss otherwise, and that is the emphasis is being placed upon the health of the migrant families. We have said practically nothing, just one reference, to single men who are also engaged in agriculture and are migrants and this is a forgotten group. It is in this group that we have found most of our TB, for example, although I think we have made progress. In 1955 the morbidity rate was 20 per 1,000. In 1966 it was 3.6 per 1,000. We are formulating plans to adequately or at least more adequately incorporate this group, which is sizable, in our next year's program if we can afford it.

I would like to introduce exhibit A for insertion in the record.

(App. A follows:)

APPENDIX A

PROVISION OF COMPREHENSIVE HEALTH SERVICES FOR MIGRANT AGRICULTURAL WORKERS AND FAMILIES IN SAN JOAQUIN COUNTY—SAN JOAQUIN COUNTY MEDICAL SOCIETY PROGRESS REPORT, AS OF NOVEMBER 30, 1967

During the period April 1–November 30, 1967, health services for migrant agricultural workers and families were provided as proposed in the original comprehensive plan, with the exception that inpatient care in community hospitals could not be provided, because this portion of the project was not funded.

I. *Administrative Accomplishments* during the period April 1–November 30, 1967, included:

A. Execution of agreements for support of the project and provision of services:

1. Contract No. 664 with the California State Department of Public Health, for support of fixed clinic services at Harney Lane and Matthews Road Camps (\$76,322).

2. USPHS Grant No. MG-157 (67) for support of mobile clinic services (\$60,901).

3. Contract No. 140 with the California State Department of Public Health for additional support of fixed and mobile clinic services (\$25,000).

4. Agreement with the San Joaquin Local Health District for provision of public health nursing, clinic nursing, health aide, and clerical services at migrant medical clinics and in migrant camps.

5. Agreement with Regional Demonstration Center, Migrant Education (Tricounty Migrant Education Project), for provision of medical, public health nursing, and related services for children included in the migrant education project.

B. Development of plans for implementation of the project, including specific procedures for clinic operation, referral and consultation, coordination of in-office and clinic services, records.

C. Recruitment of medical, dental, and ancillary personnel:

1. 112 physicians from all areas of the County agreed to provide in-office service and/or to staff the medical clinics.

2. 41 dentists from all areas of the County agreed to provide dental services.

3. Five clinical laboratories, five pathologists, and seven radiologists agreed to provide clinical laboratory and radiological services.

D. Design, procurement, and equipping of a mobile medical clinic unit.

II. *Medical Services.*—During the period April 1 to November 30, 1967, medical services were provided at—

A. *Harney Lane Migrant Camp.*—Services initiated on April 17, 1967, five evening clinics per week, 3 to 4 hours/session:

Number of clinic sessions.....	148
Number of individuals served.....	1, 043
Number of clinic visits.....	3, 133
Average attendance per clinic session.....	21. 2

B. *Matthews Road Migrant Camp.*—Services initiated on May 15, 1967, five evening clinics per week, 3 to 4 hours/session:

Number of clinic sessions.....	133
Number of individuals served.....	764
Number of clinic visits.....	2, 193
Average attendance per clinic session.....	16. 5

C. *Mobile Medical Clinic.*—Services initiated on July 10, 1967, one night per week at each of five locations, 3 to 4 hours/session:

Vernalis:

Number of clinic sessions.....	19
Number of individuals served.....	293
Number of clinic visits.....	532
Average attendance per clinic session.....	28. 0

Terminous:

Number of clinic sessions.....	21
Number of individuals served.....	105
Number of clinic visits.....	249
Average attendance per clinic session.....	11. 9

Thornton:

Number of clinic sessions.....	21
Number of individuals served.....	215
Number of clinic visits.....	478
Average attendance per clinic session.....	22. 8

Linden:

Number of clinic sessions.....	20
Number of individuals served.....	154
Number of clinic visits.....	342
Average attendance per clinic session.....	17. 1

Acampo:

Number of clinic sessions.....	19
Number of individuals served.....	119
Number of clinic visits.....	202
Average attendance per clinic session.....	10. 6

Total, Mobile Clinic Unit:

Number of clinic sessions.....	100
Number of individuals served.....	886
Number of clinic visits.....	1, 803
Average attendance per clinic session.....	18. 0

D. Total, All Clinic Services.—

Number of clinic sessions.....	381
Number of individuals served.....	2, 693
Number of clinic visits.....	7, 129
Average attendance per clinic session.....	18.7

Medical services at the Harney Lane and Matthews Road clinics were terminated on November 10 and November 17, respectively, when the camps were closed for the season. Mobile clinic services were terminated at Acampo, Terminous, and Vernalis on November 17, by which time most migrant families had departed from these areas. The mobile medical clinic continues to visit Linden and Thornton once weekly.

E. In-Office Medical Services.—In-office services were initiated during July, 1967, after funding of all components of the project was assured. As of November 30, 533 referrals had been made, 310 (58.2%) of which were successfully completed:

	Physician office		Private laboratory		X-ray		Dental		Total	
	Referred	Completed	Referred	Completed	Referred	Completed	Referred	Completed	Referred	Completed
Harney.....	59	35	90	74	17	11	20	9	185	129
Matthews.....	67	40	32	21	12	9	45	23	156	93
Mobile.....	75	27	55	35	33	18	28	8	191	88
Total.....	201	102	177	130	62	38	93	40	533	310

Reports on referrals continue to be received. Some patients deliberately delayed acceptance of referral until they were no longer working. The final proportion of successful referrals (on which reports will be received) will undoubtedly be higher than the 58% presently recorded.

F. In-Hospital Care.—The hospitalization component of the original comprehensive plan was not funded. All patients in need of hospital care were therefore referred to San Joaquin General Hospital. During the period April 1–November 30, 89 patients were referred for in-patient care:

	Obstetrical care	Other inpatient medical and surgical	Total
Harney.....	13	19	32
Matthews.....	10	24	34
Mobile.....	5	18	23
Total.....	28	61	89

Recorded referrals and admissions for hospital care do not adequately reflect the need of migrant families for such care, for the following reasons:

(1) The Harney Lane camp operated at capacity for less than seven months; Matthews Road camp was occupied for six months, but operated at full capacity for less than four months. The mobile clinic service was provided for less than five months; no service was provided in outlying areas during the months of April, May, June, during which months San Joaquin County experiences the largest influx of migrants (cherry season).

(2) San Joaquin General Hospital staff may not admit all referrals, particularly some for whom, in the opinion of clinic physicians, elective procedures are indicated. The number of such patients has not yet been documented.

(3) Inpatient care was provided at San Joaquin General Hospital for some migrant individuals who received no clinic services at the camps, but went directly to the Hospital. Efforts are under way to identify these individuals.

III. Conditions For Which Medical Services Were Provided.—A statistical record was prepared for each service provided in the program. Analysis of these records is now in progress, and detailed tabulations of conditions diagnosed and treated

and of services rendered, are not yet available. Preliminary review of clinic records indicates that comprehensive services have been provided for a wide range of conditions:

Adults served at the clinics were found to have a wide range of chronic conditions: anemia, arthritis, diabetes, other endocrine problems, hypertension, chronic respiratory disease, obesity, minor and major surgical problems.

Approximately 17% of all clinic visits were for diagnosis and treatment of respiratory infections.

Obs.-gyn. services included prenatal care, family planning, diagnosis and treatment of g.u. infections and other gynecologic problems. Obs.-gyn. services were provided regularly by qualified gynecologists at each clinic location; these sessions were conducted in addition to the general medical clinic sessions. Special efforts were made by Health Aides to promote client acceptance of prenatal and family planning services:

	Prenatal		Family planning and other gynecology		
	Receiving care	Delivered in San Joaquin County	Patients	Visits	Pap smears
Harney.....	37	13	53	71	48
Matthews.....	33	10	70	79	70
Mobile.....	28	5	60	72	59
Total.....	98	28	138	222	177

Approximately one-half of all clinic visits were made by children. Services included not only care for acute illnesses, but also examination and counselling of well infants, preschool, and school age children. Qualified pediatricians staffed each clinic at least once weekly. Although children having acute problems were seen daily, effort was made to refer children to the pediatrician whenever possible.

Immunizations were provided at all clinic sessions. Some 3304 immunizations were administered (DPT, DT, Polio, Measles, Smallpox). The numbers of completed series of the several immunizations have not yet been tabulated. Particular effort was made to immunize adults as well as children.

Tuberculin skin tests were done routinely for children and for as many adults as possible. The Health District and Bret Harte clinic provided chest x-rays and other indicated examination for tuberculin reactors. To date, followup has been completed for 72 of 106 such referrals. One case of active tuberculosis was diagnosed. One adult male "converter" and seven tuberculin positive children were placed on INH prophylaxis after receiving complete evaluation. Local, intrastate, and interstate followup on other tuberculosis suspects continues. Although tuberculosis case-finding efforts have not yet been evaluated adequately, the prevalence of tuberculosis among migrant families does not appear to be as high as that observed among single male transients in this County. (In a continuing case-finding program which has been conducted since 1953, the active tuberculosis case rate among these men has ranged from a high of 20.2 cases per 1,000 men examined in 1955 to a low of 3.4 per 1,000 in 1966.)

IV. *Public Health Nursing, Health Aide, and Related Services.*—Detailed reports on Public Health Nursing and Health Aide services are not yet available. Public Health Nurses and Health Aides served at each clinic location five nights per week, as provided in the project plan. In addition, Public Health Nurses and Health Aides paid from regular Health District budget provided services daily to all camps and the two day care centers, during regular working hours.

Amblyopia screening and audiometric screening were provided for children attending the two day care centers during the summer months. Public Health Nurses provided followup for children found in need of further examination.

Two Health Educators on Health District staff assisted physicians, other members of clinic staff, Public Health Nurses, and Health Aides, in providing health education services. Educational materials were provided in Spanish as well as English. Although project staff participated in some group activities, person-to-person contact was emphasized.

Medical, nursing, and related services were coordinated with the activities of a Federally funded migrant education project conducted in the two fixed camps. Particular effort was made to ensure that preschool and school age children received medical evaluation and other preventive medical services.

V. *Population Served.*—Accurate figures regarding the population served are not available at this time. However, estimates derived from several sources

indicate that at least 6000 persons had immediate access to medical and related services provided by the project.

Occupancy at the two fixed camps varied during the seven month period:

Harney Lane—low of 75 families, high of 126 (June).

Matthews Road—low of 42 families, high of 140 (September).

Data regarding family size and length of stay in the fixed camps are available, and will be analyzed. Public health nurses have identified several groups of migrant families who did not live in the fixed camps, but who utilized the camp medical clinic services.

Estimates only are available for the migrant population in the areas served by the mobile medical clinic:

Acampo, 400-500 (includes 40 families in one private camp).

Linden, 1000-1200 (several private camps).

Terminus, 50-75.

Thornton, 150-200.

Vernalis, 500-550 (80 families in private camps).

Continued effort will be made to obtain more reliable estimates of the migrant population during various times of the year.

In previous years, the migrant population in San Joaquin County has been estimated as 12,000-13,000. A large proportion of total migrants comes to this County during cherry harvest (May-June). Although medical services were initiated at the Harney Lane Camp in April, the mobile clinic service did not start until July. Operation of the mobile clinic during the period April-June next year will allow provision of care for a greater number of migrants than received service this year.

VI. *Costs.*—All claims for payment for services and supplies have not yet been received, and project records have not yet been audited. However, current review of records indicates that all components of the project have remained well within the amounts budgeted. All services provided will be subjected to cost analysis when the projects are completed.

VII. *Problems Encountered.*—

A. The hospitalization component of the comprehensive project could not be implemented, because funds for this purpose were not available. Individuals in need of inpatient care were referred to San Joaquin General Hospital, resulting in loss of continuity of care.

B. Initiation of in-office care and utilization of laboratory resources were necessarily delayed until adequate financial support was assured in July.

C. Facilities at Harney Lane and Matthews Road Camps were less than ideal for clinic activities. A portion of available space was necessarily used for other camp activities (educational and social). Opening of the second unit at the Matthews Road Camp improved the space situation for the clinic at that location.

D. Attendance at the first few sessions of the mobile clinic was low, even though efforts to stimulate attendance were made prior to the clinic dates. Public Health Nurses and Health Aides devoted additional time to locating migrant families and providing information about available services, with the result that mobile clinic attendance increased during succeeding weeks.

E. Dental care was provided for a relatively small number of individuals. The project budgets included only token amounts for dental care, and referrals initially were limited to patients having dental emergencies. Late in the summer, permission was granted to use otherwise uncommitted funds for purchase of additional dental services. However, time did not permit development of a more comprehensive service before the fixed camps were closed.

VIII. *Plans for 1968.*—Physicians in San Joaquin County believe that the feasibility and desirability of providing comprehensive medical services for migrant families have been demonstrated. If adequate financial support can be obtained, services for 1968 will include:

1. Outpatient medical services at the fixed migrant camps, beginning in April, 1968. As the existing State OEO contracts terminate March 31, 1968, medical services can be provided at Harney Lane and Matthews Road camps only if funding is assured prior to that date.

2. Mobile medical clinic services to outlying areas in which migrant families will reside. Experience gained during the first five months of the current project will be utilized in determining the locations to be served. Consideration will be given to providing medical services for single male agricultural workers, if facilities are provided for housing these men next

year. As the existing contracts for support of the mobile medical clinic terminates on June 30, 1968, provision of services during the summer and fall will be contingent upon receipt of assurance that this program will be funded during 1968-1969.

3. In-office medical, dental, laboratory, and radiological services. During a five month period, this project has demonstrated that migrant individuals have a need for medical services more comprehensive than can be provided in a camp clinic. The project has also demonstrated that, contrary to the beliefs of some, migrants will accept referral to private resources, if assisted in doing so.

4. Hospitalization in community hospitals in the areas in which migrants reside. Continuity of care can be achieved only if in-hospital care can be provided by the physicians who are providing outpatient care. Migrants are entitled to the same quality of care as are residents of the area, and such care must include hospitalization.

The present program is supported by three State and Federal contracts in the amount of \$162,223. Experience gained during the past eight months indicates that this amount, plus approximately \$10,000 additional for dental care (primarily for children), would allow provision of an adequate level of outpatient services during the period April 1, 1968-June 30, 1969. The addition of \$50,000 for hospitalization would allow provision of truly comprehensive services.

The figures recorded in II-F above regarding hospitalization represent a minimum estimate of the need for inpatient care. As indicated in the comprehensive plan originally submitted in February, 1967 (QV), available information indicates that the migrant population in San Joaquin County will represent a group at risk of approximately 3000 person-years, would require approximately 2100 days of inpatient care, if such care were readily available, and would cost approximately \$100,000. Previous estimates of the cost of in-hospital medical care and the source of the local share of the cost of hospitalization are still valid.

Dr. GIANELLI. Now, just so you won't think that this is a one-man project, I would like to submit exhibits B and C. These are speeches delivered by the president of our county seat, Dr. John Morzumi, one delivered in Chandler, Ariz., and another in northern California.

Senator WILLIAMS. That is not in the material that you presented?

Dr. GIANELLI. I will submit them. I didn't want to confuse you with all of the papers. I thought perhaps you would think we were trying to run competition to the Government, but in both reports a prominent position is given to our agricultural program and I will leave these with the secretary.

(The material referred to previously follows:)

WESTERN CONFERENCE ON FUTURE DIRECTIONS AND DECISIONS IN MEDICAL CARE

(Comments from the San Joaquin County Medical Society, John Morzumi, M.D., President)

Public Law 89-749 has been the cause of a deep sense of urgency in the minds of the members of the San Joaquin County Medical Society. This feeling is as much borne out of what we don't know as what we do know and what our experience has been. I would like to take a few moments to outline what our experience has been in the few areas that are appropriate to the discussions of this conference.

REGIONAL HEALTH FACILITIES PLANNING

Our Medical Society became interested in the concept of regional health facilities planning in 1953. A local attempt had been made by our Hospital Council to organize a regional health facilities planning council and their grant application had been denied. It was during this period that the Medical Society recognized the need for regional planning and passed a resolution supporting the concept.

Upon a request from community leaders, the Medical Society loaned its staff and resources in an attempt to organize a regional health facilities planning council that would meet with the approval of the State Department of Public Health

and the U.S. Public Health Services. A six-county region was established and an application was drawn up and submitted. This application was ultimately approved, resulting in the establishment of the North San Joaquin Valley Regional Health Council. Our county society's executive secretary served as the initial executive director during this organizational period and until an adequate staff was secured.

Our involvement at the present time is as follows:

1. General support as a matter of policy.
2. Financial support.
3. Representation through individual physician members appointed to the local county committees and to the governing board.

We are strongly committed to the principle of voluntary planning and would be interested in seeing this type of program become more vital and virile under any new structure set up to qualify for Public Law 89-749.

Last month our county medical society joined with our County Board of Supervisors and with the North San Joaquin Valley Regional Health Council in adopting a joint resolution which issued a general call to the community for interest and involvement in the establishment of a regional program that would qualify under Public Law 89-749.

HEALTH PROFESSIONS TRAINING COUNCIL

The Medical Society, in cooperation with several other agencies, has long recognized the serious implications involved when there is an inadequate supply of para-medical personnel coupled with a rising demand for such services.

Because of this concern, the Medical Society organized, in April, 1966, the Health Professions Training Council in an attempt to evaluate and to promulgate ways to recruit and develop medical manpower to meet these needs. The Council is composed of representatives from education, hospitals, medicine, nursing, and employment. Membership in the Council is held by representatives of:

- San Joaquin County Board of Supervisors.
- San Joaquin County Hospital Council.
- San Joaquin General Hospital.
- Director of Nursing, San Joaquin General Hospital.
- San Joaquin Delta College.
- Division of Nursing, San Joaquin Delta College.
- California State Department of Employment.
- Stockton Unified School District.
- District Nurses Association.
- Visiting Nurses Association.
- San Joaquin Local Health District.
- Longterm Care Facilities Association.
- San Joaquin Valley Regional Health Planning Council.
- University of the Pacific.
- San Joaquin Dental Society.

The purpose of the Council is to:

1. Obtain and synthesize data on the volume of jobs, their location, wage rates, personal and educational standards and relationships to job advancement and career opportunities.
2. Determine the need and supply of para-medical personnel and project this into the future.
3. Analyze the cost factors involved in school courses and facility clinical training under varying patterns of operation.
4. Explore the methods of teaching, length of training period and the effectiveness of various teaching aids.
5. Analyze the possibilities of career advancement training and design a system to implement such a program.

The first meeting of the Council was held in October of 1966. Since that time the Council has had several study projects before it and has made some recommendations that have led to meaningful programs. The medical profession has been surveyed to ascertain whether or not there was a need for a training course for medical assistants. A refresher course for R.N.'s was stimulated at our local junior college. A recommendation has been made that hopefully will help lead to the establishment of a baccalaureate program for nurses at the University of the Pacific. Upon the Council's recommendation, a nurses aid training program using M.D.T.A. funds was established in cooperation with the State Department of Employment. A survey of the local dental profession resulted in the presentation of a course at

San Joaquin Delta Junior College for employed dental assistants and a two-year course for dental assistants will be started at San Joaquin Delta Junior College in 1968. In general however, the Council has felt inadequate because of lack of staff and financing although all the member agencies cooperated. The Council must rely on the staff of the county medical society.

The Council has made a proposal to the Community Health Services of the United States Public Health Service, Region IX for a grant to carry on their work. The initial proposal was made in January, 1967.

Discussions with persons in Community Health Services has led us to believe that although the need for financial support of this type of program is apparent, our particular grant proposal will probably not be accepted at this time. An alternate suggestion was made to us which we would readily accept. This proposal was to study the potentiality of placing at the Medical Society's and at the Council's disposal an employee of the Public Health Department to help carry out staff functions. This person would assist in carrying out staff functions of the Health Professions Training Council and work in other areas of similar interest.

AGRICULTURAL WORKERS

The San Joaquin County Medical Society could not possibly exist in an area such as ours without being aware of and concerned for the health needs of agricultural workers. Each year we can expect approximately 12,000 migrant agricultural workers through our county. For the past ten years, through one form or another, the Medical Society has been attempting to establish a pilot program in order to not only render care to these people but more importantly, to develop means by which their needs can be analyzed and programs developed in order to meet these needs.

It was not however, until April 1 of this year that the Medical Society was able to successfully implement a program. This program receives funds from four sources:

1. Office of Economic Opportunity, \$76,322.
2. United States Public Health Services, \$60,901.
3. State of California, \$25,000.
4. Regional Demonstration Center, Migrant Education, \$18,680.

These amounts are for a grant period of April 1, 1967 to March 31, 1968. The proposal is a two year proposal. The proposal for the second year is similar to the first with the exception that initial money that was initially budgeted and not funded is being requested. This additional money amounts to approximately \$100,000.00 and is for private hospitalization for persons to be covered. This particular proposal is through the Medical Society's Foundation for Medical Care and in cooperation with the San Joaquin Local Health District, the San Joaquin Pharmaceutical Association, and the San Joaquin County Board of Supervisors. The project objectives are:

A. To provide comprehensive family health services for migrant agricultural workers and families through provision of:

(1) Medical outpatient clinic services at Harney Lane and Mathews Road migrant camps.

(2) Mobile outpatient clinic services in areas in which migrant agricultural workers reside, and which are far removed from other sources of medical care available to such workers and families: Acampo, Linden, Terminous, Thornton, Vernalis.

(3) Continuity of care between outpatient clinic sessions, by establishing fee-for-service arrangements with general practitioners in each of the areas in which agricultural workers reside.

(4) Hospitalization in community hospitals when inpatient care is indicated.

(5) Public health nursing, environmental sanitation, and health aide services in all areas in which migrant agricultural workers reside or work.

B. Coordinate family health services provided by project staff with health services available through all other resources in the community.

C. Obtain and evaluate precise information regarding health problems of migrant agricultural workers and families:

(1) Extent and types of unmet medical needs.

(2) Volume of medical and paramedical services required to meet identified needs.

(3) Manner in which needed services can best be provided.

(4) Cost of providing the indicated services.

(5) Problems related to coordination of community health service resources.

Accomplishment of this objective will provide the medical, sociological, and fiscal information needed in planning to meet the health needs of migrant agricultural workers on a continuing basis.

Project needs and background

San Joaquin County lies in the mid-portion of the central valley of California, near the junction of the San Joaquin and Sacramento Rivers. The economy of the County is predominantly agricultural: of the 1409 square miles, approximately 90 percent is devoted to agricultural activities; the value of agricultural commodities produced annually exceeds \$224,000,000.

As of July 1, 1966, the estimated population of the County was 278,800. A little over one-third of the population resides in the City of Stockton, which is located near the center of the County; an additional 40,000-45,000 individuals live in suburban areas adjacent to Stockton. The remainder of the population resides in five smaller cities and in the unincorporated areas.

Population estimates and 1960 Federal Census reports indicate that: During the past five years, the population of San Joaquin County has increased at the rate of approximately 1.9% per year; the population includes a high proportion of young persons and an increasing proportion of older individuals; the proportion of Negroes, other non-whites and Mexican Americans is high, particularly in the City of Stockton; a high proportion of the total population is in the lower socioeconomic group; average educational level is low; and approximately twenty per cent of all housing units are substandard.

During 1965-1966, unemployment rates ranged from a low of 4.3% in September to a high of 9.6% in February; throughout the year, seasonal agricultural workers constitute a large portion of the unemployed group. Employment figures listed include domestic residents, domestic migrants, and some 4580 Mexican Nationals, and 574 other foreign contract laborers.

Method of procedure

Medical and related health services will be provided by the San Joaquin County Medical Society, through the Foundation for Medical Care and in cooperation with the San Joaquin Local Health District and other agencies as follows:

A. Fixed outpatient medical clinic services are established at:

(1) Harney Lane Migrant Camp—estimated maximum capacity: 480 persons. Clinic services are provided five nights per week, Monday through Friday, 7-10:00 p.m.

(2) Mathews Road Migrant Camp—estimated maximum capacity 800 persons. Clinic services will be provided five nights per week, Monday through Friday, 7-10:00 P.M.

At both camp sites, services will be provided for an estimated 3000 persons who will be residents of the camps during the period April 1-October 31, 1967, and to such other migrant workers and families living nearby who can be encouraged to utilize the health services offered. Services described below will be provided without any type of eligibility determination. Efforts will be made, however, to identify individuals who may be eligible for service under one or more of the several public medical care programs (e.g. Medi-Cal, CCS, Federal Medicare), and to assist such individuals in obtaining needed care.

B. Mobile medical clinic services will be provided for migrant workers and families living in or near Acampo, Linden, Terminous, Thornton, and Vernalis, once weekly at each location, on a regular schedule, during the period April 1, 1967-March 31, 1968. Clinic hours will be arranged to meet the needs of clients in each location.

C. Outpatient medical services will be provided in the offices of private physicians located nearest to each clinic site, to provide service at times other than regularly scheduled for clinics. Insofar as possible, private care will be provided by the same physicians who have served at clinic sessions, in order to provide continuity of care.

D. Clinical laboratory and radiological services will be provided through existing arrangements with service facilities, as established by the Foundation for Medical Care.

E. Inpatient care will be provided in seven open-staff community hospitals located in Stockton, Lodi, Manteca, and Tracy. Specific referral procedures will be developed.

F. Public health nursing, environmental sanitation, and health aide services provided in the project will be coordinated with related services

provided by the San Joaquin Local Health District and other community agencies.

The program is too new to produce any meaningful statistics or obviously any conclusions.

REGIONAL MEDICAL PROGRAMS FOR ASSESSMENT OF QUALITY OF MEDICAL CARE

The San Joaquin County Medical Society, through its Foundation for Medical Care, last month signed an agreement with the California Committee on Regional Medical Programs. The agreement calls for the cooperative efforts of the Monterey County Medical Society's Foundation for Medical Care, the Santa Clara County Medical Society's Foundation for Medical Care, and our Foundation. These Foundations have agreed to a program whereby a statistically selected sample of cases of patients treated for heart disease, cancer, stroke and related diseases will for a period of time be reviewed by a committee of physicians in the three counties and the information transmitted to the California Committee on Regional Medical Programs. Representatives from Stanford Medical School will cooperate in the program. After a review of the cases, an additional purpose of the program will be to develop programs required to supply any deficiencies in patient care which may appear as a result of such review.

SAN JOAQUIN FOUNDATION FOR MEDICAL CARE

No discussion of the review of services and the quality of medical care, utilization of medical manpower and the like would be complete without mention of the work of our Foundation for Medical Care. Established in May of 1954, the Foundation is a subsidiary corporation of the Medical Society. Membership in the Foundation is open to all practicing physicians in our county. The establishment of the Foundation arose out of public needs and desires for certainty of coverage and more comprehensive coverage. In addition, the Medical Society added the meaningful purpose of the review of quality of care rendered under any prepaid programs the Foundation might sponsor. Currently our Foundation for Medical Care is sponsoring prepaid programs that cover approximately one-half of the insured population of our county. These programs are underwritten by fifteen different insurance companies plus California Blue Shield and Blue Cross. Professional claims arising from these programs are reviewed by practicing physicians. This review has resulted in accumulated knowledge concerning quality of medical care rendered in our community. This awareness has led directly to individual education of physicians, general education of physicians through postgraduate courses and Medical Society programs and disciplinary action in cases where the educational process failed. In actuality, the Foundation for Medical Care represents a county-wide committee for medical audit, tissue, and utilization committee all rolled into one.

Our Medical Society's implementation of county-wide utilization review for extended care facilities has added another dimension to this type of activity.

MEDICAL MANPOWER PROJECT

The U.C.L.A. School of Public Health, working through a grant from the Ford Foundation, is currently involved in a program with our Foundation for Medical Care entitled "Medical Manpower Project". The purpose—to study and to try to relate the care of users of medical care to the type of care they are actually using. In this connection the study is attempting to learn in fine detail how many hours of doctor time, nurse time and technician time are required to provide specific care during the period of the study. A Foundation group with comprehensive coverage has been chosen for this study. The group is the International Longshoreman's Warehouseman's Union, Pacific Maritime Association Health and Welfare Program. A similar study for a similar period of time is being completed at the Ross Luce Clinic in Los Angeles.

SUMMARIZATION

In general we would conclude that our involvement in the various programs aforementioned has led directly to a realization on the part of the medical profession that we do have a definite and ever-increasing responsibility in the area of planning, health manpower and quality of medical care. There is also being

developed on the part of our general public an awareness that their local medical profession is indeed interested in their well-being.

I would hope that future challenges, as yet unknown to us, will be met with ever-increasing vigilance and vigor by us all.

REMARKS, 10TH COUNCILOR DISTRICT OFFICERS MEETING ON COMPREHENSIVE HEALTH PLANNING, DECEMBER 2, 1967

(Presented by John I. Morzumi, M.D., President, San Joaquin County Medical Society, Stockton, Calif.)

That Public Law 89-749 is currently a law of the land, that comprehensive health planning is part of the public domain, that the highly individual circumstances of a given local community or political subdivision or a grouping of contiguous and mutually augmenting geographical entities must dictate the implementation of provisions of that law seem to be a logical interpretation of the impact of that law. It is true that one can argue about the semantics of the phrase "comprehensive health planning," the precise meaning of which may be quite variable. We in San Joaquin have elected to assign as broad a meaning as is practical. This means that in any area of health problem where physicians are directly or indirectly involved, we mean to become more knowledgeable and lend our expertise.

Traditionally physicians everywhere were not only considered to be doctors to alleviate suffering, but highly educated and intelligent citizen leaders in matters of education and government civics. As American society became increasingly complex and as demand for acquisition and practical application of scientific knowledge became more intense, the individual physician unconsciously and gradually retreated from the sphere of the public health. The individual doctor-citizen became myopic and lived his life in the microcosm of his private practice. It is now time and opportunity for us to reacquire leadership in matters of health for the public commonweal. That is the challenge of Public Law 89-749.

It is obvious that some of the problems of a large metropolitan poverty population are quite different from those of a migrant agricultural group. The need for basic health care remains the same. There is immediate recognition that distance to be traveled, the type and cost of available transportation, the socioeconomic bases for the behavior patterns of such disparate groups greatly influences whether or not such persons can or do, indeed, seek medical care. Local knowledge of such determinates should dictate the directional course and alternatives that need to be discovered for reasonable solution of local problems.

We in San Joaquin County, or as a matter of fact, any other planner at the State or Federal level, are in no position to direct or implement the health care of the people of Watts. On the other hand, for example, we have recently learned what must be done for the migrant farmworkers in our area. For 10 years we attempted to establish some type of pilot program not only to render care but also to develop methods for analyzing migrant farmworker needs and programs to meet their needs. We thought that a prepaid plan with participation by growers and grower groups might permit these workers to obtain medical care. We were not successful in promoting that scheme. However, in April of this year, we successfully implemented a program. An outline of that program is in the paper submitted to the Western Conference on Future Directions and Decisions in Medical Care recently concluded in Chandler, Ariz.

We learned some lessons which need to be mentioned. It was vital in the planning stage and subsequent application of our proposal to both State and Federal agencies that we not only had acquiescence but active cooperation and participation of the local health department officer. He had certain expertise regarding the numerous funds that might be available and the form and letter of our application which would be most conducive to favorable action. His, in fact, was the agency which the previous year attempted with some success in having residents from our county hospital to man such a clinic. This year volunteer doctors from our community went at night to two fixed clinics operated at two large labor camps built and sponsored by the local political subdivision. These were maintained each week night from 7 to 10 p.m., or whatever time it took to take care of sick people. They were referred to consultants when necessary and given specific date and time appointments for special problems. Many in turn failed to keep these appointments. I am not implying, therefore, that consultants should be available at these clinics, for that would not be efficient use of medical manpower. What I am saying is that we realized that this group of people who depend on a seasonal harvest as their sole means of making money to maintain themselves

economically independent would not and could not take time off during their maximum earning hours or days to seek and obtain medical care unless they were seriously ill. They feel that they could not afford care not because of the doctor's bill necessarily, but because of loss of income time. Thus we needed to seek them out and convey medical care to them even at night. This, then, reveals the need to educate these people in prophylactic care, that it is economical to seek care earlier to prevent more serious illness which would require additional medical manpower and expense. The righteous platitude of "let them come to us" was and is inadequate if not irresponsible. So we recognize not only pure medical needs but the efficient utilization of medical manpower within the context of present times and local situations. This may not be comprehensive but it is responsible health planning. As a part of the whole problem of health planning it is comprehensible and certainly a measurable contribution to comprehensive health planning.

What I have just related is, of course, only a small segment of a recognizable hiatus in health care and planning which can be found in all communities. There are other examples of doctor and medical society involvement with the local community. Presently we are engaged in a survey in identification of the less-advantaged population groups in Stockton and San Joaquin County. The county hospital administration has completed an independent survey of the sources of origin of its inpatient and outpatient load and is preparing an official report. Individual physicians, the medical society, the public health officer, and people residing in disadvantaged areas will be conducting surveys of the medical needs of such areas. Our county medical society is engaged in a study of the county hospital which is located 5 miles outside of Stockton from which originate the majority of the hospital patient load including those who seek emergency care and clinic visits. It is essential to collect and collate these pieces of intelligence in order to be able to come up with meaningful and integrated recommendations. Another example—an approved rehabilitation center is 40 to 50 miles distant in a mountain community because it was able to utilize facilities which used to be primarily used for the care of tubercular patients in our area. There is reason at least to question the efficient utilization of such facilities for the geographical area that it purports to serve. In a recent conversation with an old friend of mine I learned that a small, relatively isolated community in Wyoming was the site of a full rehabilitation facility with a resident physiatrist, orthotist, and other supporting personnel. Of course, the people of that community and the physicians using or wishing to utilize such a facility should influentially participate in the decision of appropriate and efficient medical utilization of that facility. When an air pollution conference was held 2 months ago in Fresno, we were fortunate enough to find a local physician who was intensely interested in that topic and who has acquired a certain expertise. He will serve as liaison and resource man between the medical community and local government agencies.

The control of agricultural cultivation to prevent peat dust problem is an area that by local ordinance is vested in the office of the district attorney in my community. Do we not need his expertise, and does he not need our knowledge and advice? Obviously example after example can be cited such as alcoholic and mental health clinics, highway safety and education, drug abuse control and education, noise abatement, and even zoning practices as affecting the totality of community health. After all, isn't this what comprehensive health planning is about?

Due to special circumstances in the organizational make-up, the executive administrative personnel and devices available in the San Joaquin Medical Society, we may be able to do a few more things than in other counties but even we cannot cope with the total problem nor do we want to. For comprehensive health planning is a function of and for the entire community and not the sole domain of doctors. Hence lay and medical thought leaders, including the local public health department, have formulated a steering committee for organizing the San Joaquin Comprehensive Health Planning Association to which interested health organizations, governmental agencies, and other interested community groups have been invited to appoint representatives. This group will select a board of directors to represent proportionately the consumer public and the health profession and will draft the articles of incorporation and bylaws. The initial support is from the medical society but in a very short while we would need financial support from the county government and anticipate a request for planning funds under the provisions of Public Law 89-749. This, then, is a summary and analysis of what Public Law 89-749 means to us in San Joaquin County. If we have assisted you in your understanding it better, let me say that we do not pretend to know it all. We also seek information and advice from others who

experience similar and comparable problems and who have sought and found solutions.

Dr. GIANELLI. Then I just happen to have a few pictures of our newest addition, a mobile clinic. They are just snapshots. If I can have one minute I will explain it briefly.

Senator WILLIAMS. Can we look at them while you are talking, Doctor?

Dr. GIANELLI. You may. This is how we are spending our money for the U.S. Public Health Service. We are representing this unit.

Senator WILLIAMS. This picture shows a trailer.

Dr. GIANELLI. This is a trailer. We are renting it because our actuary said that this was the best way to handle it and also in the off season we remove the partitions and it doubles as a blood bank collecting unit. We have a four-county area and we will take this around and secure blood donations from the other counties.

Senator WILLIAMS. You have one trailer in this mobile unit?

Dr. GIANELLI. We have one trailer. It goes to five different locations in the counties. People enter at one end and are processed. There are five forms that have to be filled out. They can go down a narrow corridor to the nurse's station at the other end if that is indicated, such as in children who are there just for immunizations and do not have to see the physician. The central area contains doctor's consultation room, examining room, toilet, and wash basin.

Senator WILLIAMS. You mentioned skin testing for TB. Is that part of this mobile unit's activity?

Dr. GIANELLI. Yes, sir.

Senator WILLIAMS. The TB test is called a Tine test, is it not?

Dr. GIANELLI. Right.

Senator WILLIAMS. It is just a little pin prick?

Dr. GIANELLI. Nothing much to it, and the nurses do it.

Senator WILLIAMS. Did you hear the presentation of our last witness, Mr. White?

Dr. GIANELLI. Was that the last speaker?

Senator WILLIAMS. Yes.

Dr. GIANELLI. I couldn't hear him too well. I heard some of his remarks. I didn't hear the early part of his presentation.

Senator WILLIAMS. He has about 1,200 workers at peak season. He is obviously trying to make available to his workers the various health services that are now becoming available under the Migrant Health Act. It is not complete by any means.

Are you getting that kind of cooperation from the growers in your community?

Dr. GIANELLI. We are not.

Senator WILLIAMS. Is there anything you could do to persuade them that it is good business to have workers who are in good health?

Dr. GIANELLI. Well, as I indicated, we spent 6 years trying to do this. They are living in a different world, a world that we have left behind, of noninvolvement, and of individual identification rather than group identification. You just can't get these people to change overnight. They feel as though it is somebody else's responsibility.

I made a remark to the California Farm Bureau Federation meeting which I was asked to address a couple of months ago. The statement was made after my presentation by one of the growers that they didn't see where this was their responsibility and I pointed out to them that

this past winter through redevelopment we had torn down nine blocks of central Stockton which housed the single men that were engaged in agriculture primarily, and because we had an exceptionally wet winter for California that these people were hungry and cold, and ill, and they organized themselves and marched upon the mayor's residence asking for help. His remark too was, "The city of Stockton has no responsibility toward you."

About 3 months ago we recalled the mayor so that perhaps there is some hope.

Senator WILLIAMS. That is by petition of how many people? How do you do that?

Dr. GIANELLI. You have to sign up a certain percentage. I don't know what it is offhand.

Senator WILLIAMS. Then it goes on the ballot?

Dr. GIANELLI. And it went on the ballot, right.

Senator WILLIAMS. I am not going to ask which party was involved. We will leave well enough alone.

Dr. GIANELLI. It is possible.

Mr. BLACKWELL. Dr. Gianelli, in your statement you refer to this current budget request of \$315,000. My arithmetic indicates that you received about \$162,000 of your request. Is my arithmetic correct?

Dr. GIANELLI. Yes, sir.

Mr. BLACKWELL. The men in your profession generally are not known to be big spenders so I am assuming that your original figure was a fairly large request, is that correct?

Dr. GIANELLI. The largest item that was not funded was the request for hospitalization and this was not allowed because of lack of funds.

Now, we had to more or less guess at the amount that we would need for hospitalization. Actually I am surprised that the figure was only some \$11,000, as you saw. I mean we had 36 patients, as the record shows, who were hospitalized and their hospitalization cost is \$11,000. Of course, it would cost more if they were in private hospitals, not from the standpoint of hospital cost, but there would be a fee for service charge of the private physician because these people were taken care of by house officers in the employ of the county. But it is a good deal for the county to work with. I mean we have a commitment from the county board of supervisors for matching funds. California is on a 50-50 basis matching funds to \$50,000. It is good business for them, too. They have 100-percent coverage for these people now. If we put them in a private hospital they drop their cost by 50 percent. But they know, of course, we are not going to let these people who need hospitalization and treatment get away.

Mr. BLACKWELL. Do you have an estimate on the number of the migrant population that you did reach with your project services?

Dr. GIANELLI. Well, from the figures that I have given you it is roughly 20 percent.

Mr. BLACKWELL. Are you speaking in reference to the 14,000 migrants?

Dr. GIANELLI. Somewhere along 12,000 or 14,000. I was talking about 12,000.

Mr. BLACKWELL. Do you know the per capita investment in persons reached?

Dr. GIANELLI. As you can see, this report is up through November 1. Now, we are still in the process of receiving bills. We just don't have that figure for you. The doctors take anywhere from 2 to 6 months to submit their bills. Maybe you haven't had that experience, but overall we have had experience that they are a little bit lax and I tried to get this figure for you yesterday because I thought it might be asked. I don't know how much we have spent. But we have played it conservatively feeling that it would be much better to end up with excess money than to have to abandon the project somewhere along the way.

Mr. BLACKWELL. Could you give us an estimate of the amount needed to provide your present level of care to all of the migrants in your county reaching roughly 20 percent of 12,000?

Dr. GIANELLI. I don't know. Certainly the major percentage or the amount per person will decrease as time goes on. I mean after all, our clinic investment is there. I mean we pay so much rent per month for the trailer and it is used more. We pay no more rent for it so the cost will drop down.

We have another budget in, or shortly will be submitting it. We are asking for \$350,000 for this coming year. With this amount I think we could do a much better job in not only getting more people, but also extending the services as I have mentioned—hospitalization, dental care, and a larger formulary. This is another area that is a thorn in the side of physicians, that they are working with a very abbreviated formulary.

If you know anything about physicians, they are sort of prima donnas when it comes to prescribing medicines. It might be the same drug under a different name, but they have to have their own brand, this type of things.

As I say, we have to take this into consideration when we are working with a large group of men who are doing this on a voluntary basis.

Mr. BLACKWELL. What in your opinion is the effect on the individual from this lack of funding for hospitalization? Does he have much prospect of shopping around in another county?

Dr. GIANELLI. I don't think so. I can't speak with any authority for the rest of the State of California, least of all for Oregon and Washington, but I think most counties have a minimum residence requirement, and I believe it is a year in most places. I don't know of any that is less offhand, which means that these people are not going to get this because they are not going to be 1 year in one place, I don't believe. Some of them will, of course, and some won't.

Mr. BLACKWELL. So there will be a lack of hospital care although, in the professional opinion of a physician, it is needed?

Dr. GIANELLI. Right.

Mr. BLACKWELL. That is all the questions that I have.

Senator WILLIAMS. I will state that Senator Murphy, of California, did regret very much that he couldn't be here. This is the windup week for this session of Congress and the major business before us now is conferences with the House to iron out differences in bills and he had to be at the joint conference with the House on the education bill that the Senate passed in somewhat different form than the House.

I think he has a couple of amendments to the education bill that he will try to persuade the House to accept.

You are a member of the American Medical Association?

Dr. GIANELLI. Yes, sir.

Senator WILLIAMS. Are you getting cooperation from your colleagues in the association on this migrant health program which you so eloquently described?

Dr. GIANELLI. At what level?

Senator WILLIAMS. The practicing doctors.

Dr. GIANELLI. We are getting good cooperation at the county level as I have indicated. At no time, as I mentioned, have we suffered from a paucity of competent professional involvement. At the State level we are getting good cooperation. At the national level—well, I think perhaps you should understand the structure of organized medicine, that there is a great deal of county autonomy, county medical society autonomy, and we have no directors from AMA saying that we have to do this or we have to do that. The fact of the matter is we do pretty much as we please. We have not been reprimanded. At least at the State level they are very happy with us.

It might be interesting, if I can digress just a moment. The State of California is having a little argument over Medi-Cal. We have been selected to run a pilot program starting the first of January 1968 wherein we are providing Medi-Cal recipients medical care at so much a month, will be paid a premium of so much a month per recipient, and we will then take the risk. We are limited in risk to 10 percent. If we lose more than that the State says it will come to our aid, but our figures that we gave for prepayment runs about one-third under what it cost this previous year per recipient and we have been in this business for quite a while. You say we are poor businessmen, but we are still in business. We don't expect to lose this challenge.

Senator WILLIAMS. You certainly obviously devote a great deal of time to this work is bringing better health care to farmworkers. It must be a demanding situation for you to meet your regular private patient obligations and still do all this work.

Dr. GIANELLI. I have two very good partners who grumble some, but so far haven't thrown me out of the partnership.

Mr. MITTELMAN. I just wondered, Doctor, whether any other medical societies have chosen to copy, to emulate your wonderful example in California or in any other place that you might know of?

Dr. GIANELLI. Oh, yes, they have in California. There are other county seats that might not be doing it the same way we are doing it, but certainly are involved in the care of migrant agricultural workers. There are other counties and perhaps somebody is more knowledgeable here than I am on that. We certainly won't take all the credit for it. What we will take credit for, though, is for originating the foundation concept which is serving as a vehicle for the implementation of the migrant health program and also is serving as a vehicle for the pilot study for Medi-Cal. So that is a very useful instrument.

The foundation concept is rather general in California, at least in the Central Valley, and San Diego County—we skip over Los Angeles County—and it has spread even as far east as New York State so it is not unknown in medical circles.

Mr. MITTELMAN. I would just like to congratulate you and your society for instituting this program. It is certainly a remarkable example of what public-spirited citizens can really do to make an impact on a severe problem of this kind. I only wish that there were a great many more like you.

Dr. GIANELLI. Thank you very much.

Senator WILLIAMS. Well, we will do our best to cooperate with your great efforts, Doctor. We will try to pass this bill as soon as we can.

Dr. GIANELLI. With enough money for hospitalization, I hope. Thank you.

Senator WILLIAMS. Do you want to stand by while your colleagues make their statements?

Dr. GIANELLI. Yes, sir.

Senator WILLIAMS. We will now go to the director of the Laredo-Webb County Health Department, Mr. Jose Gonzalez. Is that the name of the county, Laredo?

Mr. GONZALEZ. No, sir, Laredo is the city. Webb is the county. Ours is a city-county health department. I just happen to have a little map with me that shows the work that we did in Laredo this past year.

Senator WILLIAMS. Thank you. We can see it.

Mr. GONZALEZ. Mr. Chairman and gentlemen, first of all, it has been real gratifying for me to know that the migrant has persons like Dr. Gianelli at the other end of the line. I represent the opposite end, the home base area, or one home base area.

Laredo was one of the first programs after Congress passed the Migrant Health Act in September 1962. I believe I am right in saying that there are now approximately 100 projects in about 40 States and Puerto Rico receiving grant assistance.

I believe that Laredo was the sixth to apply for and receive a grant, back in early 1963—and thanks to a demonstration program started by the National Communicable Disease Center and the Texas State Health Department in Laredo in 1955, with continuous evaluation studies being made, we in Laredo are in perhaps a better position than most other migrant grant locations to measure the effectiveness of the migrant health program.

A health index survey made in 1966, with the aid of statisticians from Atlanta and Austin, confirmed previous findings that a large "pocket of resistance" made up of the Laredo migrants and their families, approximately 20 percent of the city's population, and impervious to repeated health department efforts prior to 1963, is now finally on a par with resident citizenry in respect to the immunization level of children; adult response to tuberculosis heaf testing; enteric disease morbidity, previously much higher among migrants, and compliance with sanitation regulations in their homes and premises.

This is unequivocally and entirely due to the work being performed directly with migrants and their families since 1963 by the nurses, sanitarian, and health educator of the Laredo migrant health program.

When it was first announced that Laredo would start a program that would bring public health to our migrants, there was a very obvious and a very widespread awareness that the Migrant Health Act was a real godsend—a real pioneering act of the Congress to remedy years of neglect of a very significant number of American citizens.

Laredo is a home base of anywhere between 12,000 to 15,000 migrants and their families, who leave the city each year, and these make from 17 to 20 percent of the population.

In a situation which I believe typical of all the home base areas, particularly the large ones, a dynamic local public health program was actually being ineffective, because it was not touching 20 percent of the population.

Since the work of public health in a local community is really directed, for the most part, to the lower socioeconomic levels of that community, then 20 percent of our total population missed really means that we were not being very successful with 40 to 50 percent of the population we were working with.

In a city with as large a population of migrants as Laredo, our very limited success with the migrant and his family was adversely affecting the overall public health picture of the community, of course.

With 20 percent of the population not cooperating, or cooperating very little, it was really impossible to control communicable disease; to effectively raise the immunization levels of the children of Laredo; to carry out a complete environmental health program; and what was more important, to solve Laredo's greatest problem, the high rate of tuberculosis.

There were many reasons why we were not having much luck with the migrant and his family, the two main ones being, first, the fact that the migrant was out of the city 5 to 7 months of the year, and the second one was the lack of enough personnel to fastidiously and effectively stick with the migrant and convince them to attend our clinics and improve their health and sanitation practices.

The third reason, and in many ways the most important, was the nature of the Mexican-American migrant himself.

Some of the personnel of the health department who had tried to work with the migrant before the Migrant Health Act was passed did not believe that anything could ever convince them to follow many of our recommendations.

It was not that they ever opposed the health department openly. What little effort that was directed at the migrant, and it was never enough before 1963, was usually met with a complete lack of interest.

Laredo's widely publicized environmental health demonstration program, which saw the elimination of over 5,000 privies in a period of 7 years, met its match in dealing with many of our migrants.

They refused to eliminate their pit toilets, just like they refused to immunize their children, or participate in our citywide tuberculin testing for tuberculosis. They felt that since they spent such a short time in Laredo, they did not have to obey the health code.

They would tell our nurses that they were doing all this up north, where they were working—getting their shots, getting chest X-rays, et cetera. Of course, they had no records to prove it, but there was no way of making them do it. I am sure they told the same story at the other end of the line.

The fact remained that the children were not getting immunized; the tubercle bacillus was probably being spread around the country, or maybe being brought back into Laredo. The migrant's premises were unkempt and dirty 6 or 7 months out of the year, making it difficult for the health department to make their neighbors that stayed home comply; and they were not bringing their families to receive the medical help that they needed.

As I mentioned before, the very nature of many of the migrants also played a strong part in this. The fact that the city of Laredo now, 4 years later, has a higher immunization level in preschool children, for DPT and polio, than the national average, and that the children of migrants now have the same level as the rest of the community, has been a real achievement, considering the inability a

few short years ago of many of our migrants to translate from one culture to another in medicine.

As a matter of fact, this is more surprising, since many of them still have that fatalistic viewpoint on disease—they feel that even though they are immunized against the disease, they can still catch it.

That such an about-face in the conduct of the most recalcitrant of the "hard-to-reach" in Laredo, the migrant, would ever happen would have been considered extremely unlikely a few short years ago. That it would ever happen in 3 years is unbelievable.

It happened because a small group of dedicated professional public health workers, financed by the migrant health program, centered their efforts on this 20 percent of the population.

Also, it happened because of a rather curious phenomenon which I, as a Mexican-American myself, understand perhaps better than most.

The Migrant Health Act, which allowed the Laredo-Webb County Health Department to hire two badly needed additional nurses, a sanitarian, and a health educator, also brought about a rather unexpected and very impressive change in the attitude of the migrant himself.

While some continued to be reluctant, large numbers of migrants started coming to the clinics that had never come before—because it was a program that Congress had passed for them. This I was told personally by several of them, they were now coming to the health department to get what was theirs.

As I said before, as Mexican-American, I can understand this. The reluctance of a great percentage of the so-called hard-to-reach in public health is due only to pride.

As I mentioned before, an environmental health demonstration program was started in Laredo in 1955, under the auspices of the National Communicable Disease Center and the Texas State Health Department.

Laredo had before this a very high infant mortality rate, particularly a very high infant mortality due to diarrhea, high morbidity rates in enteric diseases, a high morbidity rate in tuberculosis—as a matter of fact, a very high everything.

From 1955 to 1962, great strides in public health were made in Laredo, but then we became aware that we were not having much luck with a very large percentage of our population, composed of migrants and their families, who spent a great deal of time out of the city.

While I did not have time to break up the statistics between 1954 and 1962 as compared to now, I have here a handout which I prepared for a talk I gave in Houston last September.

This, gentlemen, is the first handout at the end of my talk in the report that I hope you have.

I can assure you gentlemen that the difference between 1954 and 1962, which is the last year we had without the migrant health grant, was not as marked as you see between 1954 and 1965.

The Laredo migrant health program added two things to our health department within a period of 2 years which gave an unbelievably sharp rise to all our progress charts, of which only a few are represented by this handout.

Those two things that were added were the family health service clinic for migrants, and the migrant environmental health program.

Thanks to this grant, this large pocket of resistance, which we had to contend with before, is now gone.

As you can see, this principal way of showing the public health of a community, infant mortality rate, has been cut in half. Our infant mortality rate now is actually slightly under the national average.

Senator WILLIAMS. Do you have with you your budget figures showing the division of money to various parts of the program?

Mr. GONZALEZ. No, sir; I do not.

Our migrant grant this year is approximately \$60,000. This does not include hospital, which we are getting next year, hopefully.

However, we have for the most part now an integrated program. For instance, to the \$60,000 we could well add at least one-third of the \$20,000 that we have for our dental health clinic for children. One-third of the children that receive that clinical help are migrants.

This is from other than migrant funds.

Senator WILLIAMS. Do you get any State money?

Mr. GONZALEZ. Yes, sir.

Senator WILLIAMS. What is the proportion of State and Federal funding?

Mr. GONZALEZ. Well, the State health department gives our local health department approximately \$78,000, and this is really difficult to break down, Senator, but when we figure that in our clinics, our general medical clinic, in particular, one-third of the people we see are migrants.

Then we can say that one-third of that could very well go to the migrants.

Senator WILLIAMS. Are there many programs similar to yours elsewhere in Texas?

Mr. GONZALEZ. Yes, sir. There is a big one in Hidalgo County, which is the biggest county, as far as migrants are concerned. Out of the approximately 105,000 migrants from south Texas that leave each year, 25,000 come from Hidalgo County alone. They have an excellent program.

Senator WILLIAMS. That is also on the border?

Mr. GONZALEZ. Yes, sir.

Senator WILLIAMS. Hidalgo?

Mr. GONZALEZ. Yes, sir.

Senator WILLIAMS. As is Laredo?

Mr. GONZALEZ. Right; yes, sir.

Senator WILLIAMS. What is the town across from Laredo? Reynosa?

Mr. GONZALEZ. That is across from Hidalgo County, yes, Reynosa. Nuevo Laredo is across from Laredo.

Of course, I can only speak for Laredo, and there are differences between the places where our migrants go to work to and the home base area.

But our end of the line is also very important. In many ways, the most important. If the Laredo migrant calls any place his home, it is Laredo, where he goes to spend the winter months and Christmas.

We firmly believe that the close association that our migrant health staff has had with them has given a little bit more meaning to the word "home." Everyone wants to be accepted somewhere, by somebody. You do not have to be cultured and educated to want to be—wanted.

The identification of this program as a migrant health program has done that for them. They have opened up, as they had never done before.

The primary goal of public health is to influence and motivate man's behavior. Before anyone can be motivated in doing what you want him to do, that person has to be influenced by the public health worker attempting it. And in this I believe our staff has been immensely successful. The migrants consider them their friends. They consider our clinic, their own clinic, to which they look forward to coming back the following winter.

This change that we are now seeing in many of our migrants has taken time, and it has not come easily. It has taken a continuous and persistent effort by our staff patiently working with the same families every year, after they get back home, and the migrant is responding.

He has not only found out that there is a health program that takes care of him and his family, but he knows that wherever he goes, this health department will insure that there is a proper followup for conditions requiring repeated medical attention.

One of the most encouraging things of all is that the migrant is now beginning to take responsibility for learning and applying better homemaking and personal health practices.

To be sure, the Laredo migrant is the unpardonable frustration of many a sociologist who contends that all Mexican-Americans would rather see a "curandero," or healer, than a medical doctor, and that they all believe in witchcraft, which is a lot of nonsense.

Witchcraft does exist, but to a very small extent. The curandero bit stems from their background. Most are descendants of people who came from the rural areas of Mexico, where there were few doctors, so some had to learn what to do in emergencies and rely on folk medicine.

Many still rely on folk medicines, when they cannot afford a doctor, but this does not cure their children or themselves when they really get sick. Folk medicines are not antibiotics—and many of them have now seen the effects of antibiotics. And they are seeing now that their children do not have to die when they get sick—even from serious illness—and even when they are following the crops.

Just how much they believe in antibiotics, and in coming to see a medical doctor when one is available to them, physically and economically, is shown by the number of them that have attended our clinics since the program started.

Handout No. 2 shows a 3-year period, from 1964 to November 1967.

We did not add a family health clinic until the second year of our grant, so data on migrants was not kept before. They have always been seen in our health department clinic, though not in such numbers.

Since 1964, 4,921 migrant persons have attended our general medical clinic. This clinic is financed mostly by local and State funds. Only 15 percent of the cost of the clinic is financed by the migrant health grant. Yet almost 30 percent of the people seen there are migrants.

Our migrant immunization clinic, staffed by our migrant health program nurses, has had 21,771 clinical visits in this period. Our tuberculosis control program, financed by other than migrant grant funds, has taken 1,469 X-rays of migrants during this time, though

the health educator, financed by the migrant program, has played a big hand in this.

Just to cite one more figure from handout No. 2, our dental health clinic for children, which I mentioned, financed entirely from other than migrant health grant funds, has seen 810 children of migrant families in the short period—15 months—that it has been operating.

Two of the most significant figures I have cited above are the close to 5,000 migrants, or members of migrant families, that have taken advantage of our general medical clinic, an enormous increase in migrant participation from years past.

The other one is the almost unbelievable figure of almost 22,000 clinical visits in our immunization program.

These figures do not include December of this year. December is always our biggest month.

The second part of handout No. 2 also shows some of the accomplishments of the migrant environmental health program. The interest shown by the migrants in our clinical requests has been matched by their enthusiasm in cleaning up their yards and premises, and in complying with environmental health regulations.

Chief among the accomplishments of our project sanitarian has been the elimination of 132 privies from homes of migrants, with accompanying sewer connections.

The 1966 Texas migrant labor report of the Good Neighbor Commission of Texas states that there has been a big increase in the number of families migrating out of Texas in 1965 and 1966 as a result of the termination of the Bracero Act in 1964. This is resulting in a cessation of competition from alien workers.

In 1964, the last year of the Bracero Act, only some 129,000 migrated. In 1965, a total of about 167,000, including migrants and their families, migrated, followed by 162,000 in 1966, and this year has been described as one of stabilization in the use and availability of farm labor in Texas.

Out of the 162,000 that migrated in 1966, about 129,600 migrated out of the State, and about 32,500 remained entirely in Texas. This then indicates an increase, if anything, in our work with the migrant.

The one matter that I firmly believe we have not perfected is actually one of the very first points considered when the original Texas-Michigan study was made—health service continuity.

This has been a difficult problem, providing this continuity of health services on an interstate basis, particularly when many of the migrants do not even know where they are going to end up after they leave Laredo.

In all fairness, I believe that progress is finally being made in this regard, thanks to the State program in Austin, which is now demanding that all referrals from other States come through them, for a centralization of this most important item.

I feel that, in summary, the Migrant Health Act has accomplished more than it ever set out to do, in identifying this program as the migrant's very own. The more than 100,000 south Texas migrants of Mexican descent needed this almost as much as they needed the long-awaited and invaluable public health benefits the migrants are now finally receiving.

In providing the funds for additional personnel to our health department to conduct this program, the Migrant Health Act is not

only providing health benefits to one of the populations in our country that needed it the most, but it is also assisting and maintaining the health of the resident citizens.

This is evident in Laredo, where the Migrant Health Act brought a large recalcitrant segment of the population under the influence of public health.

The migrant health program has been the single most effective long-range program ever conducted by the Laredo-Webb County Health Department, particularly in results obtained from dollars spent.

In the light of recent statements made by the Surgeon General of the United States, Dr. William J. Stewart, that health is not being made available to the people who need it, the migrant health program stands out as one program that is most assuredly doing exactly what it was intended, providing health to a people who need it.

(Attachments to Mr. Gonzalez's statement follow:)

COMPARATIVE SURVEY FINDINGS, 1954 AND 1965
LAREDO, TEX.

Population:				
1954	.....			59,350
1965	.....			65,780

Description	1954		1965	
	Number	Percent	Number	Percent
Environmental:				
Deficient housing	5,383	38	4,257	28
Privies	5,424	33	1,294	9
Deficiencies in refuse storage	.....	83	.....	29
Animals and poultry	.....	28	.....	9
Mortality:				
Infant mortality per 1,000 live births	48	.....	26.3	.....
Infant deaths due to diarrhea	18	.....	0	.....
Morbidity:				
Diarrheal infections	3,491	.....	591	.....
Syphilis (per 100,000)	108	.....	61.5	.....
Tuberculosis (per 100,000)	155	.....	147	.....
Polio	8	.....	0	.....

PREVENTIVE, 1965

	Percent
Dogs vaccinated against rabies	68
Preschool children protected against smallpox	64
Children protected against measles (natural and artificial)	87
Children, 6 months to 14 years, vaccinated against DPT	76
Estimated status of polio protection (0 to 14 years)	81

HANDOUT NO. 2. *Migrant health project operations, 1963-67*¹

Activity	Total
1. Clinics and other services (migrant persons seen):	
(a) General medical clinic	4,921
(b) Private physicians	62
(c) State commission for the blind	30
(d) Hospitalization	8
(e) Maternity clinic	886
(f) Well-child clinic	423
(g) Crippled children's clinic	66
(h) Venereal disease clinic	54
(i) Welfare agencies	97
(j) Migrant immunization clinic (visits)	21,771
(k) Chest clinic (X-rays)	1,469
(l) Dental clinic	810

¹ Information tabulated through Nov. 30, 1967.

<i>Activity</i>		<i>Total</i>
2. Nursing services:		
(a) Home visits	-----	5, 689
(b) Referrals from home visits to migrant immunization clinic	-----	10, 557
(c) Referrals to other sources of medical service or health-welfare services	-----	4, 119
(d) Immunizations given	-----	21, 757
(e) Heaf (tuberculin) tests given	-----	4, 742
(f) Serological test for syphilis	-----	1, 800
3. Environmental sanitation:		
(a) Number of inspections	-----	1, 568
(b) Discrepancies	-----	² 3, 533
(c) Corrections	-----	³ 617

² These include substandard homes, inadequate sewage disposal, unapproved solid waste disposal, rodent and insect nuisances, poor environmental sanitation, etc.

³ These include corrections or improvements obtained on above discrepancies. This figure also includes 132 pit privies eliminated.

HANDOUT NO. 3.—Number of families and States (Laredo migrants)

Minnesota	239	Indiana	26
California	133	Washington	18
Wisconsin	127	Oregon	7
Michigan	116	Oklahoma	5
Illinois	101	Florida	4
Idaho	94	Kansas	3
North Dakota	93	Alabama	3
Wyoming	73	Montana	3
Texas	71	New Mexico	3
Nebraska	69	Iowa	2
Colorado	59	Mississippi	1
Ohio	40		
Utah	28	Total	1, 318

HANDOUT NO. 4.—Migrant family and worker's head count survey (72.5 percent complete), 1966-67

Families registered	1, 318
Number of individuals	7, 701
Children registered:	
1 to 5 years of age	1, 247
6 to 12 years of age	1, 666
13 to 18 years of age	1, 426
18 years and up	725
Number of children in school while in Laredo	2, 731
Number of actual workers migrating	3, 386
Number of employed while in Laredo	688
Number of unemployed	630
American citizens	908
Immigrated	410
Property owners	827
Renters	369
Other (living in same household with relative)	122
Inside plumbing	776
Septic tanks	5
Pit privies	366
Cesspools	31
No facilities (use neighbor's or relative's)	18
Galvanized garbage cans	609
Open, unapproved cans	551
No garbage containers	36
Standard housing	540
Substandard housing	656
Nuisance	4
Poor environmental	21
Rodent	13

Remarks: Information for 1,318 inspections mentioned is complete. Total of 503 inspections not mentioned, as these have to be reevaluated.

Senator WILLIAMS. That statement certainly is complete, and we are certainly appreciative.

You are what we describe as a public health administrator. Is that right?

Mr. Gonzalez. Yes, sir.

Senator WILLIAMS. How many people do you have working with you on this program for migrants?

Mr. GONZALEZ. Under the migrant grant, sir, we have two nurses, a sanitarian, and a health educator. We have just added an assistant to the sanitarian.

Senator WILLIAMS. Most of the people that you describe as farm-workers have a long period of residency in Laredo, maybe 4, 5, 6 months?

Mr. GONZALEZ. Usually the majority of them get to Laredo in September and October, and leave in April and May.

Senator WILLIAMS. Do you have many people coming across the border, daytime workers in agriculture?

The term we use to describe these workers that come over on a daily basis from Mexico is "commuters."

Mr. GONZALEZ. We have a large number of commuters. I would say around approximately 6,000 come to work in Laredo from across the river, the so-called green carders, but I don't know what percentage of these are in agriculture eventually.

Senator WILLIAMS. Can you reach those that are in agriculture with the migrant health program?

Mr. GONZALEZ. I would say not, Senator, because our health department sees only the residents from this side.

Senator WILLIAMS. I see. You still have not been able to break the barrier or fear that people have of getting immunization shots "up north."

Mr. GONZALEZ. No, sir. I make the statement that we have broken it. I think that in the past 4 years we have made great strides in that.

Senator WILLIAMS. Would it not help, though, for those who still have not lost their anxiety about going to a doctor or a clinic to have a medical profile that they can keep with them, and that you could consult to determine past services.

Mr. GONZALEZ. They have these. We give all the heads of the families a complete record of immunizations and all services, medical and clinical services, that we give them.

We have instructed them, and they are, I think, now getting around to following the practice of keeping this record with them everywhere they go.

Senator WILLIAMS. Is that true in California, Doctor?

Dr. GIANELLI. Yes, sir. They have a family health record, and they keep pretty good track of it, too. They come back the second year, and many of them still have it. They don't lose it.

Senator WILLIAMS. That was my next question: Do they honor the record, and keep it?

Dr. GIANELLI. Better than I thought they would.

Senator WILLIAMS. How about Michigan, Doctor?

Dr. LOCEY. Unfortunately, this is not true. Only around 15 or 20 percent actually have any form of records with them at all.

Senator WILLIAMS. Before we come to you, Dr. Locey, do we have questions of Mr. Gonzalez?

Mr. BLACKWELL. Mr. Gonzalez, we have heard other witnesses discuss the necessary steps to improve the environmental health part of the migrant health problem.

Improved sanitation is needed in the United States. We all are generally familiar with the still more serious environmental health problem just across the border in Mexico. We saw it in Elsa. We saw it in a few other towns during our Texas hearings, and from a layman's viewpoint, I understand that this is the context from which there is the most likelihood of an epidemic stream.

Do you regard this as something to worry about, with the commuters coming across in such large numbers?

You said that there are 6,000 commuters in your area, and this is just one crossing point in Texas. At many points on the Texas border there are large numbers of workers coming across for a daily work tour, and then returning to Mexico, and I think we know the kinds of conditions to which they are returning.

Mr. GONZALEZ. Mr. Blackwell, we in Laredo I think are fortunate in enjoying a very close association with our Mexican counterpart, the health department in Nuevo Laredo.

We have, however, in the past four and a half years, been doing a very strong effort to immunize all our children from TB, polio, measles, and smallpox, with I believe also very good results.

In June of 1966, Nuevo Laredo had a polio epidemic. They had 27 cases.

Mr. BLACKWELL. Was that in Laredo?

Mr. GONZALEZ. On the Mexican side, 27 cases of polio, whereas we had one case of polio, so I think that even though we cannot speak so well on the major problem of TB, we are holding our line in most things, and Nuevo Laredo, I think, has also a very effective health department now.

Mr. BLACKWELL. What year was the polio epidemic?

Mr. GONZALEZ. In 1966.

Mr. BLACKWELL. That is the point. You had a polio epidemic across the border in 1966, and in this case it was a disease for which you fortunately, in your area, already had an extensive immunization program.

It is not certain that the same success has been experienced all along the U.S. side of the Texas border with our own citizenship. Of course, we have no immunization program for some other diseases.

Mr. GONZALEZ. I think we have made a strong effort to give the information to the new Commission on Border Work on the Mexican-United States border of what our programs are, including TB.

We have not really solved the problem that can be on the border, and for this we are going to need a united effort, even more than what we are now conducting.

In all fairness, I would like to say that during the polio epidemic in Nuevo Laredo—I believe it can happen to any city that was not as immunized as it perhaps should have been—they immunized in a period of 48 hours 9,000 children. They brought nurses from everywhere and they just went from door to door to immunize kids.

Mr. BLACKWELL. This was in Laredo?

Mr. GONZALEZ. This was on the Mexican side.

Mr. BLACKWELL. When an epidemic occurs, do you have a massive effort to deal with it?

Mr. GONZALEZ. Yes. If it weren't for that, there probably would have been more. They did conduct a rather effective program at that time.

Mr. BLACKWELL. This really is not a sound way of dealing with epidemics, though, trying to stop them after they have already broken out, and currently there are no procedures for having knowledge of the health status of these individuals at border crossings.

There is no required health certificate, unless for example they are working in a cafeteria on this side.

Mr. GONZALEZ. Yes; everybody that handles food does need a good kind of certificate, but I believe that most people that are working on this side have to have their X-ray at the U.S. Quarantine—Public Health Service Quarantine Station—at the bridge.

Mr. BLACKWELL. That is when they are first certified?

Mr. GONZALEZ. Yes.

Mr. BLACKWELL. Then all of the many years afterward—

Mr. GONZALEZ. They don't have it.

Mr. BLACKWELL (continuing). Anything can happen, and there is no procedure for knowing about diseases following initial certification?

Mr. GONZALEZ. This is right.

Mr. BLACKWELL. TB, for example, could develop after the admittance procedure?

Mr. GONZALEZ. Yes.

They could ostensibly pick it up on this side, and we do have a rather effective system of followup in conjunction with their health department.

Whenever one of the residents of Nueva Laredo gets sick of TB, they pick him up right away, and they report him to the Mexican side, but this is the biggest problem that we have.

Mr. BLACKWELL. It is cheaper by far to have identification and prevention procedures, though, than dealing with an advanced case of TB, or having to program immunization for 12,000 people; isn't that right?

Mr. GONZALEZ. Yes, sir.

Mr. BLACKWELL. Is that correct?

Mr. GONZALEZ. That is correct.

Mr. BLACKWELL. Are you able to supply now, or perhaps subsequently, an estimate on the cost of providing adequate medical care to the migrants, the migrant population in your county? Do you have a per capita figure on your project?

Mr. GONZALEZ. Not really, Mr. Blackwell. Actually, about 18 months ago, our health educator estimated that the migrant was getting \$18 per head of our public health prevention.

Mr. BLACKWELL. Is that all migrants, or the ones you are reaching?

Mr. GONZALEZ. These are the ones we are reaching, and this I do not believe is correct.

We never publicized the figure, because, since we have an integrated program, where the migrants come to clinics not financed by the migrant program, and since we have other people that have come to clinics that are financed, this has been difficult to ascertain.

When you have a population of 20 percent migrants all over the city, actually in a way the best program is just a shotgun program. We have been able to be more successful that way, because in the one section of Laredo, which is the northeast section, migrants and their

families do very well, and you can now see very beautiful little homes that they have. They painted them up, spruced them up.

They take care of them during the time they are gone. Their yards are clean, and a very large percentage of these migrants are certainly not a blight on the community now.

Mr. BLACKWELL. What proportion of that migrant population do you think you are reaching? Twenty percent? Thirty percent?

Mr. GONZALEZ. We feel that it is between 30 and 40 percent that are coming to the clinics, that are following our clinical recommendations.

Most migrants have been approached by our health educator, sanitarian, and his assistant. Almost all have been seen and visited. They are participating in the services that we have for them.

We think that 40 percent would be a good figure to say that are taking advantage of what we have now.

I could be wrong in this, but many, many of them now don't even go to our clinics. They will go see their own private physician.

Mr. BLACKWELL. The migrants in Laredo settled in what, generally speaking, is part of an urban area in the fringe of Laredo, or in the city?

Mr. GONZALEZ. Inside the city limits; yes.

Mr. BLACKWELL. In Hidalgo they are more scattered throughout the rural areas?

Mr. GONZALEZ. Yes; it is out in the country, not so much in the city, but then Hidalgo, like I said, has an enormous number of migrants, and their families. They have approximately 25,000, just that county alone.

Mr. BLACKWELL. So it is obviously easier to reach the migrant settled inside the city limits?

Mr. GONZALEZ. Definitely.

Mr. BLACKWELL. So your 30 or 40 percent would be how much higher than in a county like Hidalgo, for example?

You could not logically expect them to have the same success in reaching them as you have in Laredo.

Mr. GONZALEZ. I believe so.

I am not too acquainted with the Hidalgo County program, but I think that they are having more success.

Mr. BLACKWELL. But your success is better than generally throughout the rural counties?

Mr. GONZALEZ. Let me say it is easier.

Senator WILLIAMS. Thank you very much, Mr. Gonzalez. Your presentation has been a big contribution to our deliberations here.

Mr. Gonzalez, do you know whether there is a health program under this act in Starr County?

Mr. GONZALEZ. I believe that that is covered by the statewide program, Senator. I do not think that they have a local program.

I know Zapata County just south of us does have a program now.

I am not sure if Starr County is included in the Hidalgo County program. It may be a multicounty program. I think it is under Dr. Copenhagen. He may be in Zapata and Starr Counties also.

If not, then it is covered under the State program.

Senate WILLIAMS. Thank you very much.

We will now hear from Dr. Robert Locey, the director, migrant health program, in three counties in Michigan.

We kept you waiting a long time, Doctor, but better late than never.

Dr. LOCEY. I hope I have enough calories to continue, here.

Senator and staff members of the Subcommittee on Migratory Labor, I am very pleased to be able to represent the southwestern corner of Michigan to you.

When I introduced myself, I did not mention the names of the towns, and I think if I mentioned the names of any of the towns in our area, I doubt if you would recognize them.

Senator WILLIAMS. Oh, we have been there.

Dr. LOCEY. Well, I am glad to hear that.

Senator WILLIAMS. That is good cherry country, too.

Dr. LOCEY. Yes, and you made reference to strawberries at one time.

I think with all due respect to Florida, that you really ought to come see ours sometime. Our area is one of the most diversified crop areas of the country, and the growing season opens up in May with asparagus and closes with grapes and apples in the late fall.

Our particular agricultural industry requires large numbers of seasonal farmworkers, and thus we rely heavily on migrant laborers.

The U.S. Department of Agriculture lists one of our counties, Berrien, as the Nation's third-ranking county in the utilization of migrant workers, and another of our counties, Van Buren, in the eighth ranking position.

Our peak utilization time is usually the middle of June, when some 23,400 migrants are on hand, 19,800 of which are of working age.

We generally maintain 6,000 to 10,000 seasonal workers during the 8-month harvest period, which covers some 25 different crops. To house this large influx of people, we have approximately 700 camps.

When I first became director of the associated health departments in November of 1964, I was charged to do something about "the migrant problem."

Being new to the area, I did not know what this problem was. However, I soon discovered it was a situation of grave concern, and one about which the community was quite ashamed. In fact, it may have been a very strong factor in finally organizing an approved health department in our area.

In talking with doctors, dentists, hospital administrators, pastors, growers, city folk, and heads of civic and voluntary agencies, I found the community divided in itself, each willing to blame the other, and no one willing to take the leadership to solve this problem.

This was not surprising, in view of the magnitude of the situation. Because our communities are largely agricultural, the tax base was not felt to be sufficient to undertake a program that would meet the needs of these people.

Our ratio of doctor to resident population is low, and that same ratio for dentists is even lower. Paramedical manpower is at a premium.

The many small political jurisdictions acted as so many fences, each enclosing a typical rural or semirural conservative people. Yet, the fact remained that the migrant suffered during his tenure with us, and that unnecessarily high medical bills for migrant medical care were being paid by the taxpayer, due to lack of preventive care, and of early care in cases of illness.

Data obtained for the year 1964 showed that area hospitals had a loss of some \$90,000, due to uncollected bills for migrant care. The Berrien County Welfare Department reported a cost of approximately \$38,000 in 1964 for outpatient visits.

Because the migrant worker waited until he was very sick before seeking help, it taxed our already hard-pressed medical manpower.

The doctors were not so distressed at the additional hours they had to put in for migrant care, but were more concerned about the followup on these people. They were concerned about the migrant's ability to obtain the prescribed medications that he should have, and about the living conditions that their sick patients had to be returned to.

Dentists in our area could handle only emergency care. No thought was given to the remedial aspect for migrants.

Organization was the only answer to the problem, and organization could only be attained through use of the Migrant Health Act of 1962. Since we were dealing with an interstate problem, we felt it was a fair and just use of Federal funds.

We were more than willing to put in our 25 percent. In fact, our contribution greatly exceeded that amount.

We knew that somehow we would have to develop some kind of educational program to stimulate migrants to seek care in the early stages of illness, that we would have to urge growers to afford adequate housing and a decent environment, to have safe water supplies, proper sewage disposal facilities, and suitable provisions for personal hygiene, laundry, and recreation; that we must somehow educate the migrant into the proper use of the facilities furnished by the grower; and that we must coordinate the health activities of official and voluntary agencies that were then providing assistance to migrants.

In looking at the map of the tricounty area, you can see, too, that we would have to provide facilities in the area where the camps were most prevalent.

In this case, the camps are indicated by red dots, the medical facilities in blue, and the dental facilities in green, and you can see that these facilities are not in the area where the migrants are most prevalent, and so we then established the three facilities that you see in a triangular fashion.

After months of planning and organization, we came up with a project that would cost approximately \$1.28 per migrant per biweekly period for 13 biweekly periods. This is based on a biweekly average of 8,657 migrants from April 15 through October 15.

This is a very small amount, it is true. However, we tried to keep it practical in terms of the medical manpower we had available, our ability to recruit additional personnel, and the little experience that we had.

We would have been content that first year with just holding our own, while we were working out the bugs in the system and recruiting qualified personnel. However, our medical program was busy from the very outset. The number of outpatient visits supported in total or in part by the migrant health project for 1966 was 2,469.

The doctors working in the clinics, and again I make reference to our medical societies. I feel that congratulations are in order to them.

We have a hundred doctors. About a third are specialists, which reduces the number practicing—well, not practicing, but doctors seeing private patients—to 66, and 44 of them are in these migrant clinics.

But they were enthused about the quality and continuity of care given, and the followup of these cases in the field.

Administrators at the local hospitals noticed a decrease in hospitalization of migrant workers, and members of their families. Physicians having offices nearest to the growing areas and physicians on call for hospital emergency rooms said that emergency calls for migrants had lessened considerably.

Growers felt that lost time in the fields due to illness was lessened, giving them more man-hours of work, and there were indications that many of the laborers would return next year because of the respect afforded them at the clinics.

As one migrant put it, "This is the first time I felt treated like an equal human being."

Our division of environmental health licensed 634 of the estimated 700 camps. Within this number of camps, 2,108 item violations were noted, and orders were issued for their correction.

Because of the shortage of personnel, only 93 camps were visited a second time. Among these 93 camps, 224 violations were listed at the time of the initial visit. At the time of the second visit, 147 corrections had been made, for a percentage correction of 65.6 percent, which was much better than the compliance rate for the State of Michigan as a whole, which was 39.9 percent.

I believe that this in some way reflects the value of a complete project. If the grower sees that the doctors, dentists, health department, civic and voluntary agencies are pitching in in one united effort, then he is more likely to go along.

At the time of the initial camp visit for licensure inspection in 1967, the number of violations recorded dropped by 58 percent, to 1,224. By the end of the 1967 season, our records show that over \$110,000 had been put into improvements and new housing by the growers.

It is very difficult to compile, analyze, and compare data regarding costs and losses for medical care on seasonal laborers, due to several factors, including the present rapid rise in cost of medical care, and differences in the definition of migrant laborers among medical facilities, in policies of welfare departments, and in the number of migrants from year to year.

However, it is possible that any lowering of outpatient and inpatient costs for migrants could be related to the availability of facilities for early diagnosis and treatment of disease, to health education, and to the improvement of housing.

From the standpoint of outpatient cost, it is worth noting that in Berrien County the average cost per outpatient visit recorded by the department of social services in 1964 was \$12.78, while, in spite of rising medical costs, the cost per outpatient visit recorded by the migrant family clinics in 1966 averaged only \$7.22. For referrals made by project field personnel directly to private physician offices or hospital emergency room, the cost was only \$9.36.

Also worth noting is the comparative data on direct relief medical payments made by the Berrien County Welfare Department, both before and after the project started.

In June, July, and August of 1965, the cost was \$6,488.34. In these same months of 1966, the cost was only \$3,079.30, or a reduction of \$3,409.04.

The total cost for outpatient services during these same 3 months dropped from \$9,898.32 in 1965 to \$9,050.60 in 1966.

Although the difference is not striking, it is a definite break in the trend of increasing medical care costs for the indigent.

In terms of hospitalization during these same 3 months of 1965, \$45,886.94 was spent on noncategorical hospitalization, which included migrant labor medical care costs. In 1966, the first year of the project, the cost for noncategorical hospitalization was only \$39,521.95, or \$6,345 less.

However, if you compare the first 5 months of 1965 and 1966 for noncategorical hospitalization, 1966 shows an increase in cost over 1965 by almost \$30,000. Thus, the cost for noncategorical hospitalization had actually taken a sudden change from an increasing to a decreasing trend during the time the family health clinics for migrants were operating.

Such figures as the preceding ones, which are used as indexes to evaluate the progress of the migrant health program, cannot give the entire picture. Yet, they do give an indication that preventative care and early care is less costly.

Such early care is afforded the migrant through the program developed by our communities as a result of the Migrant Health Act of 1962.

The savings in terms of outpatient care and hospitalization in no way make up for the total cost of the project, but this is more than made up by a more knowledgeable migrant, a healthier migrant, and one who is more productive, and who is less of a burden on the taxpayer. The value is immeasurable in terms of the migrant's dignity.

One of the greatest fears at the beginning of the project was that migrants who had higher than average capabilities for that class of people, and who were more stable from year to year than most seasonal workers, would abandon paying for their own care, as they had done in the past.

This proved to be untrue. Private physicians have reported that through the first and second years of the project those migrants who had been previous patients and were paying for their care were continuing to come to their office, and were continuing to pay their bills.

Our report for 1967 is being compiled, but is not yet completed. However, from observation, we know that our program has improved significantly. This year we had an outbreak of diphtheria, which we were able to handle efficiently and effectively.

After the situation was cleared up, I shuddered when I reflected on what we would have done had we not had the migrant health project.

Although we have made a great deal of progress, I am sure that you realize how difficult it is to develop something of this proportion in a 2-year period of time. We had hoped to be sufficiently organized by the time our project ran out, on June 30, 1969. Even then we will need some continuing financial support.

To say, or give the impression, that our current program will be sufficient at the end of 3 years, would be misleading. We still would not have sufficient environmentalists to inspect all camps at least twice during the season. We still would not have sufficient nurses and health education aides to make the meaningful personal contacts necessary in many problem areas.

We still would have difficulty in bringing remedial dental care to just the migrant children involved, and routine screening procedures for vision, hearing, tuberculosis, and other chronic diseases would, for the most part, be imperfect.

In our experience, it would seem desirable not only to continue the Migrant Health Act, but to furnish additional matching funds to increase the small expenditure of \$1.28 per migrant per biweekly period.

We have some very conservative people in our area, but as a whole they see the value of the money that has been spent, and are for raising the amount of money that will do the job properly.

In my opinion, there is still much to be done on a Federal level. At the present time, most family health clinics within any particular migrant stream operate independently of one another. Hopefully, a cohesiveness of such clinics can be brought about to produce increasing continuity of care.

The effectiveness of the entire program could also be enhanced if migrants could be evaluated, preventive measures begun, and needed consultation given before leaving their home base.

We are now faced with the threat that the Migrant Health Act will no longer exist after June 30 of 1968. As I understand it, one of the reasons for the discontinuation is to make more money available for the Comprehensive Health Planning Act.

In effect, this would mean diluting migrant health moneys over a much broader population. This may be the right and just thing to do for categories of a universal nature, such as heart, cancer, stroke, diabetes, tuberculosis, and others which are common to all localities.

However, the migrant situation is not a universal one. It is a problem experienced by relatively few localities. These localities by their nature are rural, and do not have the resources to meet the needs of the migrant worker and his family.

If you throw migrant health moneys into a general pot with these other disease categories, you are treating the migrant as a disease entity, which indeed he is not.

Although he may speak another language, or be of a minority group, he is a human being, deserving of respect. He is necessary to the economy and productivity of this Nation. Although he is an American, he is, in many instances, an unfortunate captive of his work, because of his education, background, and capabilities.

The migrant health program is just not a mechanism to provide immediate, acute treatment and improvement of living conditions. It is designed with a lasting effect in mind, to educate and to promote and maintain the health of an underprivileged group of Americans who must eventually take their place in the mainstream of American life.

This will come as their education and social acceptance improve, and as they are replaced by mechanization.

I hope you do not see our request to continue the Migrant Health Act as a selfish move, for we are interested in more than the growing of fruits and vegetables. We would like to see America grow in a manner commensurate with its very honorable preamble. Thank you.

(Attachments to Dr. Locey's statement follow:)

TABLE I.—BIWEEKLY NUMBERS OF SEASONAL AGRICULTURAL WORKERS BY LOCATION OF ORIGIN, BERRIEN, CASS, VAN BUREN COUNTIES, 1966

Date (1966)	Local	Intrastate migratory	Interstate migratory	Total
April 15.....	750	75	225	1,050
April 30.....	1,250	75	475	1,800
May 15.....	1,200	60	740	2,000
May 31.....	2,100	200	2,900	5,200
June 15.....	2,050	375	4,200	6,625
June 30.....	4,290	1,125	17,985	23,400
July 15.....	3,245	430	10,925	14,600
July 31.....	2,810	665	7,675	11,150
August 15.....	2,765	705	7,345	10,815
August 31.....	3,155	360	8,010	11,525
September 15.....	2,880	420	6,905	10,205
September 30.....	2,555	195	5,285	8,035
October 15.....	2,260	165	3,710	6,135
Biweekly average.....	2,408	373	5,875	8,657
Weekly average.....	93.6	14	226	4,326

SOURCE AND MOVEMENT OF SEASONAL AGRICULTURAL LABORERS

According to data gathered by the State Health Department for the year 1966, the following states supplied seasonal agricultural labor to the state of Michigan in the percentages given as follows:

	Percent
Texas.....	69.8
Florida.....	11.4
Louisiana.....	4.2
Missouri.....	3.3
Mississippi.....	1.5
Minnesota.....	1.1
Arkansas.....	1.0
Other States.....	3.9
Michigan.....	3.8

Based on Michigan Employment Security Commission data shown in Table I, the composition of all seasonal farm workers on the basis of the biweekly average was as follows:

	Percent
Local.....	27.8
Intrastate.....	4.4
Interstate.....	67.8

Date of Clinic _____

J. Time spent in the past 12 months in other states or counties. List by months:

SECTION II

J. PRIMARY CONDITION DIAGNOSED BY M.D. (Note: Please identify primary condition by "1" and secondary condition by "2".)

I. Infective and Parasitic Diseases (002X) Tuberculosis ☐ (0081) Case ☐ (0082) Contact ☐ (0083) Suspect ☐ (0290) Syphilis ☐ (0300) Gonorrhea ☐ (0850) Measles ☐ (1319) Dermatophytosis ☐ (1360) Pediculosis ☐ Other _____	X. Diseases of the Genitourinary System (590X) Cystitis ☐ (6050) Male Genital Organs ☐ (610X) Female Genital Organs ☐ (620X) Menstrual Disorders ☐ (6340) Other _____
II. Neoplasms ☐ (140X)	XI. Complications of Pregnancy ☐ (640X)
III. Allergic, Endocrine System, Metabolic, and Nutritional Diseases (240X) Diabetes ☐ (2600) Malnutrition ☐ (2860) Obesity ☐ (2870) Arthritis ☐ (2880) Other _____	XII. Diseases of the Skin and Cellular Tissue (690X) Impetigo ☐ (6950) Eczema ☐ (7010) Dermatitis ☐ (7039) Other _____
IV. Diseases of the Blood and Blood-forming Organs (290X) Iron deficiency anemias ☐ (2919) Anemia, unspecified ☐ (2930) Other _____	XIII. Diseases of the Bones and Organs of Movement ☐ (720X)
V. Mental, Psychoneurotic, and Personality Disorders ☐ (300X)	XIV. Congenital Malformations ☐ (750X)
VI. Diseases of the Nervous System and Sense Organs (330X) Epilepsy ☐ (3530) Conjunctivitis ☐ (3700) Otitis ☐ (3900) Other _____	XV. Certain Diseases of Early Infancy ☐ (760X)
VII. Diseases of the Circulatory System (400X) Cardiovascular ☐ (4400) Hypertension ☐ (4470) Other _____	XVI. Symptoms and Ill-defined Conditions (780X) Found in which System: _____ (Roman Numeral or Write In)
VIII. Diseases of the Respiratory System (470X) Pharyngitis ☐ (4729) URI ☐ (4750) Pneumonia ☐ (4939) Hypertrophy of Tonsils ☐ (5100) Other _____	XVII. Accidents, Poisoning, and Violence (800X) Injury ☐ (8580) Insect Bites ☐ (8590) Other _____
IX. Diseases of the Digestive System (530X) Dental Caries ☐ (5300) Ulcer ☐ (5400) Gastroenteritis ☐ (5710) Other _____	Special Conditions and Examinations without Sickness Pre-natal care ☐ (Y061) 1st Trimester ☐ (Y062) 2nd Trimester ☐ (Y063) 3rd Trimester ☐ (Y070) Post-partum ☐ (Y091) Family Planning ☐ Well Baby and Child-care ☐ (Y005) Laboratory test ☐ (Y011) Screening Procedure ☐ (Y012) Immunization ☐ (Y020) Follow-up examination after disease, injury, or operation not needing further medical care ☐ (Y039) No Pathology ☐ (Y098)

EXHIBIT I

HARVEST TIME FOR FRUITS AND VEGETABLES GROWN IN SOUTHWESTERN MICHIGAN

	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER
Asparagus						
Strawberries						
Sweet Cherries						
Gooseberries						
Black Raspberries						
Red Currants						
Red Raspberries						
Sour Cherries						
Dew Berries						
Blueberries						
Snap Beans						
Cucumbers						
Apples (Summer)						
Tomatoes						
Potatoes						
Peppers						
Peaches						
Cantaloups						
Eggplant						
Pears						
Plums						
Lima Beans						
Grapes						
Apples (Fall)						
Cauliflower						



Number of migrants by county
based on data obtained from the
Public Health Service Publication
No. 540, Revised 1966.

Project M-107 shown in red

Total Number of Migrants - 79,421

MIGRANT LABOR UTILIZATION—10 TOP-RANKING COUNTRIES¹ IN THE UNITED STATES, 1966

County	State	Estimated peak population	
		Number of workers	Number of persons
Fresno.....	California.....	22, 000	27, 500
Palm Beach.....	Florida.....	16, 757	27, 928
Berrien.....	Michigan.....	11, 100	12, 500
Grand Traverse.....	do.....	9, 100	10, 230
San Joaquin.....	California.....	9, 000	11, 250
Santa Clara.....	do.....	8, 200	10, 350
Marion.....	Oregon.....	7, 500	10, 700
Van Buren.....	Michigan.....	7, 435	8, 360
Yolo.....	California.....	6, 930	8, 652
Riverside.....	do.....	5, 960	6, 810

¹ According to a joint report; U.S. Department of Labor, Bureau of Employment Security, and the U.S. Health Service.

TABLE II.—MAN-HOURS SPENT AT MIGRANT HEALTH CLINICS AT LACOTA, SODUS, AND KEELER BY TYPE OF PERSONNEL, 1966

Physicians.....	222
Nurses.....	536
Laboratory technicians.....	215
Clerical.....	264
Health aides.....	184
Volunteers.....	584
All personnel.....	2,005

TABLE III.—OUTPATIENT VISITS SUPPORTED IN TOTAL OR IN PART BY THE MIGRANT HEALTH PROJECT, 1966

Facility	First visit	Revisits	Total visits
Keeler Migrant Health Clinic.....	727	434	1,161
Sodus Migrant Health Clinic.....	489	118	607
Lacota Migrant Health Clinic.....	81	30	111
Berrien General Hospital.....	233	158	391
Watervliet Community Hospital.....	32	5	37
Mercy Hospital.....	7	0	7
Memorial Hospital.....	2	1	3
Pawating Hospital.....	1	0	1
South Haven Community Hospital.....	9	1	10
Lakeview Hospital.....	9	0	9
Lee Memorial Hospital.....	70	0	70
Private physicians.....	35	16	51
Dentists.....	6	5	11
Total.....	1,701	768	2,469

TABLE IV.—PATIENT VISITS BY AGE AND SEX, MIGRANT HEALTH CLINICS, LACOTA, SODUS, AND KEELER, 1966

Age group	Sex	Number of 1st visits	Percent	Number of revisits	Percent	Total visits
0 to 1.....	M	66	12.7	33	13.8	99
	F	56	7.3	23	7.0	79
1 to 4.....	M	96	18.5	35	14.6	131
	F	108	14.1	50	15.4	158
5 to 14.....	M	150	29.0	70	29.2	220
	F	189	24.7	70	21.6	259
15 to 24.....	M	82	15.8	24	10.0	106
	F	160	20.9	56	17.2	216
25 to 44.....	M	80	15.4	41	17.1	121
	F	183	23.9	91	28.0	274
45 to 64.....	M	36	6.9	32	13.3	68
	F	68	8.9	34	10.4	102
65 plus.....	M	7	1.3	4	1.6	11
	F	0	0	0	0	0
Unknown.....		16		19		35
Total, all ages.....	M	517	39.9	239	41.1	756
	F	764	59.0	324	55.6	1,088
	U	16	1.7	19	3.3	35

TABLE V.—TYPES OF ILLNESS SEEN IN CLINICS BY AGE GROUPS, MIGRANT HEALTH CLINICS, KEELER, SODUS, LACOTA, 1966

	0 to 1	1 to 4	5 to 14	15 to 24	25 to 44	45 to 64	65 plus	Un- known	Total
Infectious and parasitic diseases.....	4	26	25	9	11	0	0	0	75
Neoplasma.....	1	0	0	5	1	0	0	0	7
Allergic, metabolic, and nutritional disease.....	3	0	2	9	7	10	0	0	31
Diseases of blood.....	0	3	1	1	1	0	0	0	6
Mental and personality disorder.....	0	0	0	0	0	0	0	0	0
Diseases of the nervous system.....	16	21	56	15	16	9	0	3	136
Diseases of the circulatory system.....	0	3	3	4	13	14	0	0	42
Diseases of the respiratory system.....	42	71	137	58	85	47	1	3	444
Diseases of the digestive system.....	28	45	15	6	20	20	1	0	135
Diseases of the genitourinary system.....	0	0	9	40	26	10	0	1	86
Deliveries, pregnancy.....	0	0	10	36	30	0	0	0	76
Diseases of the skin.....	9	29	63	21	16	6	1	7	152
Diseases of the bone.....	0	0	3	1	8	10	1	0	23
Certain disease of early infancy.....	9	2	1	1	1	0	0	0	14
Ill-defined conditions, symptoms and senility.....	25	12	25	27	48	26	2	2	167
Injuries, accidents and external causes.....	2	12	50	32	33	6	1	6	142
Special conditions and examinations; No sickness.....	9	4	27	28	31	6	0	2	107

TABLE VII.—LABORATORY TESTS PERFORMED DURING MIGRANT HEALTH CLINICS, KEELER, SODUS, LACOTA, 1966

Type of test	Keeler	Sodus	Lacota	Total
Serology.....	59	27	1	87
Urinalysis.....	91	28	4	123
Hemoglobin.....	75	12	7	94
Hematocrit.....	67	11	4	82
WBC count.....	63	12	1	76
Differential.....	59	12	1	72
Culture.....	105	0	4	109
Sensitivity.....	42	0	0	42
Blood sugar.....	9	0	0	9
Parasites.....	7	4	2	13
Gram stains.....	2	0	0	2
Uric acid.....	2	0	0	2
Total.....	581	106	24	711

TABLE VIII.—DRUGS DISPENSED BY AGE GROUPS, MIGRANT HEALTH CLINICS, KEELER, SODUS, LACOTA, 1966

	0 to 1	1 to 4	5 to 14	15 to 24	25 to 44	45 to 64	65 plus	Un-known	Total
Analgesics and antipyretics.....	15	19	30	39	67	36	4	2	212
Anthelmintics.....	4	6	2	0	0	0	0	0	12
Antibiotics.....	82	90	229	107	119	62	5	3	697
Antihistamines.....	11	9	28	19	27	5	1	3	103
Relaxants.....	3	3	1	4	17	8	1	3	40
Digestants.....	20	26	13	9	14	2	1	0	85
Expectorants.....	8	19	25	11	18	6	0	1	88
Vitamins.....	5	10	14	5	11	5	0	0	50
Hormones.....	0	0	2	1	3	1	0	0	7
Narcotics.....	0	3	0	1	2	0	0	0	6
Other anti-infective.....	1	24	21	4	5	0	0	0	55
Other.....	5	10	15	10	23	27	0	2	92

TABLE IX.—TOPICAL FLUORIDE TREATMENTS, COVERT, BERRIEN SPRINGS, AND SODUS MIGRANT HEALTH PROGRAM, 1966

Location	Total number of children	Percent receiving applications				Number completed
		1st	2d	3d	4th	
Covert.....	46	100	100	89.1	89.1	41
Berrien Springs.....	88	100	100	94.3	94.3	83
Sodus.....	78	100	100	69.2	69.2	54
Total, all locations.....	212	100	100	83.9	83.9	178

TABLE X.—REMEDIAL DENTAL CARE REFERRALS FROM COVERT, BERRIEN SPRINGS, AND SODUS MIGRANT HEALTH PROGRAM, 1966

Referral location	Number of referrals	Number of restorations	Number of extractions	Number of other treatments	Completed cases
Covert.....	6	6	4	8	5
Berrien Springs.....	3	6	0	0	1
Sodus.....	13	37	8	6	13
Total, all locations.....	22	49	12	14	19

TABLE XII.—A COMPARISON OF THE LIVING UNIT TYPES IN BERRIEN, CASS, AND VAN BUREN COUNTIES

Type of facility	Number of units			Percentage by unit type		
	Berrien	Cass	Van Buren	Berrien	Cass	Van Buren
Motel.....	57	2	44	10.8	6.0	12.2
Cabin.....	325	17	224	61.7	51.5	61.8
Barracks.....	15	2	10	2.9	6.0	2.8
Multipurpose.....	89	4	46	16.8	12.2	12.7
Other.....	41	8	38	7.8	24.3	10.5
Total.....	527	33	362	100.0	100.0	100.0

TABLE XIII.—COMPARISON OF CAMP CAPACITY RANGES IN THE TRICOUNTY AREA MICHIGAN REPORTS, 1966

Capacity range in workers per camp	Number of camps		Percent	
	Michigan	Tricounty	Michigan	Tricounty
5 to 24.....	1,217	281	47.3	44.3
25 to 49.....	827	205	32.1	32.3
50 to 99.....	392	102	15.2	16.2
100 plus.....	138	46	5.4	7.2
Total.....	2,574	634	100.0	100.0

TABLE XV.—DISTRIBUTION OF HOUSED AGRICULTURAL WORKERS BY COUNTY, TRICOUNTY AREA, 1966

County	Number of camps	Total worker capacity in licensed camps	Percent of area workers in licensed camps
Berrien.....	359	9,461	38.8
Cass.....	23	945	3.9
Van Buren.....	252	13,986	57.3
Total.....	634	24,392	100.0

TABLE XVI.—SOURCE OF WATER SUPPLIES SERVING TRICOUNTY CAMPS COMPARED WITH MICHIGAN EXPERIENCE

Water source	Michigan		Tricounty	
	Number	Percent	Number	Percent
Municipal.....	73	2.8	15	2.4
Private.....	2,496	97.0	616	97.0
Both.....	5	.2	3	.6
Total.....	2,574	100.0	634	100.0

TABLE XVIII.—TYPE OF SEWAGE DISPOSAL SYSTEMS UTILIZED FOR TRICOUNTY CAMPS COMPARED WITH MICHIGAN

Type of system	Michigan		Tricounty	
	Number	Percent	Number	Percent
Municipal.....	30	1.2	13	2.0
Private.....	2,538	98.6	620	97.8
Both.....	6	.2	1	.2
Total.....	2,574	100.0	634	100.0

TABLE XX.—COMPARISON OF COOKING FACILITIES IN TRICOUNTY AREA WITH MICHIGAN EXPERIENCE

Type of facility	Michigan		Tricounty	
	Number	Percent	Number	Percent
Central.....	8	3.4	5	0.8
Individual.....	2,454	95.3	623	98.3
Both.....	33	1.3	6	.9
Total.....	2,495	100.0	634	100.0

TABLE XXII.—COMPARISON OF RULE VIOLATIONS AND NUMBER OF ITEM VIOLATIONS TRICOUNTY, 1966

Rule	Rule violations	Item-rule ratio	Item violations
5, camp maintenance.....	36	1.0	36
6, water supply.....	163	1.3	201
6a, camp area.....	42	1.0	44
7, shelters.....	46	1.3	60
8, fire safety.....	182	1.7	301
9, lighting and ventilation.....	233	2.0	474
10, heating.....	7	1.9	13
11, cooking and eating.....	69	1.0	69
12, bathing facilities.....	147	1.1	164
13, toilet facilities.....	264	1.6	415
14, laundry facilities.....	3	1.0	3
15, sewage disposal.....	32	1.0	32
15a, refuse and garbage.....	234	1.3	296
Total violations.....	1,458	1.4	2,108

TABLE XXIII.—COMPARISON OF CAMP LICENSES ISSUED BY TYPE AND BY INSPECTIONAL AGENCY

Type of license	Total number	Number inspected by State highway departments	Number inspected by local highway departments
Full.....	559	187	372
Provisional.....	70	20	50
Temporary.....	5	2	3
Total.....	634	209	425

TABLE XXIV.—SUMMARY OF FINDINGS OF RULE VIOLATIONS AND CORRECTIONS ON 93 CAMPS HAVING 2 OR MORE INSPECTIONS, TRICOUNTY AREA, 1966

Area	Number of camps revisited	Number of initial violations	Number of corrections	Number of new violations
Berrien.....	62	153	98	16
Cass.....	1	5	5	0
Van Buren.....	30	66	44	22
Tricounty total.....	93	224	147	38

TABLE XXV.—CORRECTION RATE FOR RULE VIOLATIONS FOR CAMPS HAVING 2 OR MORE INSPECTIONS, TRICOUNTY, 1966

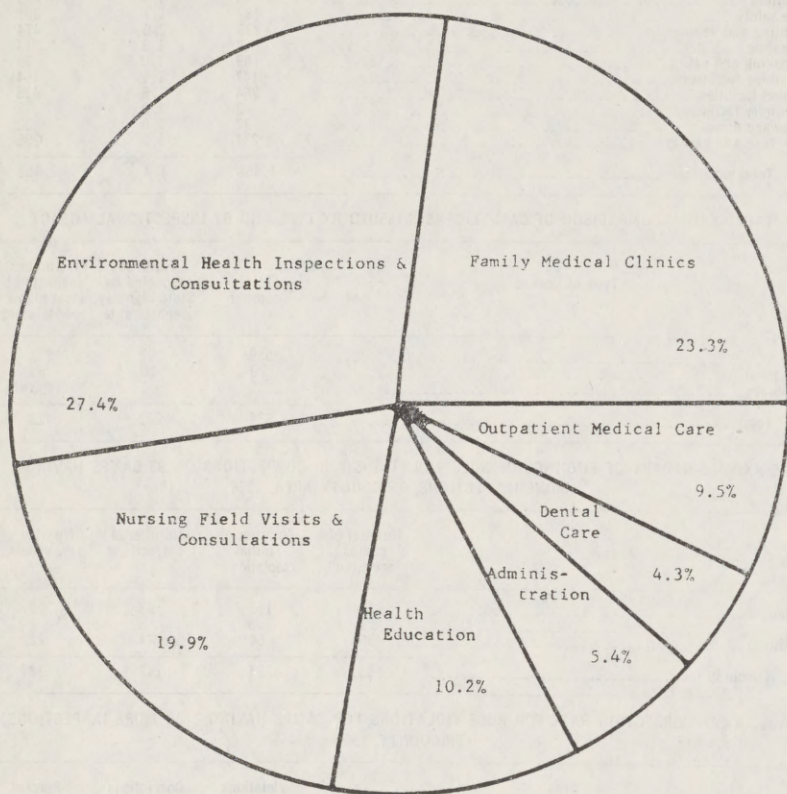
Area	Violations	Corrections	Percent corrections
Berrien.....	153	98	64.1
Cass.....	5	5	100.0
Van Buren.....	66	44	66.6
Tricounty total.....	224	147	65.6

TABLE XXVI.—FREQUENCY OF RULE VIOLATIONS BY COUNTY FOR TRICOUNTY AREA, 1966

[Violations expressed in percent of camps inspected]

Rule	Tricounty	Berrien	Cass	Van Buren
5. Camp maintenance.....	5.7	5.5	0	6.4
6. Water supply.....	25.7	30.1	17.4	17.1
6a. Camp area.....	7.2	10.0	4.4	2.0
7. Shelter.....	7.6	9.3	4.3	5.5
8. Fire safety.....	28.8	30.2	17.4	24.0
9. Lighting and ventilation.....	36.8	47.4	13.0	22.6
10. Heating.....	1.1	2.0	0	1.3
11. Cooking and eating.....	10.9	14.6	4.3	9.5
12. Bathing facilities.....	23.2	6.2	52.1	51.7
13. Toilet facilities.....	41.3	51.8	13.0	31.7
14. Laundry facilities.....	.5	.8	0	.4
15. Sewage disposal.....	5.1	6.9	0	2.8
15a. Garbage and refuse disposal.....	36.8	46.0	13.0	26.2

PERCENTAGE DISTRIBUTION OF EXPENDITURES
MIGRANT HEALTH PROGRAM - 1966



INFORMATION AVAILABLE ON ADMISSIONS AND COST FOR MIGRANT LABOR HOSPITALIZATION PRIOR TO START OF MIGRANT HEALTH PROGRAM

Hospital	Time interval	Number of admissions	Gross cost	Paid by migrant	Paid by insurance	Uncollected
South Haven	August 1964 to August 1965	96	12,253	1,413		10,840
Lakeview	do	114	7,541	1,240	769	5,530
Lee Memorial	January to September 1965	10				1,238
Pawating	Annually	8				11,000
Mercy	January to September 1965	32				14,000
Watervliet	Annually	33				14,500
Memorial	do	8				11,000
Berrien General	April to October 1964	420	58,880	1,200		57,680
Total						88,288

¹ Estimated.

Senator WILLIAMS. Thank you very much, Dr. Locey.

It sounds like this migrant health program is a full-time occupation for you.

Dr. LOCEY. Yes; it could occupy that. Unfortunately, with the small manpower we have, I have to go across the whole gamut of public health.

Senator WILLIAMS. Are you in private practice in addition to this work?

Dr. LOCEY. No. As you say, it is a full-time job among the migrants, and I have all three counties.

I think another thing I should point out, too, is that Allegan County, which is not shown, resides just above Van Buren, and this program has done a great deal to break down political boundaries.

It is probably one of the best examples of comprehensive health planning that you can find, because Allegan County, along the shore of Lake Michigan, too, has a great number of camps, and although this is not within our jurisdiction, it is served by our project, a good program, an areawide program to try to meet the needs for that particular area.

Senator WILLIAMS. You have in the appendix of your statement a lot of statistical material. I am sure it would be very helpful to us, and it will be included in the record.

Mr. BLACKWELL. Yes, sir.

Senator WILLIAMS. We have a lot of pictorial matter, too, which we probably can't include, and yet I will keep it in our committee files.

The Migrant Hospitality Center, the Keller School, and Northrup Lodge all look like wholesome and healthy places for the various activities that are going on there.

Dr. LOCEY. We, too, have a mobile clinic that we pull up next to Northrup Lodge, that you mentioned, and the Migrant Hospitality Center.

We use these areas for the reception center, for registering health education, and then we use our migrant health clinic for the base itself.

Senator WILLIAMS. You shuddered to think what would happen if the outbreak of diphtheria had not been controlled.

Was there fear of an epidemic?

Dr. LOCEY. This particular case we are reporting, it took us about 20 telephone calls. By 11 o'clock that evening, we had the entire camp of 90 people isolated. They all had nose and throat colors. They were all given their booster shot, their diphtherin, and five cases we found carrying this pathogenic strain of diphtheria were immediately hospitalized and isolated, and therefore we were able to contain this thing, and not see it spread.

We couldn't have come anywhere near that. We could have rationalized afterward, "Well, this is a situation. We don't have the personnel. This is way out in the country. We don't have facilities."

But it is still a job. It was the proper thing to do.

Senator WILLIAMS. And you attribute the national program as the major contribution to taking care of that particular acute disease situation?

Dr. LOCEY. Well, I certainly think it helps, because, as I say, we act pretty much in an independent manner, and if there are clinics in every migrant area acting in that manner, we are going to be much further ahead.

But I still think, of course, there should be a greater liaison and communication between the number of migrant clinics throughout the country that exist especially in one given migrant stream.

Senator WILLIAMS. A lot of the diseases that you deal with are highly contagious; are they not?

Dr. LOCEY. Well, you will find in the statistics that the major diseases we come across are respiratory diseases.

From the standpoint of dangerous communicable diseases, there may not be many, but when they occur, they are important.

We did have one case of poliomyelitis that was discovered in our clinic in 1966.

Senator WILLIAMS. You are in agreement with all our other witnesses that addressed themselves to this appropriation, that the migrant health program should stand on its own feet, and not be put in the common pot, as you said, with the comprehensive program, because it might well get lost there?

Dr. LOCEY. Yes, sir.

Senator WILLIAMS. And we had directors of the health departments of four or five States, and they, without our asking them to comment, all volunteered the same observation that you did.

We did not ask you, did we?

Dr. LOCEY. No.

Senator WILLIAMS. So it came purely as an observation that you make from the fields where you work. Is that right?

Dr. LOCEY. This is correct.

Senator WILLIAMS. Well, we certainly kept you late, and, as I said the other day, while we feed the spirit and feed the mind, the time comes when we ought to be feeding the body. So at 1:22 we adjourn this hearing, and I cannot guarantee this, but we feel confident that your apprehension that this program might die on June 30 next year can be allayed, or dismissed, because on this committee I think we are in general agreement that the program must continue.

We are going to have some editorial problems in completing the record, with some charts and graphs and statistics, so without objection, the staff will be authorized to edit it for publishing purposes.

(The following material was subsequently received.)

ARIZONA STATE DEPARTMENT OF HEALTH,
Phoenix, Ariz., December 19, 1967.

Re S. 2688.

Hon. HARRISON WILLIAMS,
Chairman, Migrant Health Subcommittee,
New Senate Office Building, Washington, D.C.

DEAR SIR: The fertile valleys of central and southwestern Arizona constitute one of the nation's largest and most important agricultural areas producing close to \$300 million worth of cotton, vegetables, grains, citrus, alfalfa and other agricultural products, accounting for more than ten per cent of Arizona's economy.

An estimated 40,000 domestic migrant farm workers are employed year-round throughout the agricultural areas in Arizona, following the harvest seasons from county to county within the State or inter-state from California, Texas, New Mexico to Utah, Nevada, Colorado, Oregon and Washington.

The average family income of these migrants is far below the poverty level, averaging about \$1200 annually from our own observations in Migrant Health Clinics.

To protect the health of this high risk minority group, to provide for them at least a minimum decent and healthy environment, immunization and other preventive services, as well as medical and dental care when need arises is a public health responsibility of crucial importance for the economy of the State and needed in the humanitarian tradition of this great Nation.

The task becomes further complicated by the great distance the migrant worker and his dependents must travel to available health facilities, by his low income, lack of transportation, and indeed, often by his ignorance, lack of education and understanding of even the most basic principles of health protection.

Only through the efforts of comprehensive community planning involving the migrants, the farmers, community leaders, as well as voluntary and governmental health agencies can we hope to make inroads into the many and serious health problems affecting the migrant farm worker and his family. But planning alone is worthless when lack of funds stymies inception of the plan.

The Migrant Health Act of 1962 brought hope to the migrants, made communities look and realize their needs, and thus not only stimulated the planning process but provided the needed funds to assist Arizona communities in carrying out their plans. Through the incentive of the Migrant Health Act, Maricopa County and later Pima, Pinal and Yuma counties initiated migrant health projects that brought preventive and curative medical, nursing, nutrition and sanitation services to the migrants and their environment. In 1966, the Arizona State Department of Health started a statewide program of consultation and support to local efforts with emphasis on evaluating needs and progress, stimulating interest for health services in areas with migrant population where the need was not met, and searching for more effective methods for the delivery of health services at the time and place where the health dollar spent would do the most good for the money.

Federal funds for migrant health projects in Arizona, supplemented by an estimated equal amount of local funds or services, provided for well-child and maternity services, family health clinics, family planning and immunization clinics, nutrition services, sanitary camp inspections for all farm labor camps, medical social work services, nursing visits, health education programs, contractual laboratory and X-ray diagnostic services, medical care, dental care, drugs and partial hospitalization cost for over ten thousand migrant farm workers and their dependents.

Yet, we have still a long way to go before reaching the goal of providing just the most needed services to all migrant farm workers in Arizona. In Cochise County, nursing service is the only available service for hundreds of migrant families. In Graham and Greenlee counties, nothing but very limited strict emergency services are available for an estimated seven to eight thousand migrants.

Even in Maricopa, Pima, Pinal, and Yuma counties, where successful migrant health projects have been established, our best estimate indicates that only fifty per cent of the migrant population are recipients of needed services. There is need for establishing basic health services in Cochise, Greenlee and Graham counties. There is need for expansion of migrant clinics in several areas in Yuma, Maricopa, Pinal and possibly Pima counties. There is need for expansion of dental services which in most areas are not available or limited to emergencies or to children under 9 or 10 years of age. There is need for payment of full cost for hospitalization in counties which simply cannot afford to carry their part of the cost. There is need for expansion of health education efforts in all migrant areas of the State in order to effectively improve the utilization of preventive services and thereby make real inroads in the health status of the migrant farm worker and his family, enabling him to take his rightful place as a wanted, needed, healthy and gainful individual in the community, which, after all, is dependent on his work ability for its own economy.

Through the extension and expansion of projects and Federal funds, as proposed in Senate Bill 2688 for a five-year period, it will be possible for this State through orderly and comprehensive planning to help integrate all service to the migrants.

It is needless to say that I endorse Senate Bill 2688.

For further documentation of the need for passage of Senate Bill 2688 I am enclosing a copy of Arizona's Health, Vol. 1, No. 3, November, 1966, which supplements and illustrates the points that I have made in this letter.

Sincerely,

GEORGE SPENDLOVE, M.D., M.P.H.,
Commissioner.

CASA GRANDE CLINIC,
Casa Grande, Ariz., January 11, 1968.

HON. HARRISON WILLIAMS,
Chairman, Migrant Health Subcommittee,
New Senate Office Building, Washington, D.C.

DEAR SIR: At this time of pending legislation, I felt that a short line about the Migrant Health Family Services Project in Pinal County, Arizona, might not only be timely but might explain some of our positions relative to the Program.

As you probably already know, Pinal County is an agricultural county in southern Arizona employing a rather incredible number of domestic migrant farm workers each year. Although the health problems of this particular group have improved considerably over the past several years, the conditions to a newcomer (such as I was in 1955) to this particular area, would make our medical problems appear quite primitive. It is only through such Migrant Health Legislation as we now have that we are able to cope with the problem to any extent.

May I express my complete accord with the general feeling of the need, services, and the desirability of Migrant Health Legislation such as Senate Bill 2688. It will only be through legislation such as this that any inroad into migrant health problems may be made.

Thanking you for the privilege of communicating with you, I remain,

Sincerely yours,

R. F. SCHÖEN, M.D.

SAN JOSE, CALIF., December 20, 1967.

Re extension of Migratory Health Act.

HON. HARRISON A. WILLIAMS, JR.,
Chairman, Subcommittee on Migratory Labor,
Committee on Labor and Public Welfare,
U.S. Senate, Washington, D.C.

DEAR SENATOR WILLIAMS: In 1965 I established a family health service clinic for migrant seasonal farm workers in the South Santa Clara County area of California under the sponsorship of the County Medical Society. In 1966 and 1967 we received a Migrant Health Grant to keep the clinic in operation. The number of separate migrant individuals who come into this area during the crop season is estimated to be over 7,000 and 55% of these are youth. Ninety percent of these migrants are Mexican-Americans.

There is an abundance of statistics which I could present in order to indicate the significant health services provided by our clinic and the crucial need to continue to provide health care to migrants. However, I am sure you have sufficient statistical data to prove your point for extension of the Migratory Health Act. Nor do I have the time to describe a variety of other services and activities associated with the clinic; suffice it to say that in addition to providing basic health care, we are involved in a number of social, educational welfare and recreational activities.

But there is something even more significant than all those things that results from the clinic of this sort, and I should like to relate a personal experience in an attempt to explain what I mean.

Shortly after we started the clinic in 1965, I had the opportunity one night to examine a 17-year old Mexican girl named Maria, who had arrived from Texas one week previously. She came to the clinic directly from a long day in the fields, with a complaint of headaches of three months' duration. Though dirty and tired, she was vivacious and attractive in her ragged jeans and workingman's shirt. She was highly intelligent and had a personality which charmed everyone it touched. Examination revealed signs of an advanced brain tumor. Through an interpreter I confidentially explained the seriousness of the problem to her father, who became extremely upset, particularly because his wife, Maria's mother, several years before had died from a brain tumor. Maria was sent to the County Hospital immediately, and I have never seen her since. The story might end here. However, several subsequent events have contributed toward making Maria a significant part of my life. I later learned that she was operated upon that same night for what proved to be a malignant tumor, and she was left with paralysis of one side of her body. Some inter-faith migrant volunteers heard about her and took it upon themselves to "adopt" her, as it were, with daily visits during the many months of difficult rehabilitation in the hospital; you can imagine how many loving relationships developed in the process. The father and the other

children in the meantime had to move on to Salinas for work and survival. One night at the clinic, about two weeks after I had seen Maria, I discovered her father sitting among other patients waiting to see me. I was informed that he had made a special trip to personally thank me. He merely grasped my hand, and with tears in his eyes said: "Maria lives . . . gracias!" and then he quickly turned and left.

The next contact occurred six months later when I found an unexplained package of Salinas celery on the front porch of my home. Then I heard nothing until six months ago, when just by chance I heard a progress report on Maria from a local inter-faith migrant volunteer who had kept in close touch with the family from the very beginning. Maria had finally left the hospital and rejoined her family in Salinas and had managed to complete her high school studies in time for June graduation despite a severe handicap of one-sided weakness and speech difficulties. But the volunteer who gave me the report was much more excited about something else. She had just learned that Maria had accepted her invitation to spend the summer as her guest in San Jose!

How many lives in how many ways have been favourably effected by this one little migrant clinic . . . we'll never know completely. But we *do* know in part!

There are many, many Marias migrating throughout our country, and I sincerely hope we can consider them as much with compassion as with computers. I urge that Senate Bill #2688 be passed.

Respectfully yours,

STANLEY A. SKILLICORN, M.D.

COLORADO DEPARTMENT OF PUBLIC HEALTH,
Denver, Colo., December 19, 1967.

HON. HARRISON A. WILLIAMS,
*Chairman, Migrant Health Subcommittee,
New Senate Office Building, Washington, D.C.*

DEAR SIR: In reply to your invitation to submit a written statement in connection with the extension of the Migrant Health Act. We hope the following comments will be of assistance in assuring the passage of this much needed legislation.

Each year, approximately 20,000 migrant workers and their family dependents are engaged in the production of Colorado field crops. The classic problems of their mobility, poverty, and cultural isolation are compounded by the nature of crop production in our state. Due to the decentralization of farm housing, and the subsequent dispersion of the migrant population, delivery of health services is a difficult task.

1. A serious void exists in meeting the in-patient hospital care needs of migrants in Colorado. Hospital care is an essential, but missing, link in the chain of comprehensive health care, which is being forged under the auspices of the State Migrant Plan for Public Health Services.

2. Medical and dental service are both areas in which expansion is needed in order to meet the total need of the target population. Public health nursing must be made available to more migrants in order that medical and dental services may become available to all who need them.

3. Due to lack of sufficient Environmental Health staff, problems have been attacked on an area-by-area basis, rather than as a whole. Many areas in the state have not yet been subjected to intense scrutiny as to environmental conditions. Often, as project emphasis is shifted to a new area of the state, housing conditions in the area just left begin to deteriorate again.

4. Each year the efforts of the dental hygienist, employed by the project, yield more cases of need than available funds can provide for. We are certain that even her intensive efforts have not uncovered all of the migrants' dental health needs.

5. The current amount of our grant, MG 09 is \$157,581.00. This is the amount authorized for the calendar year, which will end December 31, 1967. In order to meet some of the needs referenced above, a continuation request was submitted for the period January 1, 1968 through December 31, 1968 in the amount of \$262,048.00.

6. This level of funding would have provided for the employment of a full-time public health nursing supervisor and consultant, whose duties would be to involve greater numbers of county level public health nurses in migrant health matters. Some progress was made during the current calendar year in this direction and it was found that the yield in direct services to migrants far exceeded expectations.

7. It was planned to employ an additional dental hygienist for six months to assist the full-time hygienist in screening and referral work during the migrant season.

8. Also included, was provision for a very modest in-patient hospital care program. It was estimated that an absolute minimum of 365 patients would require care at an average of $3\frac{1}{2}$ days per patient and at an average cost per patient of \$215.00, with an estimated total cost of \$78,475.00. In that Public Health Service (Migrant Health Branch) guidelines would have restricted us to only 53% of this, a total amount of \$41,592.00 was applied for. Provision was also made for commercial transportation of patients to hospital facilities.

9. In order that the public health nursing program could be expanded in an orderly fashion, two critical areas were chosen to receive assistance. These were the Northeastern Colorado Health District and the Adams County area of the Tri-County Health Department of the metropolitan area. In both cases, provision was planned for the employment of a public health nurse during the migrant season in those respective areas.

10. A realistic increase in funding for dental services was requested which would have doubled the amount of patients who could have received care in 1968.

11. While no specific plans were incorporated in the application for the expansion of the Environmental Health Program, increases would have become necessary in view of the housing regulations recently promulgated by the U.S. Department of Labor. This would have required the employment of an additional sanitarian and three sanitarian aides. This, together with the other personnel increases would have required additional clerical assistance at the State level. The total amount required to fund this additional activity would be approximately \$46,000.00 annually; this would be in addition to the \$262,048.00 originally requested for the on-coming calendar year: a total of \$308,048.00. Even this amount would not meet the need for a full-scale assault upon migrant health problems.

12. The current level of grant support, \$157,581.00 to which we are to be held during 1968, does not realistically reflect migrant health needs in Colorado. It is barely sufficient to maintain program momentum. It will not enable us to make the necessary increases in program effort which are referenced above. Hospitalization, even at the minimal level planned, will remain unavailable, there can be no increase in meeting medical and dental needs, the public health nursing program will not progress at the necessary rate of speed, nor will any substantial improvement in the environmental health program be possible. Moreover, normal salary and other cost increases will make it necessary to omit or cut back some existing activities.

It is our hope that necessary legislation will be enacted which will enable our project, and others, to deliver health services at a realistic level to this segment of our population.

Sincerely,

R. L. CLEERE, M.D., M.P.H.,
Director of Public Health.

TALBOTT FARMS, INC.,
Palisade, Colo., December 29, 1967.

Hon. HARRISON WILLIAMS, Jr.,
Chairman, Subcommittee on Migratory Labor,
U.S. Senate, Washington, D.C.

DEAR SIR: The Talbotts are probably the largest private employers of migrant labor in the state of Colorado. We have been in the fruit business here since 1942. We want to give our support to S-2688 which will continue and extend the funds for Migrant Health Services, such as we have been receiving under S-1130.

As growers, we have been greatly benefited by the health services given the agricultural migrants of our county. It has helped us recruit labor; it has stabilized our labor supply as it causes many more workers to return; and it has been a great convenience to us by making night clinics available. Fewer hours of work have been lost and the general health and productivity of the workers have been higher.

Your support of S-2688 will be greatly appreciated.

Yours truly,

Mrs. H. A. TALBOTT,
Secretary-Treasurer, Talbott Farms, Inc.

P.S.—We could send oral testimony in support of this bill by tape, if it would be helpful.

MESA COUNTY MIGRANT COUNCIL, INC.,
December 29, 1967.

Hon. HARRISON A. WILLIAMS, Jr.,
Chairman, Subcommittee on Migratory Labor,
U.S. Senate, Washington, D.C.

DEAR SIR: The Mesa County Migrant Council, composed of representatives of clubs, agencies, lodges, churches and service organizations, urge the passage of S 2688 extending and increasing the present Migrant Health Act.

If the committee could see the splendid results accomplished with a modest amount of funds made available to us through the previous bill, S-1130, all doubt as to the efficacy of the program would be removed.

During the six months Mesa County has large numbers of migrant agricultural workers, a Public Health nurse visits the ranches, providing health teaching and counselling, screening for diseases such as tuberculosis, and giving immunizations. Night clinics are held during the fruit season when there is a tremendous buildup in the population of fruit areas. Medical care is provided over the entire county in any physician's office, without cost to the migrant. The doctor is reimbursed at a certain proportion of the Blue Cross fee.

The grower and the general population have benefited as well as the migrant. We cannot too heartily urge the continuation of this splendid program.

Yours very truly,

Mrs. H. A. TALBOTT,
Chairman, Migrant Health Committee.

SARASOTA COUNTY HEALTH DEPARTMENT,
Sarasota, Fla., December 19, 1967.

Hon. HARRISON A. WILLIAMS, Jr.,
Committee on Labor and Public Welfare,
Subcommittee on Migratory Labor,
U.S. Senate,
Washington, D.C.

DEAR SENATOR WILLIAMS: I wish to take the opportunity, so kindly afforded by your office, to comment on your Bill S-2688 to extend and expand the Migrant Health Act which will otherwise expire at the end of the current fiscal year.

By way of introduction, I would like to point out that I am now a local health officer with an ongoing Migrant Health Project and also a member of the U.S.P.H.S. National Migrant Project Review Committee. I was formerly Director of the Florida State Migrant Health Project as Director of the Bureau of Maternal & Child Health, Florida State Board of Health. In these capacities, as well as in previous local health work in Florida, I have been associated with Migrant Health programs for a period of over fourteen years. During these years I have observed Local, State and Federal programs from all three levels and feel better qualified than the average public health official on this subject.

The immediate reaction might be that I am a partisan representative, since I have an axe to grind as a Migrant Health Service Project Director. I do have an axe to grind, but not due to my connection with a Migrant Health Project! My axe, the one to which I have dedicated my professional career, is to assure to the best of my ability that every human being over which I have any jurisdiction receives every health service and every health protection that my staff and budget will permit. The \$22,000.00 that I receive for the Migrant Health Project is a small part of our total operational budget of \$500,000.00 annually. While it permits us to mount a program we could not otherwise fund, it is not enough to warrant a "personal axe letter", unless this program were important to me for other reasons! *It is!*

I have seen migrant families living in pasteboard boxes, chicken coops, deserted automobiles and the back end of a stake-truck. I have looked into the eyes of dying infants who suffered from lack of food, clothing and similar items we consider as fundamental necessities of life. I have provided or recommended hundreds of dollars of remedial care to migrants who waited too long for \$5.00 worth of care or who sought \$1.00 worth of prevention and could not obtain it soon enough to forestall a serious illness.

I have also seen what a community can do, with only a few dollars, when a few concerned citizens take an interest in God's children. If our National Poverty and Foreign Aid Programs could be operated with the tight-fisted realism and dedication to service that I have observed in Migrant Health Projects, they would

cost much less and produce much more, I assure you. I have, incidentally, worked as a public health specialist in both Foreign Aid and O.E.O. programs and know whereof I speak!

These are the reasons this program *must* be extended and expanded to permit wider participation, nationwide. As a member of the National Review Team I have been forced to reject basically sound projects due to the shortage of funds available to continue existing programs while attempting to add necessary new projects. Priority must go to the continuing projects, where a competent job is being done. Sometimes this must be at the expense of a new project which appears badly needed.

The Migrant Health Act has made a greater, more dramatic impact on the Health of Domestic Migrants in a shorter period than any other single project with which I am acquainted. The job isn't completed yet and should funds be withdrawn prematurely, much that has been done would be abandoned through sheer lack of adequate local resources to allow continuation. I wish to commend each of you who worked for passage and extension of the previous act. It was truly a worthy achievement!

It has been said that Federally-sponsored programs never phase out, they just grow! I know this is not true because I have personally assisted in the phase-out of three federal projects in the past seven years. With continued support for our Migrant Health Project, in Sarasota County, I expect to phase it out in two to three years to make room so another needy area may participate. Our county will be ready and able to support the project by then and we fully expect it to do so within three years, maximum!

However, being familiar with each of the remaining two hundred projects in the Nation, I know that many of them will need at least five year's assistance. Many needy areas have *no* program as yet, they will need assistance, as we have, for five or more years in the future! The question is not, "can we afford to fund them, but can we afford not to?"

I submit that a Nation which can support a foreign war, good or bad—chosen or thrust upon it, cannot turn its back on the most impoverished Americans that one can imagine. You who put the people's will into action should get to know our Migrants. Have you ever really seen a migrant? Have you ever entered his hovel? Have you ever met him in the field or orchard? You cannot all see a Migrant Infant die (thank God), but you can all see a migrant family as it lives in our nation today! I commend this experience to you, you will never forget it! Every state represented on the subcommittee has migrants, so they won't be hard to find at home! There are also plenty in Virginia, Delaware and Maryland, no more than two hour's drive from Capitol Hill. Let the migrant help you decide how to vote on this critical Bill.

I have written similarly to my friend, Congressman Paul Rogers, and to my own congressman, James Haley. They are both fighting for Migrant Health, won't you do the same?

Please excuse this overlong letter. I get wound up on some subjects and, after all, you did invite my comments. Of course, you didn't ask for a book!

Gentlemen, give us the tools to work with a little longer and in adequate supply. I assure you we'll get the job done! Unlike Medicare, we won't take forever either!

Best wishes for a successful year in 1968.

Sincerely yours,

DAVID L. CRANE, M.D.,
MPH, Director.

DELRAY BEACH, FLA., December 27, 1967.

HON. HARRISON WILLIAMS, Jr.,
Senate Office Building,
Washington, D.C.

DEAR SIR: Regarding S. 2688. We have a family owned farm which we have operated for the past 9 years growing to our present size of 150 acres of bell peppers. We employ 30 Puerto Rican workers (4 with families) from September to April.

The migrant health services in Palm Beach County have been extremely useful in promoting better health among our workers and their families. I am sure I speak for the majority of the farmers in this area when I urge most strongly the continuation and expansion of the Public Health Service Act as it affects the migrants. It should be pointed out that the past several years have seen a minor revolution in the agricultural economy. These people are being paid

more money and in many cases they are assuming more permanent positions in the work force. It is to be hoped that by increased attention to the health and welfare of the children in particular that they will grow up ready and able to take their places in an economic climate radically different from that their parents faced.

Very sincerely yours,

TED WINSBERG.

FANCEE FARMS,
Sarasota, Fla., December 27, 1967.

Senator HARRISON A. WILLIAMS, Jr.,
U.S. Senate,
Washington, D.C.

DEAR SIR: Referring to Legislation #S. 2688, which would extend the Migrant Act for five years and also expand the program to reach twice as many farm workers, as are now being served.

We wish to take an affirmative position on this legislation as we are very much in favor of its being extended as specified in Bill S. 2688.

Very truly yours,

PAT F. FECLISE.

STATE OF ILLINOIS,
DEPARTMENT OF PUBLIC HEALTH,
Springfield, December 27, 1967.

Re extension of Migratory Health Act (S. 2688).

SENATOR HARRISON WILLIAMS,
Chairman, Migrant Health Subcommittee,
New Senate Office Building, Washington, D.C.

DEAR SENATOR WILLIAMS: The migrant health program in Illinois is nearing the end of its third year. We have been able to meet many of the needs of the migrants who come to Illinois but many objectives and needs are unmet.

Minimum health standards have not been achieved in some areas. Assistance is needed in order to bring housing conditions into compliance with the United States Department of Labor regulations.

Education for migrant children is also a pressing need compounded not only by lack of funds but also by the fact that it is necessary for children to work in the fields or care for their younger siblings during the day.

The above problem reveals the additional need for more day care centers. The 1968 migrant season will see the discontinuance of certain day care centers rather than the much needed expansion of this important program.

Family clinics and immunization programs would be of significant value to the migrant community. Growing interest in birth control is accompanied by fear that the cost makes it prohibitive. Education in this area would dispel misconceptions.

The five federal migrant health grants now approved in Illinois serving nearly 11,000 migrants are as follows:

Illinois Department of Public Health, Lee-Ogle and Vermilion Counties (MG 105C)	\$25, 365
Princeville Migrant Health Services (MG 150A)	1, 683
Jones Memorial Community Center Migrant Health Clinic (MG 151A)	15, 891
Northwest Church Council for Migrant Aid, Inc. (MG 152)	10, 305
Rock Island-Mercer Migrant Family Health Service (MG 153)	10, 280
Total	63, 524

The greatest proportion of these grants goes to pay administrative expenses only; hospitalization and doctor bill requests in the grant are not enough. We have assisted in paying unpaid hospital and doctor bills which could not be collected, using Children's Bureau Funds.

Funds from the State of Illinois Children's Bureau—Fund A have been made available to the migrant program through December 31, 1967 for pregnant women and children under 19 years of age. A dental van has also been partially supported by these funds for those who qualify. Since these funds have been cut and are no longer available the only source of funding is through the USPHS grant.

The importance of expanding the program in Illinois cannot be overemphasized. In the past three years we have been able to help only a part of the migrant population. While the migrants and their employers have displayed a responsible

attitude toward payment of medical bills, there is still a great need for assistance in this area. Little is gained if a family comes to Illinois for a season of work and medical bills to be paid require all or most of the earnings. Better cooperation from local doctors and hospitals can be expected if they have more assurance that they will be paid for their services.

The great need for facilities necessary for basic hygiene make additional health education necessary since good health habits are difficult to maintain under these conditions.

The experience we have had with migrant health referrals has been most rewarding. There is, however, need for expansion in this area, especially in the area of more complete information and more time for follow up.

A total of \$79,503 from the State of Illinois Children's Bureau—Fund A was paid for migrant health in the period July 1, 1966 through June 30, 1967. The withdrawal of these funds effective January 1, 1968, and the 1967 defeat in the Illinois State Legislature of a \$200,000 bill for migrant health appropriations for the biennium means that additional USPHS funds will be needed until at least 1969.

An additional load is being placed on the migrant program because of unfavorable weather conditions in Texas, causing migrants to extend their stay in Illinois beyond the usual three months.

A budget showing additional needs above the present grants for the period July 1, 1968 through June 30, 1969 is attached. This is a conservative estimate of the additional needs in Illinois for the next year.

Sincerely yours,

FRANKLIN D. YODER, M.D., M.P.H.,
Director of Public Health.

Needs in addition to present migrant health grants, July 1, 1968, to June 30, 1969

Personnel-----	\$22, 200
Program director-----	12, 000
Field coordinator @ \$8,000. 3 mo/yr-----	2, 000
Clerk V; clerk steno II-----	8, 200
Contractual-----	5, 100
Telephone-authorization for hospital care-----	
Connection and utilities for trailers and van-----	
Shipment of informational items, drugs, and biologics-----	
Utilities at Springfield and regions IDPH-----	
Upkeep on dental van and trailers-----	
Travel (18 major areas and 20 smaller areas)-----	4, 400
Program director (average \$100 per month)-----	
Field supervisor (average \$250 per month)-----	
Public health dentist services—dental van—remains in field April to October (7 months) (average month \$350)-----	2, 450
Commodities-----	1, 100
Dental van commodities-----	
Gasoline, tires, etc., for van-----	
Printing: Spanish-English health information materials-----	500
Equipment: Dental van—replacements per year-----	1, 000
Medical, nursing and public health services including hearing and vision screening, physical exams to enter schools and day care centers, nutrition services, nursing followup, immunizations, glasses, hearing aids, dental care, medical care, TB tests and X-ray, VD investi- gations, inpatient and outpatient hospital care (accidents more frequent, especially highway), and family planning-----	125, 000
Total-----	159, 300

MUSCATINE MIGRANT COMMITTEE,
Muscatine, Iowa, December 28, 1967.

Senator HARRISON A. WILLIAMS,
Chairman, Subcommittee on Migratory Labor,
Senate Office Building, Washington, D.C.

DEAR SENATOR WILLIAMS: In reference to legislation S. 2688, as a grantee under the Migrant Health Act, the Muscatine Migrant Committee of Muscatine, Iowa, heartily supports Congressional efforts to expand the provisions of the Migrant Health Act and to extend it for five years or longer.

The availability of Federal funds in our area to which over 1300 migrant workers and their dependents came during 1967 has provided more adequate medical care for the migrants and has relieved the community of a residue of unpaid medical bills. The hospitalization component has been of the utmost importance in encouraging and helping to provide for hospital care before injuries and illnesses have reached acute stages. Dental funds are being used to save teeth which would otherwise be lost to decay. Through the weekly, evening family health clinic, medical needs have been brought to the physician's attention which in many cases would have been neglected as a result of the high cost of medical care.

Through the efforts of the staff provided for under the Migrant Health Act, the migrants are educated toward recognizing their health problems and toward becoming increasingly responsible for their own care.

More funds are needed, however, to extend the coverage of the existing provisions and to explore such possibilities as a federally financed group medical insurance plan for migrant agricultural workers and financial assistance to growers in the construction of adequate sanitary facilities.

We assure you that the availability of federal funds is making a significant and sometimes vital difference in the adequacy of medical care for the seasonal migrants in our area and that the extension of these funds to assist with the costs of medical care for newly settled out migrants helps to ease the trauma encountered in that process. Through your efforts, there is a chance that our country's neglected will take their place among our country's respected.

Sincerely,

Mrs. THOMAS B. MANTON,
Migrant Program Coordinator.

IOWA CATHOLIC CONFERENCE,
Des Moines, Iowa, December 19, 1967.

Hon. HARRISON A. WILLIAMS,
U.S. Senate, Washington, D.C.

DEAR SENATOR WILLIAMS: I would like to go on record as supporting the extension of S. 2688, which would prolong the Migrant Health Act for a five-year period.

Very truly yours,

JAMES M. McNALLY,
Executive Director.

KANSAS STATE DEPARTMENT OF HEALTH,
Topeka, Kans., December 29, 1967.

Re S. 2688, extension of Migratory Health Act.

Senator HARRISON WILLIAMS, Jr.,
Chairman, Committee on Labor and Public Welfare, Subcommittee on Migratory Labor, New Senate Office Building, Washington, D.C.

DEAR SENATOR WILLIAMS: For the past four years, I have been privileged to serve as the medical director for the Migrant Project in Western Kansas. I am heartened that legislation has been introduced to extend the Migrant Health Act for an additional five years, as our efforts over the past years in changing cultural patterns in acceptance of medical care are only now becoming realized. The state and local health services in rural areas of Kansas are presently inadequate to meet the needs of the resident population and cannot cope with the health problems presented by migrant families.

We have been well pleased with the flexible and innovative handling of the project grants which has encouraged experimentation in the delivery of services. It also made it possible to demonstrate for a wide geographic area, a regional health service staffed by a public health team. This may point the way for reor-

ganization of traditional public health services in rural areas. We have also learned the value of utilizing health aids in motivating and communicating with the migrants.

Migrant families are rapidly changing their attitudes toward utilizing health services. The evening clinics have often run as late as midnight and served as many as 100 persons. To spend a long hard day in the field, yet still be willing to come many miles to an evening medical clinic indicates good motivation. Originally, families sought health care in the clinic for their children as a requirement for admission to licensed day care programs. Attendance at the medical clinics gradually extended to other members of the family as they realized the benefits. A major health problem which remains to be solved is child spacing and family limitation. Typical childbearing experiences are as follows: One migrant family served by the program this past summer had sixteen children. Another had six living children, two infants who died and three miscarriages. Another family; ten living children; four miscarriages, and another family with seven children all under eight years of age. These families are beginning to request help in family planning.

Although Western Kansas has a rather small migrant stream—5,000 to 6,000 persons, the problems of these people run deep. Unless continued effort comes from the Federal Government, it is probable the life patterns of migration, lack of education and lack of health care will be transmitted from generation to generation. Most gratifying in the past year has been the improved inter-state communication with better follow-up of health problems at the home base. We sincerely urge extension of the Migrant Health Act. Although additional funds probably will not be requested for the Kansas project, similar projects are needed in other areas of the country.

Respectfully submitted.

DIVISION OF MATERNAL AND CHILD HEALTH,
PATRICIA T. SCHLOESSER, M.D., F.A.A.P.,
Director.

KANSAS STATE DEPARTMENT OF HEALTH,
Topeka, Kans., December 26, 1967.

Senator HARRISON WILLIAMS,
Chairman, Migrant Health Subcommittee,
New Senate Office Building,
Washington, D.C.

DEAR SIR: Kansas has been a recipient of a migrant health grant for the past four years. This grant has allowed us to provide health services for approximately 4,000 migrants who come to Kansas each spring and return to Texas in the fall. These migrant families contain many small children and infants.

The migrant population is centered in the Southwestern part of Kansas around Garden City. This is largely a rural area with almost no public health services and a minimum of physicians and dentists.

The grant has allowed us to provide family medical clinics, dental clinics, hospitalization, immunizations, tests and x-rays for the detection of tuberculosis, family planning services, vision and hearing screening for children, prenatal care for expectant mothers, public health nursing services, sanitation and health education services, and health services to children in day care centers. None of these services would be available to the migrants if it were not for this grant.

A second grant has been utilized by the Kansas City-Wyandotte County Health Department to provide similar services for around 4,000 migrants who come to the Kansas City area each summer.

These grants total \$110,000 and are adequate to provide needed health and medical services to the Kansas migrants. We urge that this program be continued by the Federal Congress and will be pleased to supply additional information as necessary.

Sincerely,

HUGH DIERKER, M.D., M.P.H.,
Director of Health.

THE KANSAS STATE DEPARTMENT OF HEALTH,
Topeka, Kans., January 2, 1968.

HON. HARRISON WILLIAMS,
Chairman, Migrant Health Subcommittee, U.S. Senate,
New Senate Office Building, Washington, D.C.

DEAR SENATOR WILLIAMS: This is written in support of the pending migrant health legislation.

The Migrant Health Grant has been most helpful to us in Kansas in developing public health and medical care programs for migrants. I am sure that you are well aware of the needs of this group for both health education and health service, so I will not enumerate these. Through the public health nursing service we have been able to institute, we are seeing a change in health attitudes and practices that is most gratifying. More work and service will be necessary if attitudes are to be really changed and people are to continue to seek medical care when needed and to use child and self care practices that will insure good health.

To continue the program which we have started, we will need continuing support from the Federal Grant Funds. The localities in which the projects are located are not able to support the services at present and the state is not ready to assume this load without assistance.

Because of our referrals to other parts of the country when families or individuals need care after they leave our state, we are aware that there are areas with no services. Funds are needed for new services as well as for continuing programs such as ours.

I certainly hope that the health needs of a sizable segment of our population will be considered seriously and that funds will be appropriated to make possible new and expanded services as well as the continuation of those already existing.

Sincerely,

DOROTHY WOODIN,
Director, Public Health Nursing.

COMMONWEALTH OF KENTUCKY,
DEPARTMENT OF HEALTH,
Frankfort, Ky., December 27, 1967.

HON. SENATOR HARRISON WILLIAMS,
Chairman, Migrant Health Subcommittee,
New Senate Office Building, Washington, D.C.

DEAR SENATOR WILLIAMS: This is in reference to Senate Bill 2688, introduced to extend the Migrant Health Act for five years and also expand services to reach additional migrant farm workers.

I am definitely favorable to the enactment of Federal legislation to improve the health services under this program. Due to state resident requirements, it is impossible for each state to provide the level of health care that meets minimum standards.

Kentucky has provided personal and environmental health services to migrants working in Carlisle and Hickman Counties for the past three years, from funds made available through a Migrant Health Project Grant (MG-77). However, the needs of this group remain unchanged except for the treatment, in most cases of acute conditions provided during daily clinics. Very little alleviation of chronic conditions is possible with the limited resources currently available.

Although during the past project year Kentucky spent \$7,450.00 of a total grant of \$17,053.00, the unspent funds were the result of the unavailability of qualified personnel. The lack of personnel is one of the major needs for projects that are operative for short time periods.

To develop a comprehensive program to reach the total migrant population working in Kentucky, the amount of funds must more than double during the next few years. Our past programs have provided direct medical services to less than one-third of the migrant workers in the target area. Environmental improvements have also been made in the migrant camps. I have no doubts but what all these workers are in need of, at least, general medical supervision; and that a great deal more of environmental health activities could and should be developed.

An organized inter-state coordination is also vital to have a truly comprehensive program, and to this fact any legislation should place a great deal of priority.

I am enclosing a copy of our 1967 progress report for the Migrant Project (MG-77). I hope this report and my comments will be of assistance in improving the health status of the Migrant population.

Sincerely,

RUSSELL E. TEAGUE, M.D.,
Commissioner of Health.

MIGRANT HEALTH PROJECT, 1967, STATE OF KENTUCKY, HICKMAN AND CARLISLE COUNTY

MIGRANT HEALTH PROJECT

Through the combined efforts of the State Department of Health and Carlisle and Hickman County Health Departments a grant of federal funds was awarded to Kentucky to improve the health of migrants coming into Hickman-Carlisle communities during the strawberry harvest season, May through June, and to provide safeguards to this community. The Project was initially started during the harvest season of 1965. Services offered through the project included prenatal and postnatal care to migrant women, family health service clinics, dental services, environmental health services, nutrition and general health instruction.

This is the third report of project activities and covers the period of May through June 1967.

The period covered by this report corresponds with the beginning and ending dates of the strawberry harvest in Carlisle and Hickman Counties from 1 May to 15 June 1967. The contract agreements arrived at prior to the project, between the project director, physicians, and dentist, allowed for any possible overlapping in that it called for a period of services from 1 May to 30 June. This schedule was well chosen for it corresponded with this year's strawberry harvest.

The general objectives of this project are listed on the following page. Few changes have been made over the one-year period. In only one objective, that concerning the health status of the worker himself through the medical services made available to him, did the project achieve fairly comprehensive success. The clinic was set up and those that were able to take advantage of its services were well cared for.

Fewer migrants came to Hickman and Carlisle Counties this year than did last year. Excessive rainfall followed by long spells of heat caused a less plentiful harvest and the migrants didn't stay as long as they had the previous year. Also, competition from Mexican growers caused the frozen strawberry market to decline. Approximately 805 migrants came this year (figure from growers' estimate). Of these, approximately sixty percent of the working force were women. There were approximately 165 children below the working age living on the farms. Another 110 dependent children accompanied their parents in the fields picking strawberries.

The composition of migrant labor was relatively unchanged from last year, mainly Texans (Spanish speaking) and Negroes from Louisiana, Mississippi, Missouri, and Tennessee.

GENERAL PROJECT OBJECTIVES

A. To seek improvement of the environmental factors affecting the health of migrant workers.

B. To improve the health status of migrant workers employed in Carlisle and Hickman Counties through (a) medical and nursing, (b) dental, (c) nutritional, and (d) venereal disease services.

C. To provide health education opportunities for the migrant workers and for the growers through health education activities.

The Spanish speaking migrants from Texas are composed mostly of family groups. The Negro migrants, on the other hand, have a greater proportion of single workers.

This report covers the third year of a three-year period that the Public Health Service has been utilized for migrant welfare.

Previous employment arrangements had been made through crew leaders who travel with the migrants acting as agents, interpreters and intermediaries between the workers and the growers. In addition to the migrant laborers there were a small number of untrained Negro commuters from Cairo, Illinois; Tiptonville, Tennessee; Paducah, Kentucky; and Hickman, Kentucky, who assisted with the picking through the peak of the season. This year, however, there were fewer cases where "outhaul" laborers were used. The unwillingness of the farmers' part to hire the less experienced and less responsible "emergency labor" coupled with the smaller crop caused fewer to be brought in. This year there was little or no publicity made in the area newspapers concerning the migrant project. Two illustrations included in this report, taken from the *Carlisle County News*, concerned the educational program for the children this year (not a part of the health project). In this initial program seventy-three children attended school in Carlisle County and approximately the same number in Hickman County.

This program was offered during the same time that the health clinic was held. Several of the children who attended the evening classes were referred to the clinic by the school program's health nurse.

After the harvest of the strawberry crop in Carlisle and Hickman Counties the migrants go on to other harvest areas. Most go to help with the vegetable, strawberry and cherry harvests in Michigan. Others go to the mid-west for the sugar beet harvest and to Illinois and Indiana for the strawberry crops. In the late fall and early winter they return to their permanent homes in the South and work harvesting the crops there.

Future predictions of the size of the harvest and, thus, the number of workers returning next year will fluctuate in accordance with the weather picture. All the growers that I interviewed, with the exception of one, who might not plant a strawberry crop next year, will be planting more strawberries next year.

ENVIRONMENTAL SERVICES

Environmental conditions in the migrant camp themselves haven't improved appreciably over the past year (according to the local health officers who worked with the project). New living units, shower facilities and privies have been constructed on several farms this past year.

At a previous meeting on environmental health, both the growers and the health department agreed to accept as regulations the minimum environmental requirements from the Kentucky State Department of Health.

The regulations—minimum environmental requirements for migrant labor camps:

Water: Tank of sufficient size to allow water and proper amount of chlorine to remain in contact for 30 minutes prior to use.

Sewage disposal: Standard Kentucky pit privy for camp areas.

Housing:

Specification 1: New construction—10-percent floor areas; Old construction—5-percent floor area.

Specification 2: Floor spaces per person—20 square feet.

Specification 3: Refrigeration—should be more. No recommendation.

Specification 4: Insect control—should control flies and mosquitoes.

Specification 5: Showers—meet State plumbing code.

Specification 6: Garbage—pits at least 6 by 6 by 6. Disposal—backfilled daily.

None of the camps complied with the chlorination standard. All tests for contamination reported by the local sanitarian this year were negative. No improvements on the wells themselves have been made since last year. All the camps, with the exception of one, received their water from deep wells. One camp is supplied with water brought in by truck from the city water supply and is stored in a cistern. It is manually chlorinated. There is one water outlet in each camp and buckets are used extensively for transporting drinking and washing water. No plans for future chlorination have been made by any of the growers.

The privies constructed in the camps have failed to meet the minimum standards in that they are not backfilled daily. All but a few of the privies are without seats or tops and none of them are screened. In the past seats were installed in several privies; however, the migrants themselves have removed a good deal of these. The portable privies used in the fields are well maintained and are up to the public health minimum requirements.

The showers are adequate but little effort has been made to insure proper drainage. Some units' fittings are supplied by makeshift hoses and have proven more than adequate. Several new shower facilities constructed this past year have shown improvements in that they are constructed of concrete block and have the proper fittings. One grower in particular has made a remarkable effort in this particular aspect over the past year.

New living units have been constructed in the camps this year. Most of these are the movable 12' by 16' duplex-type houses. These units are covered with the standard aluminum sheet siding and are designed with dividing partitions to accommodate two families if necessary. There are some new units which have been converted from barns that have concrete floors and are so fitted that many separate units can be arranged. All the new units are sturdily built and made for versatility. More refrigerators and hot plates were purchased this year by the growers. All of the camp houses lack proper ventilation for the gas burners which, on many occasions are left burning during the early-season mornings for heating purposes. The camp houses are not screened. However, the insect problem is fortunately not critical during the harvest season.

The garbage disposal facilities are deficient in that no daily backfilling of the pits is carried out. In many cases the areas around the living units illustrate the negligence on the part of the migrants in respect to proper garbage disposal practices. Upon visiting the camps in mid-September it appeared that the growers had accomplished a cleanup in the living units and in the surrounding areas. All the units appeared clean and the surrounding areas well policed. All the garbage pits were covered properly. In most cases, the migrants' attitude is a determining factor toward the success of the environmental improvement program. Efforts made by health representatives to instruct the migrants and insure proper followup have been hampered by the growers' unwillingness to have outsiders in the camps during the harvesting season.

Most growers feel that they have fulfilled their obligations in providing proper living facilities to the migrants. They feel that much of the routine sanitary practices should be left to the migrants to accomplish. A good many migrants appeared satisfied with their housing except that a few have complained of the lack of privacy in the units themselves.

MEDICAL AND NURSING SERVICES

Objectives

1. To provide prenatal and postnatal care to migrant women.
2. To provide health supervision and pediatric care to all children in the migrant camps.
3. To improve the health of migrant workers through provision of primary and secondary preventive medical care.

The health clinic was held five days a week alternately at the Hickman and Carlisle County Health Departments. On Monday, Tuesday and Wednesday it was held in Hickman County and on Thursday and Friday in Carlisle County for a total of twenty days. The clinic hours were from 5 to 8 p.m. each evening, thus enabling migrant visitation during the after-work hours of the day. This year's clinic started one hour earlier than last year's for it was believed an earlier closing time would allow the workers more time to return to their camps and thus get enough rest for an early morning start the next day. It was hoped that this would serve to improve the relationship between the health project and the growers.

One hundred and five medical cases and sixty-four dental cases were treated at both clinics. Seventy-five medical and thirty-seven dental cases were treated at the Hickman County Clinic. Thirty medical and twenty-seven dental cases were treated at the Carlisle County Clinic. Seventy-three migrants were treated by the physicians in their private clinics for a total of eighty-seven medical problems. The dentist also saw seven migrants in his private office and performed twenty-four dental procedures on them.

Three physicians, one dentist, one dental assistant, one nutritionist, two aid-administrators (both former "gray ladies"), one clerk stenographer, and one project coordinator (Administrative Assistant of Hickman and Carlisle County Health Departments) staffed the migrant project this year. Two of the physicians, the dentist, the dental assistant, the nurse, the nutritionist and the project coordinator had experience with previous projects, thus negating much orientation training. The clerk stenographer, Mrs. Joyce Mills, underwent a three-day indoctrination program in keeping project records at the Kentucky State Department of Health and she considered this quite beneficial in the project work. The practice of rehiring experienced personnel is quite applicable in this case.

This year's clinic was conducted on simple patient-treatment basis, no screening was attempted this year as was done last year. Patients entered the clinic, were registered and interviewed by the aids and then referred to a physician or dentist. No medical histories were initiated and no examinations were given unless directed to by a physician. Transportation to the clinics was at the migrants' expense, a different policy from initial years. The first project year, transportation costs were paid by the project, i.e., the migrant crew leaders and the migrants themselves (who had their own transportation) were reimbursed for their travel to and from the clinic. More people attended the clinic the first year as a result of this added incentive, thus programs such as the examination and screening program, the health and dental hygiene program were enhanced. All the patients attending the clinic each night were seen and treated by both dentist and physician.

A new program established this year was the inpatient and outpatient treatment offered certified migrants in the Hickman-Clinton County Hospital. Arrangements were made with the hospital for receiving migrants referred there by project physicians and for emergency care. Seven migrants received hospital care during the project period and one migrant remained in the hospital for a week after

project termination. The arrangements proved quite adequate in accomplishing their objectives. Administrative control was maintained by the project.

One migrant, who was reported to be acting strangely by his fellow workers, and having a record of psychiatric treatment, was examined and diagnosed as suffering from "Schizophrenic Reaction, Paranoid Type, Chronic" and was admitted to the Western Kentucky State Hospital in Hopkinsville, Kentucky on June 15. He responded to treatment, and was thus released six weeks later to return to his group.

The farm labor representative who accompanied the migrants to the Hickman-Clinton County area was quite helpful in overcoming the language barrier, a major problem between the project workers, growers, and the migrant laborers. The medical community, a good deal of which was involved in this year's work, was very cooperative. When there was a shortage of medical and dental supplies (also a major problem this year), the local clinics and hospitals were called upon to lend out the necessary provisions.

Mr. Ashley Beckham, the Regional Public Health Service Representative, visited the clinic on one occasion and encouraged efforts towards collecting medical case histories, and some were consequently taken. Initiating and maintaining medical and immunization records is quite necessary in dealing with the migrants. More efforts in this sense, however, should be made in the permanent home areas of the migrants.

Six migrant women received prenatal care and one woman postnatal care. One delivery was made during the project period.

This year, due to the number attending the migrant school children program, fewer children accompanied their parents into the clinic. Six children received immunizations, three of these were for Smallpox, one for Diphtheria, one for Pertussis and one for Tetanus. Two were given the Sabin II vaccine. Free access to the farms during the clinic hours would have insured a wide range immunization program.

Pediatric care consisted mainly of treatment for impetigo, worms, and upper respiratory complications. Approximately twenty-one percent (twenty-three children) of the patients treated at the clinics were children from ages one through fifteen. One child was hospitalized for a period of seven days.

Seven migrants received inpatient care at the Hickman-Carlisle County Hospital. The average length of stay for hospitalization was, 5.71 days per patient. Eighteen migrants received out-patient (emergency) care.

DENTAL SERVICES

Objective

1. To improve dental care in an attempt to relieve pain and infection, and improve the home care of the mouth of the migrant workers in Kentucky

Dental services were offered on a similar basis as the medical services. Doctor Robert Jackson, an experienced project worker, treated a total of sixty-four patients of which forty-nine needed services. Of these forty-nine, forty-five were partially completed and five not started. Of the total one hundred eleven services provided, seventy-five were simple extractions, thirty-one were corrections and five were preventive.

A dental clinic was inhibited due to the initial absence of dental supplies, which had been ordered beforehand, but did not arrive during the project period. (This was a result of a delay in fund allocations and purchasing systems.) Consequently, the first two weeks of the dentists' work consisted entirely of simple extractions and routine examinations. Only after borrowing from his own clinic was he able to provide corrective services. Prior planning and coordination are necessary in order that the correct supplies be delivered in time.

Thirty-three toothbrushes were distributed and the children were urged to use soda and salt if no toothpaste was available. The hygienist and nutritionist both demonstrated proper dental care techniques, emphasizing proper home care for all who were able to attend the clinic. Again the lack of effective communication between the project and the migrants in the camps nullifies any possibility of effective dental education.

NUTRITIONAL SERVICES

Objectives

1. To assist the growers and community in understanding the need to make available foods that are in keeping with the workers and their families' cultural eating habits.

2. Assist people in food planning, purchasing, and preparation as needed.

3. Work as a member of the health team to provide nutrition services for prenatales, postpartums, infants, and children.

4. Assist workers and families and other members of the health team with any nutritional problems such as modified diets, feeding, or eating problems.

5. Work with other members of the health team in planning, preparing and implementing the phases of all health services to be rendered to the migratory worker and his family.

Sales to migrant groups in previous years have given the local grocers sufficient knowledge concerning the food requirements and habits of the workers. Some spices and ground corn were not stocked, yet substitutes were available. A certain antiseptic is in great demand yet the grocers have tried but failed to locate a wholesale source.

Most of the local grocers stated that the migrants' eating habits, especially the Texans, were above average. The Texans bought great quantities of food, picking choice cuts of meat and the most nutritious foods. The Negroes were average buyers, selecting less nutritious foods than the Texans.

Prior planning and pre-ordering on the part of the area nutritionist and the project nutritionist insured the ready supply of illustrative materials for the clinic. Charts in Spanish, obtained from the Texas Extension Service, were posted in the clinic and handouts were available for all visitors.

The project nutritionist utilized the patients' (or dependents') waiting room time for holding informal nutritional instruction. Basic food-group charts were presented and explained by the nutritionist. Home safety charts were posted. Instant breakfasts (it was found the migrants frequently missed breakfast), were prepared and samples were handed out. Tang, encouraged as a nutritious unrefrigerated drink, was served each night. Dehydrated milk was prepared beforehand and cooled and then served to the migrants. Cost charts comparing these latter items with those they substitute were posted. Peanut butter cookies were given to the children. Vitamins (Paladac and ADC), and Similac were distributed upon prescription by doctors.

This year's clinic didn't have as many children as last year's as can be illustrated by the lower clinic attendance and the number of children attending the school program. The mothers (who normally accompanied their children to the clinics) consequently were not available for nutritional instruction. Neither the nutritionist nor the health nurse were permitted to visit the camps this year. Home demonstration programs therefore could not be utilized.

VENEREAL DISEASE SERVICES

Objectives

1. To provide adequate venereal disease diagnostic and treatment facilities to migrant workers.

2. To provide all necessary information and education to these workers in order to:

- (a) Alert them to the signs, symptoms, and dangers of venereal infection.
- (b) Make them aware of the facilities available.

There were no personnel from the Venereal Disease Control Program participating in the Migrant Health Project this year. Four cases of Gonorrhea were diagnosed and treated and the results were reported to the State Department of Health. No venereal disease screening was carried out at the clinic this year.

"A comprehensive V.D. effort combined with an initial medical screening program in Texas, Louisiana, Mississippi, and Tennessee, remain the only solutions to the problem of venereal disease control. Again, a limited time period and insufficient staffing minimized the attempt at fulfilling the objectives and solving the problem of venereal disease." (From last year's report.)

HEALTH EDUCATION SERVICES

Objectives

1. To work with farm owners in such a way that they are willing to provide proper environmental conditions for workers and to personally encourage workers to improve health behavior.

2. To arouse surrounding communities to the needs of migrant workers and enlist their support in providing necessary services to workers.

3. Working with all other health professionals concerned to organize educational experiences for migrant workers involving, as far as possible, migrant leaders in the planning and carrying out of educational activities. Health educators will coordinate all group educational work in the project.

4. To insure that all educational work has carry-over value for workers as they move to other areas; for owners and communities in accepting their responsibilities for migrant labor problems and in their preparations for next year's migrant group.

Efforts on the part of the local sanitation officer and public health administrative assistant are continually being made in an effort to encourage the growers to improve the camps. The realization of public awareness, a foundation of the migrant project, has kept the growers moving. Conditions in the camps are not above the minimum standards, yet they have not declined.

If access to the farms can be realized in future projects, classes can be given in such areas as prenatal, postnatal, and infant care. Nutrition could be demonstrated more realistically, more individuals could be reached.

This year's project was supervised more by local officials, a policy which the national and state health officials believed would improve local interest and participation. A Regional Public Health Service physician did not take part in this year's project. The State Public Health Nursing services were likewise not as active. Suggestions for the use of mobile clinics and day care centers were made by the project workers who would prefer, in the future, to reach more of the migrant population.

The growers seemingly relate all the public health programs with the repeated complications in harvesting the crops. It would supposedly be more desirable to the growers if no programs were available to take the migrants off the farms thus diverting their attention from the harvesting itself.

Drugs prescribed

Panalba	Pentids 400	Decagesic
Thorazine	Antipar	Decasray
Mystedlin	Delantin	Flagyl
Veracolate	Rautrax-N	Elix. Benedryl
Kaomycin	Synatan	Citro Carbonate
Paregoric	Sparine	Garamycin Ointment
Decadron	Narlestrin	Bacitracin Ointment
Elix. Donnatal	Mellaril	Rondomycin
Medroltopical	Polycillin	Rynatuss
Gantanol	Phenobarbital	Pyrolgen Tabs
Bacillin	Darvon CPD #65	Erthramycin
Decadron	Butazolidin Alka	Mycolog Cream
Calamine Lotion	Emprin #3	Phisohex
Desenex Ointment	Ferox One	Theragan
Desenex Solution	Belladonna	
Angina Pectorin	Cosanyl	

MIGRANT SCHOOL TO OPEN

An educational program for children of migrant workers in Carlisle County for the strawberry harvest will begin Monday afternoon at Cunningham Elementary School. Burley Mathis, principal at Arlington, has been named to direct the program.

Financed by federal funds under Title I—Migratory Program, the school will be open daily from 3:30 p.m. until 7:00 o'clock with field trips planned on Saturdays. The county school system has been given a grant totaling \$16,544.07 to meet program expenses.

The federal grant will go for teacher's salaries, supplies, equipment and materials. All equipment bought for the special school for migrant's children will become the property of the county school system after the strawberry season ends and the migrants move out.

C. Joe Baker estimated that seventy children are in migrant camps now at strawberry farms owned by David Boswell and Vodra A. Hobbs. More are expected to arrive before the season ends, he said.

The first day of school will be devoted primarily to testing and seeing that the children have suitable clothing.

Transportation to and from school and one meal each day will be provided the children. Classes are planned in music, health and physical education, art and recreation. The staff will include a counselor and others to assist in the program.

LOUISIANA STATE DEPARTMENT OF HEALTH,
New Orleans, La., December 18, 1967.

HON. HARRISON WILLIAMS,
Senator, Chairman, Migrant Health Subcommittee,
New Senate Office Building, Washington, D.C.

DEAR SENATOR WILLIAMS: The State of Louisiana has had a migrant health program in Tangipahoa Parish for the past several years under the existing legislation. We certainly want to continue rendering services to the migrant health workers and if funds were available, we could expand the services rendered.

Our present program serves approximately 3,400 population with some remaining the year round. Our current budget is approximately \$20,000, and we have requested a \$33,000, budget to improve our services.

We strongly support the extension and expansion of this migrant health project.

Yours very truly,

ANDREW HEDMEG, M.D., M.P.H.,
State Health Officer.

MARYLAND DEPARTMENT OF HEALTH,
Baltimore, Md., December 19, 1967.

HON. HARRISON A. WILLIAMS, JR.,
Chairman, Subcommittee on Migratory Labor,
U.S. Senate, Washington, D.C.

DEAR SENATOR WILLIAMS: We are in full support of Senate Bill S. 2688 which will extend the Migrant Health Act and expand the program.

During the past summer, Maryland had approximately 5000 migrant workers, accompanied by over 800 children. The medical needs of these migrants have been found to be similar to the like socio-economic groups of the counties in which these migrants work. However, their lack of knowledge of available resources and the conflict of their working hours and the hours of operation of some of the medical facilities greatly complicates the problem of fulfilling their medical needs. We presently have only one Federal migrant health grant. This is in the amount of \$16,369 for the current year and is limited to Worcester County, which had less than 15% of the total migrant workers last summer. In addition, we are cooperating with a Federally funded project in West Virginia, so that an additional 9% of our migrant workers are receiving the benefits of special services available through Federal funding. Project applications are being submitted from two other counties for the coming summer. If funded, these will provide services for an additional 8% of the migrant workers.

It is our feeling that continued extension and expansion of the Federal Migrant Health Act is essential to the provision of health services for migrant workers and their families in Maryland.

Yours truly,

WILLIAM J. PEEPLES, M.D.,
Commissioner.

STATE OF MICHIGAN,
DEPARTMENT OF PUBLIC HEALTH,
Lansing, Mich., December 20, 1967.

HON. HARRISON WILLIAMS,
Chairman, Migrant Health Subcommittee, U.S. Senate,
New Senate Office Building, Washington, D.C.

DEAR SENATOR WILLIAMS: The Michigan Department of Public Health has been concerned and involved with the extension and improvement of health services to our migratory farm workers.

As you may know, Michigan ranks third among the states in the utilization of migratory workers. We estimate that 80,000 workers are required to harvest Michigan's crops valued in 1964 to be \$175,000,000. These interstate migratory workers are housed in approximately 3,000 camps in 54 counties in Michigan's lower peninsula.

Our department has taken the leadership in promoting a healthful environment, family medical clinic and hospital care programs at the state and local level, effectively utilizing the funds made possible by the Migrant Health Act of 1962, as amended in 1965.

In the event that the Migrant Health Act is terminated, Michigan will lose medical and hospital care now available to approximately 45,000 migrants or 56%

of the estimated total number of our migratory workers (80,000) and sanitation services to all 80,000 migratory workers.

Over the last four years there has been an increase of health care services for 2,500 migrants at a cost of \$9,000 to services for 45,000 migrants at a cost of \$471,043 in 1967 (not including local contributions of \$298,887). Sanitation services during this same period increased from no Federally supported program to a statewide program supported by \$176,789 of Migrant Health funds.

In 12 counties, 14 clinic site locations are providing family medical services and 20 participating hospitals are providing needed hospital care. In the various programs over 80 full-time and part-time individuals are providing the services with the cooperation of 54 participating local physicians.

We are currently assisting four local health departments in the preparation of proposed medical and hospital project applications, which would make available migrant health services to an additional 15,000 migrants and dependents with a proposed budget of approximately \$100,000.

It is estimated on the basis of current expenditures, that it would cost an additional \$240,000 to extend this same range of health services to migrants living and working in the other 38 counties utilizing the services of migrants.

In order to continue the current program of essential health services for migrant agricultural workers and to provide for their extension to all migrants in the state, it is urged that the Migrant Health Act be continued and that additional funds be appropriated.

Sincerely,

R. GERALD RICE, M.D., *Acting Director.*

STATE OF MINNESOTA,
DEPARTMENT OF HEALTH,
Minneapolis, December 20, 1967.

HON. HARRISON WILLIAMS,
*Chairman, Migrant Health Subcommittee,
New Senate Office Building, Washington, D.C.*

DEAR SENATOR WILLIAMS: Through the Association of State and Territorial Health Officers we have received a copy of the invitation to submit a written statement to your committee on migratory labor. Attached is a brief account of the Migrant Health Project, Minnesota Department of Health. The statewide program was started in 1963; May 1, 1968 to April 30, 1969 will be the fifth consecutive year of this health service. Since 1966, when Migrants, Inc., an Office of Economic Opportunity funded organization, was formed, the Minnesota Migrant Health Project has cooperated with that program.

We trust that this written statement can be included in the record to support proposed legislation to extend the Migrant Health Act and to authorize funds.

We are also enclosing a copy of the project Annual Progress Report, 1967-1968.

Respectfully,

ROBERT N. BARR, M.D.,
Secretary and Executive Officer.

MINNESOTA DEPARTMENT OF HEALTH MIGRANT HEALTH PROGRAM

Project Title: Migrant Labor Environmental
Health and Nursing Service and Health Education Project (MG67)

A. There are approximately 10,000 migrant workers and dependent family members who come to Minnesota to work in sugar beet and vegetable crops each year. The crop season is from March to November. While in the state, families are housed in approximately 770 camps, most of which consist of temporary facilities.

Staff members are employed by the health project to supplement local nursing and sanitation services. These include nurses, health aides and sanitation inspectors.

The following is a brief summary of the 1967 program (as prepared for Migrants, Inc., Meeting Nov. 11, 1967):

1. Twelve nurses reached 500 families and made 2,000 nursing visits. The number of visits has never been stressed as a goal in itself. More important is the degree to which the nurses can do intensive family visiting.

2. Health Education Services through Counseling. Greatest numbers were in areas of diet or nutrition for children and adults, personal hygiene, dental, immu-

nization. "What to do" "How to do it" and "Why to do it" were focal points in teaching families. "Taking time to care" is considered essential.

3. Environmental Sanitation—Plans include addition of an inspector next year.

	Inspected	Approved	Conditionally approved	Disapproved
1967.....	769	518	249	2
1966.....	760	432	325	2

4. Employed twelve staff nurses, eight nurses aides, three inspectors. Anticipate same number of nurses and aides and four inspectors.

5. Number of school children screened: Dental 806; vision 904; hearing 887. Referrals were sent to home base for:

Dental, 170 need immediate care; 364 need care within 6 months.

Vision, 100 (61 need retest).

Hearing, 106 (91 need retest).

6. 1316 community contacts were made with 675 different individuals.

7. 4058 Personal Health Cards were issued in 1967.

8. Three clinics operated for 20 sessions serving 259 patients; 59% females, 41% males; 38 referrals were processed for prescriptions, chest X-rays, dental care, laboratory, etc.

B. Summary of requested amount and use of Federal migrant health grant for project year May 1, 1968, to April 30, 1969:

1. Personnel: Staff includes coordinator, 1½ clerks, 13 nurses, 9 health aides, 4 sanitation inspectors.....	\$56, 095
2. Supplies.....	1, 515
3. Travel—statewide transportation, meals, maintenance for 27 staff members.....	16, 867
4. Equipment.....	510
5. Family health clinics—7 clinics are proposed.....	2, 900
6. X-ray services.....	600
7. Laboratory services.....	1, 000
8. Emergency medical services.....	1, 000
9. Dental services.....	3, 850
10. Inpatient care:	
Hospital services.....	25, 160
Physicians services.....	17, 290
11. Other—includes postage, telephone, etc.....	2, 050
Total.....	128, 837

C. If the above budget request is filled, unmet needs of migrant families can be taken care of in a reasonably realistic manner.

MISSOURI ASSOCIATED MIGRANT OPPORTUNITY SERVICES, INC.,

Jefferson City Mo., December 28, 1967

Senator HARRISON A. WILLIAMS, Jr.,

Chairman, Committee on Labor and Public Welfare, Subcommittee on Migratory Labor, Senate Office Building, Washington, D.C.

DEAR SENATOR WILLIAMS: I am pleased to accept your invitation to submit a written statement in support of Senate bill 2688, which you introduced in the Senate on November 21, 1967. You will find my statement enclosed, and I hope that it will be of some small help to you in securing favorable action on your bill.

I am also enclosing a copy of "The First Year of MAMOS", a booklet we have prepared describing the goals and activities of our program, which is funded under Title III-B of the Economic Opportunity Act. Inside the front cover of this booklet, you will find a brochure which graphically illustrates the needs that we have discovered among migrant workers for health and medical services. This "HELP" appeal was sent to churches and interested individuals throughout Missouri, and more than \$900 has been donated to date. The proceeds of our Family Health Services Fund are used to provide emergency medical and health services for members of migrant and seasonal farm families. Needless to say, with this small fund we cannot begin to meet the needs that exist, but it has helped to make life easier for nearly 30 migrant and seasonal farm families.

The imperative of providing health services for migrants was underscored in dramatic fashion last month, when tubercular skin tests were administered to 77 individuals enrolled in our program of adult basic education and preemployment training. Out of the 77 tests administered 34 individuals—nearly one-half of those tested—developed positive reactions!

For those of us who work with MAMOS in attempting to provide migrants with "a way out", the need for health services is not something we affirm merely from humanitarian instinct. It is a definite, visible, concrete need with which we work each day. It may be easy to ignore statistics on migrant health, but it is impossible to ignore the man in your classroom who cannot learn because he is too sick to learn * * * it is impossible to ignore the man who has worked and studied to obtain a permanent job, only to learn that he cannot qualify for the job because of health reasons.

Migrants are not typically weaker folk. Their health problems are caused in large measure by the long hours and harsh conditions of their work, and by the fact that health and medical services are generally inaccessible to them.

You can be certain that I wish you and the senators sponsoring your bill every success. America has ignored the migrant farm worker long enough!

Most sincerely,

MICHAEL D. GARRETT, *State Director.*

STATEMENT RELATING TO LEGISLATION S. 2688

One of the most glaring needs exhibited by the rural poor is the need for health services of all kinds. The President's National Advisory Commission on Rural Poverty recently reported a startlingly high incidence of disease and premature death among the rural poor. Infant mortality, for example, is far higher among the rural poor than among the least privileged group in urban areas. Rural residents, regardless of income, are more likely to have disabling chronic health conditions than their urban counterparts. Rural people have a higher rate of injuries than urban residents and rural farm residents have the highest rate of injuries caused by work-related accidents. Despite these factors, medical care and health services are conspicuously absent from rural America.

The lack of health services in rural America is most keenly felt by the Nation's one million migratory farm workers. Typically, these migratory farm laborers work under harsh and unhealthy conditions. They are exposed to heat, cold, wind, dust, chemicals and mechanical hazards. Their crowded living quarters frequently lack sanitary toilet facilities and water that is safe and accessible for drinking and washing. In 1964, the migrants' mortality from tuberculosis and other infectious diseases was $2\frac{1}{2}$ times the national rate, and their mortality from influenza and pneumonia was more than twice the national rate. The accident mortality rate for migrants in 1964 was nearly three times the national rate.

These statistics present more than interesting information about a faceless mass of humanity. These statistics reflect the deplorable condition of one million men, women and children who travel annually to work the harvests in more than 700 United States counties. This condition is aggravated by the migrant's inability to help himself. (1) Characteristically, the migrant is a member of an economic or social minority group. Chiefly, he belongs to Negro, Spanish-speaking, Indian and low income "Anglo" minorities. (2) The migrant is poor. In 1965, his annual income from all sources averaged \$1,400. (3) The migrant lacks upward job mobility. The average migrant adult has only a fifth grade education, and many function at a far lower educational level. While the migrant necessarily acquires a degree of agricultural skill, he has little experience or skill in other work. (4) The migrant is usually ineligible for public assistance. Because his work requires extensive travel, the migrant is a non-resident in most of the areas where he does his seasonal work and cannot qualify for medical or health assistance from local public hospitals or welfare departments.

The plight of America's migrants is not going to improve automatically. Over the future of the migrant farmworker there hangs the threatening cloud of increasing automation and technology. From 1950 to 1965, new machines and methodology increased U.S. farm output by 45 percent—and reduced farm employment by 45 percent. During the next 15 years, the need for farm labor will decline by another 45 percent. In 1951, only 1 percent of Missouri's cotton was picked by machine. Today, 95 percent of this cotton is machine-picked. A single two-row mechanical picker replaces 70 workers in the harvesting of cotton. Something affirmative must be done to aid the migrant.

The adoption of Senate Bill 2688, which would extend and expand the Migrant Health Act, will not meet all the needs exhibited by America's migratory farm-

workers. However, the adoption of this legislation is an imperative first step in meeting these needs.

Minimal health services should be readily available to all Americans, regardless of race, income, place of residence or type of occupation. Because the Migrant Health Act has begun to make these services available for the first time to migrant farmworkers, and because the legislation introduced by Senator Harrison A. Williams, Jr. would expand and extend this essential program, I would urge that the Migrant Health Act be renewed in 1968 as proposed in Senate Bill 2688.

MICHAEL D. GARRETT,

*State Director, Missouri Associated Migrant Opportunity Services, Inc.
(MAMOS).*

COUNTY OF CUMBERLAND, DEPARTMENT OF HEALTH,
Bridgeton, N.J., January 4, 1968.

Hon. HARRISON A. WILLIAMS, Jr.,
*Chairman, Subcommittee on Migratory Labor,
U.S. Senate, Washington, D.C.*

DEAR SENATOR WILLIAMS: My letter is to urge you to do everything in your power to extend the Migrant Health Act for five years and to include as many more farm workers as possible. The agriculture workers whether migrant or local comprise a large percentage of the impoverished people of our county. Poor health can be the cause of the impoverishment as well as lack of education and skill.

Seasonal transient workers coming to our area to supply labor to one of our major industries, agriculture, call for additional services to supplement the local year around health services. The latter are not adequate as yet to meet the preventive and diagnostic medical needs of the local population.

Prior to receiving project funds to provide health services for the migrant worker, unpaid bills for hospital and other medical services had to be absorbed into the charges for services to the regular users of the services. These conditions added another stigma to the migrant's acceptance in the community.

The agricultural worker has benefited greatly from Federal funds supporting the health services in our County. It would be most tragic if planned programs for extended health services would have to be curtailed because of lack of these funds.

Respectfully yours,

WILLIAM P. DOHERTY, V.M.D.
Director, Migrant Health Project, Cumberland County.

SEWELL, N.J., December 29, 1967.

Re bill S. 2688

Hon. HARRISON A. WILLIAMS, Jr.,
*Committee on Labor and Public Welfare,
Subcommittee on Migratory Labor,
U.S. Senate, Washington, D.C.*

DEAR SENATOR WILLIAMS: The need to provide and increase Migrant Health Service is readily recognizable. In the 1967 Migrant season in Salem County, migrant farm workers were provided with over 1500 migrant health service visits. All needed services were not reached as desired, due to budget limitation.

The current concept of health, "The state of mental, physical and social well being and not merely the absences of disease" should be applicable to the migrant population as in other groups. The statistical records of health services to the migrants indicate that the need is there.

To provide this group with the health services to obtain "the best quality health", there is a need to continue, as well as, to increase the financial assistance for the Migrant Health Services.

Respectfully yours,

CLAIRE M. LINKA, R.N., M.S.,
*Director for New Jersey State Department of Health Services for Salem
County—Migrant Season, 1967.*

FAMILY COUNSELING SERVICE IN MIDDLESEX COUNTY,
Highland Park, N.J., December 29, 1967.

Re S. 2688.

Senator HARRISON A. WILLIAMS, Jr.,
Chairman, Subcommittee on Migratory Labor,
U.S. Senate, Washington, D.C.

DEAR SENATOR WILLIAMS: The Family Counseling Service in Middlesex County is well informed about the conditions of Migrants in New Jersey, having for the past three years participated in a Migrant Health Program in Middlesex and Mercer Counties in cooperation with other private agencies and with the New Jersey State Department of Health. Assuming availability of funds, The Family Counseling Service, in cooperation with the other agencies, will continue the program in 1968 and thereafter.

For the Board of Directors of Family Counseling Service, I am writing to express appreciation to you for having introduced S.-2688 and given it strong support. All of us associated with the Family Counseling Service believe that the living and health conditions of the Migrants represent a blot on this country's record that must be eliminated.

Thank you for your concern for these periodic residents of New Jersey who at all times are citizens of the United States.

Sincerely yours,

WALTER R. SHERMAN, ACSW, *Executive Secretary.*

MONMOUTH COUNTY ORGANIZATION FOR SOCIAL SERVICE,
Red Bank, N.J., December 28, 1967.

Senator HARRISON A. WILLIAMS, Jr.,
Committee on Labor and Public Welfare,
Chairman, Subcommittee on Migratory Labor,
U.S. Senate Building, Washington, D.C.

GENTLEMEN: We view with great interest Senate Bill 2688, which would extend the Migrant Health Act for five years. As a voluntary agency which has conducted an active health program for migratory workers and as a recipient of funds under the existing migrant health program, we know at first hand how much these federal funds can do to improve the lives of these citizens,

The enclosed clipping points up the accomplishments which we have observed over the past seven years: the growing awareness of family health needs and the use of community services by the migrant population.

When the MCOSS started a mobile clinic in a trailer in 1961, there was evident apathy among the migrant workers. Poor health was tolerated and few preventive services were used to protect the health of the workers and their families.

In seven years we have played a part in changing the attitudes of the migrants. The federal funds which assisted us in conducting the migrant health programs aided immeasurably and made possible many services which we might not have been able to perform without this financial assistance.

We are very hopeful that S. 2688 will make further progress possible.

Sincerely,

WINONA E. DARRAH, *Executive Director.*

[From the Daily Register, Red Bank, N.J., Nov. 15, 1967]

MIGRANTS ARE SERVED BY MCOSS

RED BANK.—The use of the Monmouth County Organization for Social Service health services by migrant farm workers during the past summer and early fall was described as "astounding" in a report issued yesterday by Miss Winona E. Darrah, executive director, and Mrs. Dorothy Garvin, supervisor, Freehold Health Center.

Starting in July, MCOSS sent three public health nurses into the migrant camps, set up weekly clinics at the Freehold Health Center and served a total of 479 men, women and children, in the sixth annual migrant program which got underway in 1961, when a mobile clinic was taken to various locations in the farm belt of Western Monmouth County.

As supervisor of the project, Mrs. Garvin noted that many migrant crew leaders, made aware of the health program of MCOSS in previous years, sought out the MCOSS for care of workers needing medical care.

"They called us because they knew they would be helped," Mrs. Garvin reported. "One member of the crew had broken his leg on route. He was hospitalized. A woman, diabetic, called us on her arrival to ask us to help her obtain insulin for herself and medication for her son who has inactive tuberculosis. One member of a crew was reported to us as being very ill. A nursing visit was made immediately and the man referred to the hospital, where he spent two weeks recovering from pneumonia. There was a baby with croup, a woman with a severely infected leg."

From Florida, MCOSS, received a request to provide service for a man who was found, when hospitalization was arranged, to have cancer of the larynx. An operation was performed to remove the larynx and the man has been attending the Garden State Nu Voice Club. When he returns to Florida, MCOSS will send necessary information so that his care can be continued.

PRaises COOPERATION

Mrs. Garvin praised the cooperation between various agencies of the county. She commented on interstate referrals which give a continuity to the health care provided for the families who work their way from Florida to the northeast coast harvesting farm crops.

The new concern of the migrants for their health was evidenced, Mrs. Garvin indicated, by the fact that 80 per cent of the persons sent to doctors and clinics for treatment of illness, followed through on the nurses' and clinic physician's recommendations.

The success was not as great in referrals for dental care and Mrs. Garvin expressed the belief that fear of the dentist and a lack of appreciation of the importance of dental care was responsible for the poor showing. She is recommending that MCOSS and the State Health Department, which helps MCOSS finance the summer program, consider having dental work done at the Health Center clinic.

Under the present plan, only dental screening is provided, and persons in need of dental work are referred to a local dentist.

She also recommends that nutritional advice be given at the clinic and diabetic detection tests be introduced.

The program received cooperation from the local MCAP which helped with transportation and also assisted the nurses in establishing a rapport with patients. The opening of the Freehold office of Family and Children's Service added greatly to the joint effort of the two agencies.

Also included in the migrant program was health service for an MCAP day care center. Planned Parenthood of Monmouth County assigned a physician and a staff member to the clinics.

Before the clinics got under way MCOSS nurses visited 79 farmers to explain the program and gain permission to enter their property. The farmers, Mrs. Garvin found, were "most cooperative," and the Farm Bureau "very helpful."

In the tuberculosis testing program, 393 were given screening tests and an additional 80 known positive reactors checked. There were 132 positive reactors x-rayed at the clinic, and 24 were referred to the Geraldine L. Thompson Hospital for further evaluation. Five adults were found to have inactive and one adult active tuberculosis and two children were diagnosed as active primary TB. Medication and further follow-up were recommended for all eight.

During the four month program, there were more than 1,200 visits made to migrant camps and attendance at the clinic totaled 325.

The original MCOSS mobile clinic was instituted in 1961 because MCOSS found that while the MCOSS community health services were available to the migrants, few were making use of them.

"The migrants this year have reached out for service. In the past we have had to initiate contact with them. Our efforts, of the past six years are bringing results," Mrs. Garvin said.

CONSUMERS LEAGUE OF NEW JERSEY,
Montclair, N.J., December 29, 1967.

Hon. HARRISON A. WILLIAMS, Jr.,
Chairman, Subcommittee on Migratory Labor,
Committee on Labor and Public Welfare, U.S. Senate,
Senate Office Building, Washington, D.C.

DEAR SENATOR WILLIAMS: The Consumers League of New Jersey supports S. 2688 to extend the Migrant Health Act for five years. It would be a calamity for

the agricultural farm workers in this nation if the Migrant Health Program were allowed to expire on June 30, 1968.

In New Jersey, we are especially proud of the record of accomplishment of the staff in charge of the disbursement of funds in the conduct of the Program. Previous to the initial grant, some five years ago, there was no provision for health services for workers and their families. A few children, about 100 in number, did receive health examinations when attending summer school. Prenatal care and hospital services were practically nonexistent. There were no general clinics except through one private agency. There was no method of checking on the sources of epidemics in migrant camps, such as hepatitis, intestinal disorders and viral meningitis.

The Migrant Health program under the direction of Dr. William J. Dougherty and his staff from the Health Department has in five years reached almost the entire migrant population. This was done through clinics conducted directly by Dr. Dougherty's staff or by contract with local and county agencies. In the County where the migrants are employed for the longest period of time, a special grant has been made directly to the Cumberland County Migrant Health Services. In 1967, four county governments and eight voluntary community health and social service agencies participated directly in the program under contract. Last summer in cooperation with the N.J. College of Medicine and Dentistry, five second-year medical students were enrolled in the program. Local initiative and responsibility have begun to develop but the finances for assumption of full responsibility have not been secured; if the federal grants are not renewed, the entire program with its promising start will be abandoned.

One very constructive aspect of the New Jersey Program has been the employment of a medical case worker to assist in working out family problems which often need remedial action along with the treatment of physical ailments. In 1967, medical social workers conducted over 4,000 casework interviews in counseling more than 500 families or individuals faced with social problems. Over 1,000 persons were provided with medical examination and 150 persons admitted to hospitals. Dental examinations were given to 563 persons at migrant clinics and for 1,070 children attending seasonal migrant summer schools.

As a result of these examinations, seven new cases of tuberculosis were discovered in 1967. In 1963 and in 1965, a general outbreak of *Shigella* diarrhea occurred in a migrant camp and was checked through immediate diagnosis and treatment. Other diseases, such as infectious hepatitis and viral meningitis were discovered in time to prevent general outbreaks.

As citizens of New Jersey, we value the Migrant Health Program not only for its service to our migratory farm workers, but also for the preventive work in checking the spread of epidemics which affect us all.

Sincerely yours,

SUSANNA P. ZWEMER, *President.*

PREPARED STATEMENT OF DAVID N. PRATT, MEDICAL SOCIAL WORKER, MIGRANT HEALTH SERVICES, CUMBERLAND COUNTY, N.J., RE EXTENSION OF MIGRATORY HEALTH ACT

The average American citizen living in the mainstream of our affluent society is scarcely aware of the almost invisible army of fellow citizens whose livelihood depends upon moving on the season. The idea that anyone in this day and age lives this way sounds like fantasy to them. The myriad of myths that surround the migrant's way of life serves to make him a separate citizen in his own land.

There is one fact, however, that cannot be disputed. The migrant has physical illness and social problems just like the rest of America. He needs attention to his problems just like any other person residing in the community that he finds himself. Sometimes obtaining that assistance can be difficult when one's occupation has caused the person to become a resident of no where.

The Migrant Health Program is unique in that it recognizes a migrant as a person with a need first without attention to age, category, residence, etc. The focus is upon restoring the individual back to good health so that he may resume his way of life better equipped to provide for himself and family. This approach is beginning to pay dividends. The migrant is finding the program meaningful to him. Confident now that he will be treated with dignity and at the time of urgent need, the migrant is beginning to seek services before his problems reach the crisis point.

A program that has produced such results in the space of a few years is an accomplishment to be proud of. I urge that the Migrant Health Act be extended. To deny its continuance is to deny American citizens the right to be a part of the very land in which they live.

[From The Courier-News, Dec. 29, 1967]

MIGRANT HEALTH CARE

U.S. Senator Harrison A. Williams Jr. of Westfield this week said that a million "excluded Americans" suffer from inadequate health care. These are migrant farm workers and their families.

Members of this group, Williams said, have an influenza and pneumonia mortality rate twice as high as the national average. The senator pointed out that migrants live and work in rural communities where there are only half the medical personnel and services found in an average community.

These findings were detailed in a report prepared by U.S. Surgeon General William H. Stewart for the Senate subcommittee on Migratory Labor, of which the N.J. Democrat is chairman. The report verifies a "health gap" among migrants previously suspected, but never before delineated.

The senator recently introduced legislation to extend and expand the migrant health program. The project is well started, Williams said, "but we have a long way to go."

It is still the exception, rather than the rule, for the migrant worker and his family to have available even the barest minimum of medical service, the senator said.

"We are operating this year," the senator explained, "with \$7.2 million. We could use almost double that amount of money simply to do a more effective job in the existing projects. In addition, we have many applications for new projects which the Public Health Service has been forced to turn down because of lack of funds."

Six of 10 counties that serve as "home base" for migrant workers offer no personal health care to the farm workers, the Stewart report shows.

There is no doubt that there is a large field for improvement in the nation's migrant health care program. Perhaps, now that one has gotten "off the ground" it can be expanded for the benefit of those it would cover.

STEBEN AREA POTATO GROWERS' COOPERATIVE,
Wayland, N.Y., December 9, 1967.

SENATE SUBCOMMITTEE ON MIGRATORY LABOR,
Capitol Building,
Washington, D.C.

GENTLEMEN: For many years, not all, but most growers have been genuinely concerned for the general welfare of the seasonal farm laborer.

For many years, not all, but most growers, without fanfare, have made it possible financially for the migrant people, disinherited by society, to bear their newborn, to care for their sick.

For many years, society has expected the grower to be doctor, educator, sociologist.

We believe that the migrant and his family need more adequate medical attention.

At present we are trying our best to provide medical care by arranging appointments with local medical personnel. But, medical facilities are inadequate to handle the influx of seasonal farm laborers, and rural medical personnel are few, and hard worked by permanent area residents.

We are genuinely concerned for the health and medical care of those seasonal farm laborers working in our area.

We believe the challenge of the seasonal farm laborer cannot be met by the grower alone. We believe it will take the fields of education, medicine and sociology to deal effectively with the migrant problem. We, as concerned growers, are willing to cooperate in every way with these fields to begin a realistic appraisal and practical solution to the migrant plight.

We highly recommend the extension of the Migrant Health Act, both financially and geographically. We recommend that the Act be extended with an appropriation of 13 million dollars into the 1969 fiscal year. We have already been studying, in cooperation with the Secular Mission of Steuben County, the establishment of medical clinics in Steuben County and recommend the geographic extension of the Migrant Health Act into the Steuben area.

We want it understood that the grower cannot handle the challenge of the seasonal farm laborer alone, as many in society expect him to.

We sincerely invite the fields of education, medicine and sociology to join with us in a more realistic approach to this—one of society's most urgent problems.
With genuine concern,

BERNARD M. VOTYPKA,
President, Steuben Area Potato Growers Cooperative.

NORTH CAROLINA STATE BOARD OF HEALTH,
Raleigh, N.C., December 28, 1967.

Senator HARRISON WILLIAMS,
*Chairman, Migrant Health Subcommittee,
New Senate Office Building, Washington, D.C.*

DEAR SENATOR WILLIAMS: We are pleased to have the opportunity to submit a brief report on the status of health programs for migratory agricultural workers in North Carolina. The number of our migrants is of the order of 5,000 workers from other states, and about 1,500 intra-state migrants. We estimate that there are about 2,500 non-working family members, giving us a total population at risk of approximately 9,000 persons. In addition, there are some 31,000 day-haul workers in the State.

To meet the health needs of this group, there are four family health service programs in the State, supported by Public Health Service grants. These four programs, which received a total of \$94,535 in Federal funds, are operated by local non-profit corporations, comprised of community churches, official and voluntary agencies, growers, and others. In addition, the State Board of Health received a grant of \$38,715 which provides a small staff of consultants plus a limited number of seasonal employees who are placed in the local communities. The total received from the Public Health Service for programs for migrants is \$133,250 for the current year. The local projects serve an estimated 3,885 migrants with their clinical, sanitation, and educational programs. The State Project attempts to provide consultative assistance in administration, public health nursing, environmental sanitation, and health education, to all counties with a seasonal migratory population.

To provide necessary additional health services for migrants, a projected budget was drawn up and submitted to the Public Health Service. It was realized at the time that present limitations of funds made it unlikely that full implementation of this expanded program could be realized. This proposed expansion is included as an addendum. As you see, only one additional employee is requested for the State Board of Health. An additional \$89,567 was requested to be subcontracted to those communities (already identified) which were felt to be ready to initiate new family health service projects, where such programs do not now exist. We feel that this proposed new budget total of \$142,166 would be a realistic figure which would help us to more nearly meet the health needs of the seasonally employed migratory agricultural workers. When added to the budgets submitted by the four existing local projects, there should be a total of approximately \$240,000 for clinical, preventive, sanitation and health promotional activities. It is anticipated that, for the next fiscal year, 6,000 migrants and their families could be reached through these services, at a cost of about \$40 per person.

Another element in comprehensive health care for migrants is hospitalization. Each year it has been hoped that sufficient funds would be available to aid the communities to provide adequate hospitalization, but limitation of funds have prevented the implementation of this ideal. Title XIX of P.L. 89-97 will, of course, help in this respect. Nonetheless, some funds designated for in-patient and other hospital-related care would be necessary. Hopefully, the renewal of the Migratory Health Act will make sufficient funds available so that this gap in the spectrum of services can be more adequately filled.

I hope this information will be of use to you. If additional material is required, we will be happy to try to supply it. Please be assured of our continuing interest in this program, and our hope for a continuation of the very necessary assistance which has been provided.

Sincerely,

JACOB KOOMEN, M.D., M.P.H.,
State Health Director.

EXPLANATION OF BUDGET

A. General budget

The General Budget reflects a continuation and expansion of present activities. Certain changes are reflected in the salary item, to wit:

1. The addition of an Administrative Officer. This is a new position, designed to provide a staff member who will function as a program representative. The work of this person will be to augment the present staff, to provide administrative consultation to existing projects, to assist in formation of new projects (see: B. Special Projects Budget), to assist new local project personnel (both staff and volunteers) in establishing and maintaining administrative and fiscal procedures, to assist in evaluation of local projects, and to augment the liaison with other agencies and organization providing services to migrants (e.g. N.C. Council of Churches Migrant Project, O.E.O. programs, and others).

2. Redistribution of Consultant Sanitarian time. Previously, a Sanitarian III was devoting 75% of his time to migrant activities, and other consultants, 10%. With the need for increased local services, and more immediate supervision of sanitation aides (employed through the N.C. Council of Churches Migrant Project), a slightly different pattern is required. Consequently, the Sanitarian III specifically designated as consultant will spend 50% of his time in this field, and each of the District Sanitation Consultants will increase their participation in the program to 15%. This will provide for direct involvement by staff more immediately available to the scene where needed.

3. It has been found that the education and experience of the Health Education Aides varies widely. This year, we plan to create two levels for this position, with two different salaries. The Aides with less training will receive \$365 month (4 positions), and those with greater training, \$509 month (4 positions). This will permit the Project to be more competitive in recruiting for summer work opportunities, and will help in attracting more competent personnel.

4. For the past three summers, a State Government Intern has worked with the State Board of Health's Migrant Project. These Interns are college students, paid by the State, who are assigned to a State Agency to gain work experience as well as insight into the operations of State Government. It is expected that still another Intern will work with our staff in the coming summer, and this contribution by the State is noted.

B. Special projects budget

It has been recognized that it is timely to give renewed impetus to family health service clinics to migratory agricultural workers in this state. The four existing local projects need to be augmented by others in new localities. To implement this, a special projects fund is requested. These funds will be used to establish health services in areas where they are not now available. We feel that this can best be accomplished by basing these funds in the State Board of Health, then subcontracting with communities ready to undertake this program.

The budget has been prepared on the presumption of four local projects, each having a basic package of services. These would include 2 nurses (or 1 nurse and 1 Licensed Practical Nurse), one part-time clerk, clinician services, and a medical student. Additional items are indicated in the budget. Purchase of equipment is not included, since these are pilot projects; however, there is an item for rental of necessary equipment.

It is envisioned that a variation in the pattern may occur. For example, one "package" might be broken up so that a smaller number of demonstration clinics, with part-time staff only, could be held in more than one community, rather than a summer-long program in one place. Also, differing staffing patterns may occur within a given project.

No attempt has been made to account for the community's contribution, since that would be purely hypothetical at this point. However, as in the four existing community projects, it is expected that personnel, facilities, equipment, supplies, and the like, would be contributed.

Upon the successful establishment of a demonstration family health services project in a given community, it is expected that the services will be continued. It will be determined whether continuation should be on the basis of a direct grant by the Public Health Service to the sponsoring community organization, or by a grant to the N. C. State Board of Health which will continue to subcontract. Either of these methods would be acceptable.

PROPOSED BUDGET, MIGRANT HEALTH PROJECT, NORTH CAROLINA STATE BOARD OF HEALTH

	Applicant	PHS	Total
A. General budget:			
1. Personnel:			
Salaries.....	\$24,347	\$36,740	\$61,087
Social security and retirement.....	2,922	4,409	7,331
Subtotal.....	27,269	41,149	68,418
2. Supplies:			
Photographic supplies.....		100	100
Clerical and administrative.....	100	150	250
Educational.....	400	800	1,200
Subtotal.....	500	1,050	1,550
3. Travel:			
Staff travel, 0.06/mile, 1,000 miles/month, 3 persons.....		4,320	4,320
Staff per diem, \$12/day, 10 days/month, 3 persons.....		2,160	2,160
Aide travel 0.08/mile, 1,000 miles/month, 3 months, 8 persons.....		1,920	1,920
Travel and per diem, other State employees.....	4,000		4,000
Orientation and travel, local project staff and volunteers.....		1,500	1,500
Subtotal.....	4,000	9,900	13,900
4. Equipment: Projectors, etc.....	250		250
5. Other: Printing and mailing.....	250	500	250
Total.....	32,269	52,599	84,868
B. Special project budget:			
1. Personnel:		Amount	
6 nurses, \$527/month 3 months each, 100-percent time.....		\$9,486	
4 clerks, \$328/month, 3 months each, 50-percent time.....		1,968	
2 LPN, \$328/month, 3 months each, 100-percent time.....		1,968	
Clinicians' fees \$20/hour, 2½ hours/night, 3 nights/week, 10 weeks, 10 weeks, for 4 projects.....		6,000	
4 medical students, \$400/month, 3 months, 100-percent time.....		4,800	
Subtotal.....		24,222	
Social security (4.4 percent).....		1,066	
Subtotal.....		25,288	
2. Supplies:			
Clerical and administrative \$250/project, 4 projects.....		1,000	
Clinic supplies, \$250/project, 4 projects.....		1,000	
Drugs, \$500/project, 4 projects.....		2,000	
Subtotal.....		4,000	
3. Travel:			
Staff travel 0.08/mile, 1,000 miles/month, 3 months each, 3 staff members, 4 projects.....		2,880	
Transportation of patients (e.g. bus rental), \$500/project, 4 projects.....		2,000	
Subtotal.....		4,880	
4. Equipment: Equipment rental, \$300/project, 4 projects.....		1,200	
5. Other:			
Printing \$100/project, 4 projects.....		400	
Utilities \$150/project, 4 projects.....		600	
Insurance \$150/project, 4 projects.....		600	
Subtotal.....		1,600	
Total.....		36,968	
Grand totals, PHS:			
A. General budget.....		52,599	
B. Special projects budget.....		36,968	
Total.....		89,567	

MIGRANT FAMILY HEALTH SERVICE,
Hendersonville, N.C., December 21, 1967.

Hon. HARRISON A. WILLIAMS, Jr.,
Chairman, U.S. Senate,
Committee on Labor and Public Welfare,
Subcommittee on Migratory Labor, Washington, D.C.

DEAR SIR: We wish to add our support to legislation S. 2688 to extend the current operation of The Migrant Health Program, which you and your colleagues have introduced.

The human need of the migrant laborers that harvest our crops is so extensive that unless *you* worked in this program, you would not believe that these persons were American citizens. Their plight is pitiful! A day to day existence—no work—no eat.

We who work directly with the migrants have respect for their efforts in trying to care for themselves by following the season for employment. Health Services, Education and Sanitation is a need so the migrants and seasonal farm workers can continue to try to maintain their own family welfare. In the field of health, both restorative and preventive medical and dental care is a crying need. Sex education, family planning and up-grading the education of the children in the migrant stream is a challenge to all workers employed in the program.

Federal grant assistance is *imperative* as rural communities cannot carry the financial burden of the influx of the seasonal worker who are necessary to the economy of the areas in which they labor.

Very truly yours,

CLAIRE H. BURSON, P.H.N., *Project Director.*

STATE OF OHIO, DEPARTMENT OF HEALTH,
Columbus, Ohio, December 22, 1967.

Hon. HARRISON A. WILLIAMS, JR.,
Chairman, Committee on Labor and Public Welfare, Subcommittee on Migratory Labor, U.S. Senate, Washington, D.C.

MY DEAR SENATOR WILLIAMS: The Migrant Health Act has provided better care for many migratory farm workers and their families during their stay in Ohio.

The Stark County project was the first one approved in the nation following the passage of the Act in 1962.

There are now eight funded projects in Ohio and one, Wood County, has been approved but not funded due to insufficient appropriated funds.

The total amount of monies approved for the eight projects for the fiscal year 1968 was \$295,436. Requests for the fiscal year 1969 have been prepared and total \$463,658.

Project personnel were advised to limit their requests to bare essentials since the total funds available would be insufficient to meet the demand.

The \$168,222 increase was considered minimum. The Sandusky County project anticipated a ten percent increase in service this migrant season and experienced a 100 percent increase.

The enclosed report summarizes some of the needs for Senate Bill 2688.

We sincerely support the continuation of this program and the very modest appropriation requested.

Sincerely,

E. W. ARNOLD, M.D., *Director.*

OHIO'S MIGRANT HEALTH PROJECTS GAIN MOMENTUM

To emphasize the growth in migrant health services it is necessary only to compare the years 1966 and 1967.

In 1967, there was a 78% increase in the number of migrants identified in six of the counties in Ohio which have local migrant health projects which provide comprehensive health services to migrants. In 1966, there were an estimated 12,307 migrants in the six counties. In 1967, there were 21,907. Some of the increase identified in 1967 may be due to better methods of taking a census of the migrant population. However, project personnel in every county reported that they had more migrants than in previous years. Several factors accounted for the employment of more migrants. More acres were planted in tomatoes and pickles. A number of areas started employing migrants to detassel corn.

In the same six counties there was approximately a 56% increase in the number of patients given service in the medical clinics. In 1966, 2,929 individual patients were registered at the medical clinics for service. In 1967, there were 4,582. The 56% increase in the number of individual patients registered at the clinics was accompanied by approximately a 47% increase in the total number of clinic visits. In 1966, 5,484 clinic visits were made and in 1967 there were 8,140 visits.

To provide service to the increased number of migrants seeking care at the clinics, thirty additional clinic sessions were conducted. This increased the number of clinic sessions from 146 in 1966 to 176 in 1967. A clinic in one county averaged 69 patients per session. On two evenings, the clinic staff which included two physi-

cians, four nurses, two health aides, clerical personnel and volunteers, worked hard from 6:00 p.m. until midnight to see all the patients. On one of these evenings 110 patients were registered. At the other one there were 134 patients. In two of the counties that have the largest medical clinics, some patients start coming as early as two hours before the clinics are scheduled to open. They wait patiently for their turn to see the doctor.

It is apparent that where organized medical and related health services are available specifically for migrants, the migrants will avail themselves of the services. The evening hours, simplicity of clinic facilities, interested professional and volunteer staffs, and Spanish-speaking interpreters have contributed to the migrants participation in health services.

In 1967, there was a 53% increase in the number of expectant mothers given medical service through the projects in the six counties. In 1966, there were 200 expectant mothers admitted to the clinics for health services. In 1967, this number had grown to 306. It is known that in 1966, 80 maternity patients delivered while in Ohio in the six counties and in 1967, 101 delivered. Between visits made to migrants in the camps by nurses and by health aides, it is believed that there would be a negligible number of expectant mothers who are not located and receive care during pregnancies. All deliveries taking place in Ohio occur in hospitals. One of the county projects had 68 expectant mothers registered at the medical clinic. Laboratory examinations of blood samples of these women showed 66% to have anemia.

One chronic disease which came in focus this year was diabetes. Sixty-two migrants were given medical service in clinics for this disease in 1967. Many of these were diagnosed for the first time. The concentrated efforts necessary to instruct diabetic patients in modifying diets, in personal hygiene, and in taking medications regularly for the control of the disease sorely taxed the resources of existing project staffs.

Migrant project funds are used in this state to support nursing services in nine counties. In 1967, nurses employed in these counties made approximately 5,000 visits to camps to work with the migrants. During these visits health problems were detected and arrangements made for care. Nursing care and instructions were given in caring for existing health problems. The importance of nursing services for migrants in the home cannot be overemphasized. There are many many illustrations of how a nurse who happened to be in a camp found persons acutely ill. In some instances the migrant does not seem to recognize the seriousness of the situation. One example is a visit a nurse made one evening to see a woman who was a known diabetic and who had a tooth extracted earlier in the day. The nurse found the woman in diabetic coma. An emergency admission to the hospital was arranged by the nurse. The woman recovered and had no further trouble during her stay in the state. In no county in Ohio where migrants are employed does any existing health agency have local funds sufficient to employ nursing staffs to provide the depth and concentrated service the migrants and his family need.

One of the outstanding features of health services to the migrant is the comprehensive scope of services he is now getting. He can now get services necessary for diagnosis and treatment of medical problems. Furthermore, the staff of physicians and nurses see to it that the migrants follow through with recommendations for additional care. If a patient is referred to a specialist, the nurse sees that he gets there and that recommendations are followed. Arrangements for hospitalization for patients can now be made without delay since funds for this were made available this year. As of November 1, 1967, 230 migrants were known to have been hospitalized in counties with projects for a total of 1,043 hospital days. Reason for hospitalization ran the gamut of medical problems including one patient who had heart surgery. At the time this report is being prepared another patient is hospitalized in a large medical center awaiting heart surgery. It can be said that the migrant in these six counties is no longer falling into the cracks of community health services.

Another interesting feature of health services for migrants is the system of interstate referrals of migrants who need continuing health care. As the migrants leave Ohio, a report of health problems of specific migrants who need more care is sent on to the next state to which the migrant is going. This system has been in operation now since 1964. The percentage of replies that come back from health departments in other states has increased each year. An increasing percentage of the replies indicate migrants referred are located and receive care. This percentage has risen from 57% in 1964 to 72% in 1966, the latest year for which

information is available. This means the migrant is getting continuing care as he travels about the country because of the existence of similar projects in other states.

An interesting case illustrating how the referral system works is that of a young woman who had had a radical breast amputation because of cancer in another state. A referral was received from that state with recommendations for deep x-ray therapy treatment. Arrangements were made with the local hospital for the treatments and women from a local church organization provided transportation for the many visits to the hospital for the treatments. This woman could speak no English and the volunteers spoke no Spanish. Somehow the volunteers communicated their understanding and friendship. The woman came to the state depressed because of her diagnosis and surgery. She left a well and happy woman. She received care and had found people in a strange area who were interested in her.

It has taken some areas in the state a number of years to become interested in providing health services to migrants. At this point there are at least two county health departments in Ohio who wish to plan programs for migrants and make application for grants. Additional counties undoubtedly can be motivated now to plan programs and make application grants if there is assurance that funds would be available to finance the programs.

THE GOVERNOR'S COMMITTEE ON MIGRANT LABOR,
Columbus, Ohio.

Senator HARRISON A. WILLIAMS.

DEAR SIR: I have been in contact with the office of William O. Walker and other members of The Governor's Committee on Migrant Labor and we would like to go on record of supporting the Migrant Health Act S. 2688. We feel this has been one of the best executed programs on the State and County levels. I can personally speak for Wood Co. Ohio, where I live which I feel has been well planned and administered.

Accept this statement on behalf of the Governor's Committee on Migrant Labor.

ROBERT D. MARSH, *Chairman.*

STATE DEPARTMENT OF HEALTH,
STATE OF OKLAHOMA,
Oklahoma City, Okla., December 20, 1967.

Senator HARRISON WILLIAMS,
*Chairman, Migrant Health Subcommittee,
New Senate Office Building, Washington, D.C.*

DEAR SENATOR WILLIAMS: Oklahoma has three areas that utilize migrant labor. These areas all experience the same needs for sanitation, nursing, medical and dental services.

1. Southwest Oklahoma with approximately seven counties which use both in and out-migrants in cotton and cucumber fields.

2. East Central Oklahoma comprising three counties that are major strawberry producers.

3. Central Oklahoma near Tulsa, a vegetable producing area.

The only area receiving such services at this time is in southwest Oklahoma. A migrant health project, funded from 1965 to June 30, 1968, has not only accomplished the stated objectives (furnishing and supplementing existing Public Health and medical services) but has become a focal point for all community resources available to the in-migrant as well as the out-migrant. The project serves three counties, two of which had no Public Health facilities prior to 1965. In the third county the funds are used to provide additional services through the county health departments.

The project has made it possible to provide Public Health services to approximately 8,000 migrants (Spanish-speaking) who had never known services such as immunization, pre and post natal and dental care.

The project nurses have made it possible for the migrant to be referred to resources—medical, psychological and educational—that otherwise would be beyond their reach.

The project has led to one county's voting a health levy for the operation of a county health department to insure continued health services to all people of the community.

The present Oklahoma project is funded at approximately \$85,000 per year plus the appropriate local funds.

We feel that to discontinue these services at this time would create a vacuum that would allow past and present accomplishments to regress beyond repair.

To properly serve the migrant worker in Oklahoma, the migrant project should be extended to cover another ten counties. This would require at least four additional nurses, two more sanitarians and more central administrative staff. To provide minimum services to the Oklahoma migrant we need at least \$50,000 additional Federal support.

Sincerely yours,

A. B. COLYAR, M.D.,
Commissioner of Health.

STATE OF OREGON,
OREGON BOARD OF HEALTH,
Portland, Oreg., December 22, 1967.

HON. HARRISON WILLIAMS,
*Chairman, Migrant Health Subcommittee,
New Senate Office Building, Washington, D.C.*

MY DEAR SENATOR WILLIAMS: As State Health Officer of Oregon, I wish to present a statement concerning the migrant health needs within our state.

I feel it is important to point out the significance to Oregon of both the renewal of the Migrant Health Act and the provision of additional funds.

Sincerely,

EDWARD PRESS, M.D.,
State Health Officer.

A WRITTEN STATEMENT RE EXTENSION OF MIGRATORY HEALTH ACT

Since 1963 the Oregon State Board of Health has utilized funds provided under the auspices of the Migrant Health Act to develop through its local health departments a comprehensive health service to inter-and-intra-state migrant agricultural workers and their families. It is a program that includes preventive health services, medical, dental, and hospital care, and is concerned with the total health problems of this target group.

An estimated 31,000 seasonal farm workers and their families come into Oregon each year to harvest the crops. The average population in some rural communities is doubled by the workers coming into their areas. The medical resources for the local communities are limited, especially since the majority of the harvest seasons peak during the summer months when many professional people take their vacations. This limits even more the medical resources available in these rural communities. Prior to implementation of the Migrant Health Act in 1963, every local health department concerned with an appreciable agricultural migrant population lacked sufficient resources to extend needed health care to this important group.

In 1967, approximately 27,230 of these seasonal farm workers and their families worked in nine counties having migrant health projects: the project nurses in these counties saw 17,875 individuals for health screening purposes. Of this number, 4,998 (27%) were referred for needed medical and dental care. Of those referred, 328 were diagnosed as having a communicable disease.

Fifty-nine of those referred were diagnosed as having tuberculosis or were provided health surveillance for suspected tuberculosis. Six required hospitalization in the Oregon State Tuberculosis Hospital. If case finding had been carried out in the total migrant population, it is estimated that an additional twenty-five cases of tuberculosis would have been found.

It is estimated that 9,355 of the individual migrants were not seen by the nurses in the nine project counties. Since 27% of those seen were referred for medical care, it seems logical to conclude that approximately 2,527 more migrants would have been referred for medical problems if they had been contacted during the health screening program.

This year, for the first time, the project had funds to pay for needed short-term hospitalization of migrant workers and their families. During the 1967 season, 153 patients were hospitalized at a cost to the project of \$18,731.55. This amount represents payment on the basis of only 54% of the hospital's posted medicare rate.

Sanitarians in the program working as an integral part of the local health departments inspect farm labor camps and fields to determine if the facilities provided for workers and their families are in compliance with Oregon laws and

regulations. Through frequent inspections and followup visits, considerable upgrading of both camp and field sanitation has been achieved. More needs to be done in this area.

This program has over the past four years expanded from three to ten counties (including Yamhill County) and now covers an estimated 90% of the migrant agricultural workers in the State of Oregon. Plans are presently being developed to further expand the Oregon Migrant Health Project to reach 100% coverage of agricultural migrants needing health services.

In order to meet the health needs of all of the migrant workers and their families in Oregon at approximately the same level of service as is presently being provided, additional funds in the amounts and for the purposes itemized below will be required:

1. Migrant health projects in the remaining six counties using seasonal farm workers who do not presently have projects. These six counties have an estimated 129 camps with a capacity of 3,000 individuals.

2. Additional public health personnel to provide a ratio of one public health nurse for each 1,000 individuals.

3. Itemized purposes and amounts:

(a) Personnel.....	\$35, 000
(b) Hospitalization at the present rate of 54 percent of posted medicare rate.....	23, 000
(c) Physicians in-hospital care.....	23, 000
(d) Physicians outpatient service.....	17, 550
(e) Emergent dental care.....	2, 500
(f) Pharmaceuticals.....	3, 000
(g) Special laboratory and X-rays.....	12, 000
(h) Transportation.....	3, 000
Total.....	119, 050

With the inclusion of the above stated services, the Oregon Migrant Health budget would be increased from \$380,674 to \$499,724.

In reporting on Oregon's funding under the Migrant Health Act, Yamhill County which has been a separate project since 1964 should be included. We are informed that a separate statement has already been submitted to Senator Williams by Dr. J. D. Ragan, Health Officer of Yamhill County. To avoid possible duplication we have not included Yamhill County in this statement.

In summary I should like to say that the renewal of the Federal Migrant Health Act is urgently needed and that an increase in funds will be required to enable Oregon to provide the minimum essential health services to migrant agricultural workers.

COMMONWEALTH OF PENNSYLVANIA,
DEPARTMENT OF HEALTH,
Harrisburg, December 20, 1967.

Hon. HARRISON A. WILLIAMS, Jr.,
U.S. Senate, Washington, D.C.

DEAR SENATOR WILLIAMS: It is a privilege to respond to your invitation to present testimony supporting an extension of the Migrant Health Act for five years and a doubling of present appropriations.

Five years ago, Pennsylvania was one of the first states to apply for a federal grant under the Migrant Health Act. These funds, in increasing amounts, have been used during the past five years to provide services and facilities to meet, at least in part, the more urgent health needs of the approximately 8,000 men, women, and children who constitute our migrant work force.

An initial screening of a sample of migratory workers and their dependents indicated that they suffered from many acute illnesses and accidents that required the immediate attention of physicians. A smaller number had more chronic illnesses such as heart disease, tuberculosis, and kidney disease, or needed surgery for hernias, open fractures, or obstetrical complications.

The teeth of most migrants were in poor condition. Frequently it was found that salvageable teeth had been extracted. Gums were often diseased.

Beginning in a four-county area of the State a migrant health program was developed that now provides care in 17 counties and embraces over 80 percent of the migrant population.

Family clinics are held in some counties where physicians treat illness and public health nurses provide follow-up care. In other counties migrant care is contracted for in doctor's offices.

Dental care, curative and prophylactic, is provided through contract with the Pennsylvania Dental Services Corporation.

Migrant camps are inspected by health department sanitarians throughout the season. Approval is a prerequisite for licensing by a sister department.

Where feasible transportation by bus to care facilities is provided and drugs are made available through local pharmacies.

If the Migrant Health Act is extended and additional needed funds are appropriated the greatest remaining health needs of migrants in Pennsylvania can finally be met. This is the need for the payment for hospitalization and to underwrite the cost of surgical and obstetrical care.

Failure to provide adequate prenatal and obstetrical care contributes to the high morbidity rates among pregnant migrant females. Inability to pay for needed surgery for hernia operations, to correct poorly united fractures, to repair injuries resulting from accidents—has denied migrants a badly needed health service. Hopefully, this lack can be corrected during the coming migrant season.

The migratory worker is a stranger in an unfriendly land. He is not a native. He is poor. He is tolerated by many only because he is needed to harvest the bountiful crops that are grown each year in the Commonwealth.

To provide adequate health services to migrants can be justified as meeting a well-documented human need. For those whose minds are profit oriented keeping migrant workers healthy and productive is a sound investment in the national economy.

The 1967-68 budget of \$196,005 allotted to Pennsylvania insured migrants medical, dental, and nursing care; improved their living and working conditions; and gave all who participated in the program a sense of pride in having provided an invaluable service not only to the voiceless migrants but to the people of the Commonwealth as well.

A modest increase in the 1968-69 appropriation, to \$247,783, will permit the Commonwealth to provide badly needed hospitalization, and surgical and obstetrical services to seriously ill or disabled workers and their dependents.

It is earnestly hoped that Congress in its wisdom will decide to extend this Act for a five year period and increase the appropriation to permit us in the States to give migrants the health services upon which their good health depends.

Sincerely,

THOMAS W. GEORGES, Jr., M.D.,
Secretary of Health.

STATE OF UTAH, DEPARTMENT OF HEALTH AND WELFARE,
Salt Lake City, Utah, December 27, 1967.

HON. HARRISON WILLIAMS,
U.S. Senator,
*Chairman, Migrant Health Subcommittee,
New Senate Office Building, Washington, D.C.*

DEAR SENATOR WILLIAMS: Enclosed please find the data and arguments to support the continuation and expansion of the migrant health program. It is hoped that this will be of value in extending this important legislation.

During the past three years, the program in Utah has met a very real need. Considerable progress has been made but much remains to be done.

Sincerely yours,

G. D. CARLYLE THOMPSON, M.D.,
Director of Health.

MIGRANT HEALTH NEEDS WITHIN UTAH

Continuation of the present level of funding permits only a minimum program. During the previous three years of project operation, community personnel and private industry have been mobilized toward the solution of the health problems of migrants. Previous planning, organization, and expenditures would be wasted in the event that this program was curtailed or reduced.

Additional services are needed if the health needs of the agricultural migrant laborer and his family are to be met while in migrant status.

While outpatient care is less expensive per patient, there is great need for providing hospitalization. It is generally recognized that many conditions cannot be properly managed even by the best of medical office management. Among these conditions are the more severe ones such as the critically ill and childbirth. It is assumed that childbirth should occur in a hospital. For practical purposes this is always the case with migrant mothers in Utah.

However, there are no funds for hospitalization of migrants. Hospitals must frequently absorb the cost of these deliveries since the migrant family is often unable to pay for obstetrical care.

Since there are no funds for hospitalization, surgical procedures are postponed or the cost absorbed by the hospital.

In addition, there is no provision to finance the large number of visits to hospital emergency room.

SUMMARY, UTAH MIGRANT HEALTH PROJECT, JULY 1, 1967 TO JUNE 30, 1968

Utah's Migrant Health Program is now in its third year. The objective of the program is to improve the health of the migrant and his family by providing health education, outpatient medical and dental care, payment for prescriptions, public health nursing services, and improvement in environmental health. Migrant worker health services are provided in all fourteen counties where migrants are employed. The extent of these services vary with the number of migrants and the length of time they stay in the area.

Migrants first arrive in Utah about April 1 and remain until November 1. There were approximately 5,695 migrant farm workers in Utah during the 1967 season, an increase from the 3,211 of last year.

The medical program provides payment for medical care in physicians' offices. Preventive services include chest x-rays, tuberculin testing, serological tests, venereal disease control activities, health education activities, and environmental health consultation to migrants and migrant camp operators. Services are provided at the convenience of the migrant. Clinics are held frequently at night. Health education films were shown at the clinics and public health personnel were available to discuss health problems with the migrants and their families.

To coordinate activities and bring together agencies and individuals involved in the migrant program, a statewide seminar was held in Logan, Utah, on May 3, 1967. A total of 115 persons attended this seminar.

During 1967, public health nursing services visits numbered 784 and there were 682 visits to physicians' offices.

Public health nurses made periodic visits to the migrants living in camps and to individual housing areas. During these visits the following services were provided:

- (a) Nursing care and counseling of parents on positive health practices.
- (b) Referring those in need of medical care to a physician.
- (c) Arranging for immunization and screening clinics.
- (d) Showing educational films and conducting group discussions on health and sanitation.
- (e) Teaching medical self-help as appropriate.

The value of maintaining and carrying their Personal Health Records has been emphasized to the migrants. More frequently these records are being brought into the clinics. Physicians will be further encouraged to record pertinent information on these records.

Utah's migrant labor camps range in size from a single-family unit located on a small farm to 40-unit camps owned by large corporations. Over half of Utah's migratory laborers work for individual growers. Most housing is old, consisting of abandoned buildings which have been repeatedly repaired. Environmental health services consist mainly of frequent housing inspections and consultation provided by local and state sanitarians.

The Migrant Health Program sanitarian made 282 inspection visits to 103 migrant camps during the 1967 season. During these inspections, 283 significant violations were found. Checklists prepared by the State Division of Health were used to define the camp violations. The greatest number of violations were in garbage disposal, water supplies, window screens, cleanliness of mattresses, and privy construction and maintenance.

Many problems still remain; however, significant progress has been made. The goal for next year is to improve existing migrant programs, add other needed services, and continue working with communities promoting interest and participation in the Migrant Health Program.

ANNUAL REPORT, FISCAL YEAR 1967, MIGRANT HEALTH PROGRAM

General information

The State Division of Health Migrant Health Program coordinates health services for the domestic agricultural migrant and his non-working dependents

in Utah. The project is in its third year of operation, and this report covers the period from July 1, 1967, to June 30, 1968.

The state migrant staff may at times offer direct services in areas which lack local health departments or may offer consultative services when requested by local health departments. Services offered either on a direct or consultative basis include outpatient medical care, dental care, nursing services, environmental health services, and health education.

Objectives (as listed in last approved application)

(a) To improve the health of the migrant agricultural worker and his dependents by providing multiple screening and preventive medical services and by the development of a program of positive health promotion.

(b) To provide the migrant and his family the benefit of a communicable disease control program, primarily directed at tuberculosis and venereal disease.

(c) To provide outpatient medical and dental care through private practitioners.

(d) To provide consultation and health education which will provide the basis for improvement of the migrant's living environment.

(e) To continue the development of outpatient medical care in physicians' offices and of hospitalization by working with component medical societies, local health departments, welfare, industry, county commissioners, and insurance companies.

Significant changes in the migrant situation from the previous year

The migrant population has changed very little in regard to age, sex, cultural background, origin, and residence of record. However, there were 5,695 migrants employed in Utah this year as compared to a total of 3,211 last year.

Migrants have various cultural backgrounds. The majority coming to Utah are Spanish-Americans from south Texas with a smaller number of Indians coming from Arizona and New Mexico. Most of the Indians are from the Navajo Indian Reservation in the Four Corners area. In addition to the Navajos, Ute Indians from the Uinta Reservation, Kickapoo Indians from Old Mexico, and Shawnee Indians from Oklahoma have been used as seasonal laborers this year.

The migrant population is composed of families ranging in age from infants to elderly persons. About 55 percent of the total migrant population is male and 45 percent is female. (See Table D under Part III—Sanitation Services)

The migrants come into the state in early May to work in the beet fields and migrate from county to county according to the crop need. The majority return to Texas in the fall, but a few working in the northern counties move on to Idaho in the late fall for potato harvesting. (See Table E under Part III—Sanitation Services)

This year a number of migrants have expressed a desire to remain in Utah permanently. Many of their homes were destroyed by the hurricane and flood in southern Texas. In short, they have nothing to return to. Brigham City, located in Box Elder County, will double its Spanish-American population this year from approximately 50 to 100 persons.

Economic situations

For three consecutive years the fruit in northern and north central Utah was severely damaged by a late spring killing frost. Apricots, sweet cherries, and peaches were partially or totally destroyed during the 1966 season. The 1967 season also had a late frost, but only the apricot crop received extensive damage.

Crops requiring migrant farm labor remain the same: sugar beets, cherries, green beans, cucumbers, tomatoes, peaches, pears, apples, and potatoes. Despite technological advances to further reduce the future need for seasonal labor in Utah, good crops necessitated a marked increase in migrants this year. During 1967 all counties reported a shortage of farm laborers.

The rising cost of labor is a major factor influencing the farmer to mechanize in order to reduce labor requirements. Some crops do not and are not likely to lend themselves to mechanization. These crops due to rising cost and lack of labor, will be threatened.

Medical and dental services

Utah's medical and dental program for migrant families provide services in the physicians' and dentists' offices at a time that is convenient to the migrant. Physicians in some counties have agreed to make appointments for migrants after hours, making it unnecessary for them to miss work during the daytime. Persons in need of specialized care, not available in the physician's office, have been referred to the existing facilities of the Utah State Division of Health. Six children

were referred for orthopedic care and ten adults to the Tuberculosis Control Program. (See Table A under Part I—Medical, Hospital and Dental Services.)

The dental program was delayed in starting; however, limited emergency treatment, extractions, and fillings were carried out. A survey made by public health nurses in migrant schools and day care centers showed that the oral hygiene of migrants is poor. A marked increase in total effort will be necessary to improve dental health among migrants.

Progress has been made in developing and expanding the existing program through personal contact and health education. Information regarding medical and dental care has been made available through health departments, physicians, nurses, churches, migrant councils, the Office of Economic Opportunity, and volunteers working with migrants. Health classes have been held in migrant camps at night, and the film "A Healthier Place to Live" has been of interest to the young adults and children. Health education materials have focused on the essence of healthful living and the value of a healthy environment. Many families now keep their own Personal Health Records and have presented them at clinics.

Nursing services

The number of nursing visits has increased in some counties; and in counties unable to hire additional nurses, visits have declined. This year, Cache and Weber Counties hired part-time public health nurses to work in the migrant program during this summer. In all other counties nursing services were provided by the regular nursing staffs of the county health departments. Services furnished by nurses were: (1) Regular visits to migrant camps and families. (2) Classes on health in the camps at night. Films were shown and health materials distributed. (3) Visits to day care centers and schools were these facilities were part of the community services to migrants. (4) Information regarding medical care and referral of persons found to be in need of medical care to physicians. (5) Immunization and screening clinics held in the evenings. (See Tables B and C under Part II—Nursing Services).

There was less need for immunization this season since many families had completed immunization before starting to travel in the spring. This was verified by the personal health records presented at the clinics.

Weber County rented and equipped a panel truck to furnish health services in the camps at night. It was planned that child health conferences, family planning, immunizations, and other health activities in the thirteen camps would be held from this truck. However, the health officer who was scheduled to participate in the clinics resigned and the extent of the services was limited. Public health nurses made good use of the truck for nursing conferences, immunization clinics, individual counseling, and various health activities. The following services were provided:

Visits to camps.....	35
Chest X-rays (10 referred for further study).....	82
PPD tests (2 referred).....	274
Nursing conferences.....	22
Stool specimens collected for intestinal parasites.....	64
Nursing visits.....	194
Referred to physician and dentist.....	88
Child health conferences (3 referred).....	1
Immunizations (see chart).	

General appraisal of nursing program

A shortage of nurses working in the public health programs exists in most counties. Because of the large number of migrants employed in Box Elder County, a critical need for more nursing services exists than can be provided by the local health department and the Office of Economic Opportunity. Next year additional nursing services will be added by the migrant project in Box Elder County. Nurses for these services will be recruited, oriented, and supervised locally by the Regional Nursing Consultant of the Utah State Division of Health.

Sanitation

Utah's agricultural industry is currently providing over five hundred housing units for seasonal workers. The state migrant consultant sanitarian conducts monthly inspections of these facilities in conjunction with the local health department staff. The Utah State Division of Health's "Proposed Migratory Labor Camp Regulations" are used as a guide in establishing minimal sanitary standards. Subsequent to the inspections, recommendations are made to improve the migratory worker's living standards.

State and local health departments and the Bureau of Employment Security and employers are cooperating to bring about improvement in the housing of agricultural workers.

The local office of the Bureau of Employment Security has worked closely with the state and local health departments on camp inspections to improve the living conditions of the migrants.

General description and condition of housing accommodations for migrants

Permits for migratory labor camps are not issued by state or local health departments. Division of Health Rules and Regulations governing migratory camps have been drafted and are in the process of being adopted.

Camps are inspected for 14 major items. The greatest number of violations are in grounds, bedding, screening, garbage, and toilet facilities. Of 283 violations found among 101 camps, 20 percent of these were corrected. (See Table G under Part III—Sanitation Services.)

Approximately one-third of Utah's migrant population is employed by private farmers and growers who utilize migrant labor for two weeks or less. They are housed in small single family units which are usually older abandoned farm houses or units the farmer or grower has purchased and brought onto his property for use by the migrants. The buildings are usually of frame construction with floors of tongue and groove lumber. Many of these units remain substandard because the small farmer feels financially unable to upgrade units having such limited occupancy.

Several large, diversified, processing companies have constructed permanent labor camps ranging in size from five to forty units. These are most often frame or metal barracks with cement or tongue and groove lumber floors. The majority of these camps have separate service buildings with flush toilets, wash basins, shower, and laundry facilities. All have electricity, accessible potable water supplies, adequate sewage, rubbish disposal, and sleeping and cooking facilities.

Northern Utah

Growers in the northern counties generally provide required facilities such as water, sewage disposal, garbage and refuse disposal, and service units. However, an insufficient number of these facilities are available. Water is either potable city or well system. The pit privy is still the most common toilet facility. Garbage and refuse disposal is improving. No camps in the state use any type of kitchen or mess hall facilities. (See Table F under Part III—Sanitation Services)

Southern Utah

Growers in Carbon, Sanpete, Sevier, Piute, Washington, and Wayne Counties provide fewer and poorer facilities for their migrant laborers. Most farmers and growers feel that because their migrants are Navajo Indians, and because they are used for so short a time, the cost of facilities cannot be justified. There is a problem of providing the necessary health education for the Navajo so that he would utilize the sanitary facilities properly.

During the next year there will be an effort to bring interested parties together to discuss methods for improving migrant camp facilities and the necessary improvement in other migrant health activities.

Health education

To coordinate and bring together all people working with migratory farm workers, Seminar No. 2 was held in Logan, Utah, in April of 1967. There were 115 people in attendance with representatives from the U.S. Public Health Service, state and local health departments, the Utah State Medical Association, industry, growers, church organizations, volunteers, local Office of Economic Opportunity, and migrants. Three migrant farm workers participated on the program.

Health education programs have been conducted by public health nurses, sanitarians, church groups, and volunteers. Films in Spanish and English have been shown and pamphlets in Spanish distributed.

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Many problems still remain; however, significant progress has been made. The goal for next year is to improve existing migrant programs, add other needed services, and continue working with communities promoting interest and participation in the Migrant Health Program.

PRETEST DRAFT
1967NEW-YRS
Wash., D.C.MIGRANT HEALTH PROJECT - ANNUAL PROGRESS REPORT
For July 1, 1967 through June 30, 1968
Date submitted November 8, 1967

PART I GENERAL PROJECT INFORMATION

1. Project Title Utah Migrant Health Service	2. Grant Number (use number shown on approved application) MG 98
3. Name and Address of Applicant Organization Utah State Division of Health 44 Medical Drive Salt Lake City, Utah 84113	4. Project Director Robert W. Sherwood, M. D.

PART II MEDICAL, HOSPITAL AND DENTAL SERVICES (For all Counties)

1. Patients receiving outpatient medical services:				2. Patients hospitalized:			
Age	Number of patients		Number of visits	Age	Number of patients		Hospital Days
	Total	Male	Female		Total	Male	Female
Total	410	153	257	682	Total		
Under 1 year	43	22	21	70	Under 1 year		
1 - 4 years	78	37	41	120	1 - 4 years		
5 - 14 years	85	35	50	141	5 - 14 years		
15 - 44 years	166	43	123	291	15 - 44 years		
45 - 64 years	36	14	22	53	45 - 64 years		
65 and older	2	2	0	7	65 and older		

3. Patients receiving dental service:	Total	Under 15	15 and older
a. Number of migrants examined: total	26		
Number of decayed, missing, filled teeth- Average DMF per person			
b. Individuals requiring services: total	26	7	19
Cases completed	23	1	22
Cases partially completed	2		2
Cases not started	1		1
c. Services provided: total			
Preventive			
Corrective	27		
Extraction	16		
Other	3		
d. Patient visits: total	46		

PART I

TABLE A.—ALL COUNTIES—5. MEDICAL CONDITIONS FOUND BY PHYSICIANS AMONG OUTPATIENTS, BY AGE OF PATIENT

[Pretest draft, 1967; project No. MG-98; date submitted _____]

ICD class	Diagnosis or condition	Total	Age of patient (years)					
			Under 1	1 to 4	5 to 14	15 to 44	45 to 64	65 and older
I.....	Infective and parasitic diseases:							
	Tuberculosis.....	3				2	1	
	Venereal disease.....	3				3		
	Measles.....	11	2	6	2	1		
	Infestation with worms.....							
	Dermatophytosis and other infections of skin.....	21	2	7	10	1	1	
	Other.....	5			1	3	1	
II.....	Neoplasms:							
	Malignant.....							
	Benign and unspecified.....							
III.....	Allergic, endocrine, metabolic, and nutritional diseases:							
	Diabetes.....	7	2		2	2	1	
	Malnutrition.....	3		1	1	1		
	Other.....	1			1			
IV.....	Diseases of blood and blood-forming organs:							
	Anemias.....	15		3	3	8	1	
	Other.....							
V.....	Mental, psychoneurotic, and personality disorders.....	1				1		
VI.....	Disorders of nervous system and sense organs:							
	Cerebro-vascular disease (stroke).....							
	Eye diseases.....	19	4	5	5	4	1	
	Diseases of ear and mastoid process.....	20	1	5	6	6	2	
	Other disorders of nervous system.....	10		3		6	1	
VII.....	Diseases of circulatory system:							
	Rheumatic fever.....	1				1		
	Diseases of the heart.....							
	Hypertension and other diseases of circulatory system.....							
VIII.....	Diseases of respiratory system:							
	Upper respiratory.....	58	18	17	7	15	1	
	Influenza and pneumonia.....	5			2	2	1	
	Bronchitis.....	6	1	3		2		
	Other, tonsillitis.....	54	7	5	21	19	2	
IX.....	Digestive system diseases:							
	Teeth and supporting structures.....	1		1				
	Gastroenteritis, colitis.....	43	8	6	5	18	6	
	Other.....	16	1		2	8	5	
X.....	Diseases of genito-urinary system:							
	Urinary system diseases.....	15		1	2	9	3	
	Genital system diseases.....	2				2		
XI.....	Deliveries and complications of pregnancy:							
	Complications of pregnancy.....	4				4		
	Deliveries.....							
	Complications of puerperium.....	2				2		
	Menopausal symptoms.....	9				8	1	
XII.....	Skin diseases:							
	Impetigo.....	31	3	12	14	1	1	
	Other.....	1			1			
XIII.....	Diseases of bones and organs of movement.....	14	1		1	7	5	
XIV.....	Congenital malformations.....							
XV.....	Diseases of early infancy.....							
XVI.....	Symptoms, ill-defined conditions.....	7				5	2	
XVII.....	Accidents, poisonings, violence.....	43	1	6	14	12	10	
Supp.....	Special conditions, examinations, without sickness:							
	Prenatal, postnatal care.....	17			1	16		
	Physical examination.....							
	Immunizations.....							
	Surgical or medical aftercare, followup.....							
	Fitting prosthetic devices.....							
	Other.....							
	Grand total.....	448	50	82	104	169	44	

NOTE.—Count includes patients treated for more than 1 condition during a visit; each condition was counted.

TABLE B.—NURSING VISITS (BREAKDOWN BY TYPE)

County	Total	Therapeutic	Counseling and teaching	Home	Office	School	Telephone	Day-care center	Training center	Hospital or institution	Other agency
Box Elder.....	234	32	202	133	75	2	10	2	0	5	7
Cache.....	111	6	105	75	3	0	9	2	0	3	19
Carbon.....	39	0	39	30	0	0	4	0	1	0	4
Davis.....	171	14	157	106	2	15	22	0	0	5	21
Sevier.....	13	7	6	1	1	0	0	0	0	2	7
Washington.....	22	22	0	15	7	0	0	0	0	0	0
Weber.....	194	38	156	118	71	0	4	0	0	1	0
Total.....	784	119	665	480	159	17	49	4	1	16	58

TABLE C.—NURSING VISITS (BREAKDOWN BY AGE)

County	Admission	Revisit	Under 1 month	1 to 11 months	1 to 4 years	5 to 12 years	13 to 17 years	18 to 20 years	21 to 44 years	45 to 64 years	65 and over
Box Elder.....	145	89	8	39	27	57	15	11	65	12	0
Cache.....	29	82	0	18	10	31	7	1	29	15	0
Carbon.....	19	20	0	0	0	8	10	7	8	6	0
Davis.....	53	118	0	4	18	70	25	15	24	15	0
Sevier.....	8	5	0	1	0	4	1	0	7	0	0
Washington.....	22	0	3	0	0	0	0	0	17	0	0
Weber.....	124	70	2	16	45	26	5	17	73	10	0
Total.....	400	384	13	78	100	198	63	51	197	58	0

PART II.—NURSING SERVICES
PART III.—NURSING AND SANITATION SERVICES

County	Number										Number										
1. Nursing services (field nursing):																					
(a) Visits to homes.....																					
(b) Total households served.....																					
(c) Visits to schools, day-care centers, total.....																					
(d) Migrants presenting health record on request (PHS 3652).....																					
(e) Migrants given health record.....																					

TABLE D.—NUMBER OF MIGRANT WORKERS AND DEPENDENTS

County	Under 1 year			1 to 4 years			5 to 14 years			15 to 44 years			45 to 64 years			65 and older			Grand total			
	Male		Female	Male		Female	Male		Female	Male		Female	Male		Female	Male		Female	Total	Male	Female	
	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	
Box Elder	114	63	51	455	250	205	569	313	256	797	438	359	318	175	143	24	13	11	2,277	1,252	1,025	
Cache	6	4	2	20	13	11	30	17	13	42	22	20	17	9	8	1	1	1	0	120	66	54
Weber	23	12	11	89	48	41	112	62	50	156	86	70	62	34	28	4	3	2	1	446	245	201
Davis	16	9	7	63	35	28	79	43	36	110	60	50	44	24	20	3	2	1	1	315	173	142
Salt Lake	9	5	4	37	20	17	46	25	21	64	35	29	26	14	12	2	2	0	0	184	101	83
Utah	59	32	27	235	129	106	294	162	132	411	226	185	165	91	74	11	6	5	1,175	646	529	
Carbon	7	4	3	28	15	13	36	20	16	50	27	23	20	11	9	1	1	0	1	142	78	64
Juab										10	10								10	10		
Millard										20	20								20	20		
Sanpete	5	3	2	20	11	9	25	14	11	35	19	16	14	8	6	1	0	1	100	55	45	
Sevier	5	3	2	20	11	9	25	14	11	35	19	16	14	8	6	1	0	1	100	55	45	
Piute										31	31								31	31		
Washington	33	18	15	130	72	58	163	90	73	228	125	103	90	50	40	6	3	3	650	358	292	
Iron										15	15								15	15		
Wayne	4	3	1	18	10	8	23	13	10	31	17	14	13	7	6	1	0	1	90	50	40	
San Juan										20	20								20	20		

TABLE E.—SANITATION SERVICES
[Number of migrants by month]

County	Total	January	February	March	April	May	June	July	August	September	October	November	December
Northern and north central:													
Box Elder	2,277						392	720	450	425	290		
Cache	120							70	30	10	10		
Weber	446						3	343	38	62			
Davis	315					35	150	70	40	20			
Salt Lake	185					50	100	34					
Utah	1,175					65	140	345	250	225	150		
Central and southern:													
Carbon	142						90	52					
Juab	10							10					
Millard	20							20					
Sanpete	100							100					
Sevier	100							100					
Piute	31						31						
Washington	650										650		
Iron	15									15			
Wayne	90								20	90			
San Juan	20												
Total	5,695					150	906	1,864	828	847	1,100		

TABLE F.—SANITATION SERVICES

County	Number of camps	Number of units	Number of camps occupied	Number of camps inspected	Number of inspections	Number of camps meeting standards	Number of migrants	Type of occupancy
North and north central:								
Box Elder.....	85	131	65	5	25	2	2,277	Spanish American and Navajo.
Cache.....	2	29	2	2	14	2	120	Spanish American.
Weber.....	25	124	13	25	104	2	446	Spanish American and Navajo.
Davis.....	2	53	2	2	14	2	315	Spanish American.
Salt Lake.....	8	26	8	8	42	1	184	Spanish American and Navajo.
Utah.....	12	124	9	12	33	2	1,175	Spanish American, Navajo, Kickapoo, and Shawnee.
South and south central:								
Carbon.....	15	15	15	15	15	0	142	Navajo.
Garfield.....	8	8	0	0	0	0	-----	-----
Grand.....	3	3	0	0	0	0	-----	-----
Piute.....	9	9	6	6	6	0	61	Do.
Sanpete.....	8	8	8	8	8	1	100	Do.
Sevier.....	10	10	10	10	10	1	100	Do.
Washington.....	10	22	10	2	4	0	650	Navajo and Spanish American.
Wayne.....	6	6	-----	6	6	0	90	Navajo.
Iron.....	-----	-----	-----	-----	-----	-----	15	Do.
San Juan.....	-----	-----	-----	-----	-----	-----	20	Do.
Total.....	203	568	148	101	282	13	5,695	

TABLE G.—INSPECTIONS OF LIVING ENVIRONMENT OF MIGRANTS

Items	101 camps inspected for—	Number of significant violations found	Number of violations corrected
Grounds.....	X	28	10
Sleeping rooms.....	X	8	-----
Beds.....	X	38	7
Lighting.....	X	8	-----
Screening.....	X	27	5
Floors.....	X	13	-----
Subfloor space.....	X	9	-----
Walls.....	X	5	1
Water supply.....	X	26	2
Garbage.....	X	37	6
Sewage system.....	X	12	4
Privies.....	X	42	8
Service building.....	X	17	6
Insects and rodents.....	X	13	3
Total.....	-----	283	52

STATE OF WASHINGTON,
DEPARTMENT OF HEALTH,
Olympia, Wash., December 21, 1967.

Re migrant health in Washington State.

Hon. HARRISON WILLIAMS,
Chairman, Migrant Health Subcommittee,
New Senate Office Building, Washington, D.C.

DEAR SENATOR WILLIAMS: Unmet health needs experienced by migrants have been recorded in detail, and are probably no different in Washington State than in any other area. A list of those needs would include, but not be limited to, the following: Medical care; dental care; family planning; immunizations; nutrition education; food preparation instruction.

These and other conditions are brought on, or contributed to, by: Too many communicable diseases; poor housing and sanitation; inadequate education; low income; language barriers; continual mobility; poor personal hygiene.

Each of these thirteen factors works to the disadvantage of the migrant and his family. Some are beyond the scope of the Migrant Health Act, but others, medical and dental care, case finding and disease prevention by public health nurses, and housing and basic sanitation techniques, are being attacked in Washington.

We view this only as a beginning. There are many migrants in Washington who have not yet been reached by any special services; and it is important that those areas with migrant health projects expand their activities.

The following is a list of health districts in Washington where significant numbers of migrants are employed.

Health district	Number of licensed labor	Approved capacity	Peak population
Chelan-Douglas.....	105	3,000	9,600
Okanogan.....	73	2,500	6,100
Yakima.....	56	3,600	13,700
Skagit.....	48	6,500	9,900
Whatcom.....	28	1,560	1,800
Tacoma-Pierce.....	28	1,200	900
Bremerton-Kitsap.....	18	1,000	400
Benton-Franklin.....	17	1,300	2,200
Seattle-King.....	10	500	1,500
Grant.....	6	100	4,400
Snohomish.....	4	170	200
Klickitat-Skamania.....	3	260	600
Columbia.....	1	120	2,500
Walla Walla.....	6	1,200	
Garfield.....			
Asotin.....			

¹ Jurisdictions with migrant health projects.

Reference to the above table of peak populations will indicate that the presently operating programs serve only a minority of the migrants. We estimate that the stay of migrant agricultural workers and their families amounts to some 110,000 person-months each year in the state as a whole, but only about 12,000 person-months in Whatcom, Skagit and Pierce Counties, places where migrant programs at a fair level of intensity have been carried out. The present funding under the Migrant Health Act in these three counties, serving about one-ninth of the migrant need, is \$118,496. To provide services at this intensity to the rest of the State would require then, as a rough estimate, some \$1,060,000. To fill the total need, however, could require much more. The most intensive project in the state, the Puyallup-Stuck Valley Project, is funded at \$40,324 to serve needs of migrants present for 1,600 person-months. To serve migrant needs in the state at this level would require about \$2.8 million, and even then it is worth noting that the Puyallup-Stuck Valley migrants, mostly Indians, are eligible for considerable service elsewhere under other legislation.

The extent of need may be grasped by noting we forecast, very roughly, that some 246 children will be born to migrant families while they are in Washington during the 1968 season; and that of these, a dozen will die during the first year, eight from preventable causes. About ninety-five adult migrants will also die.

The "poor health" syndrome of migrants is extremely difficult to meet. One of the most frustrating aspects of the picture is mobility. The health problems of a moving population are compounded by a here-today-gone-tomorrow culture which makes any service impossible to complete. The factor of mobility will be altered in the next few years as changes occur in agricultural economics and farm mechanization. In the meantime, we feel we must continue and expand our efforts to serve the migrant workers and their dependents who come to Washington.

A list of the current use of Migrant Health Act funds in Washington follows:

Migrant Health Act funds in Washington; total in 1968-----	\$160, 453
Washington State migrant health project (MG-145): Statewide project providing consultant services in medical and dental care, nursing, sanitation, nutrition, and social work to local projects; coordination of services to migrants within the State; and stimulation of services in areas with large migrant populations. In addition, nursing care was provided in Yakima County and sanitation services were provided in Okanogan County-----	41, 957
Whatcom County migrant health project (MG-132): Medical, dental, nursing care, and sanitation services-----	23, 788
Skagit County migrant health project (MG-144): Medical, dental, and nursing care, hospitalization, sanitation services, health education, and social services-----	54, 384
Puyallup-Stuck Valley migrant health project (MG-19R): Medical and nursing care, sanitation services, and health education-----	40, 324
(Application pending) Okanogan County migrant health project (MG-11): (will function as a service component of the Washington State project). Medical, dental and nursing care, and sanitation services-----	1 24, 695

¹ Not included total.

Sincerely,

BERNARD BUCOVE,
M.D., *Director.*

STATE OF WISCONSIN,
DEPARTMENT OF HEALTH AND SOCIAL SERVICES,
Madison, Wis., December 22, 1967.

HON. HARRISON WILLIAMS,
*Chairman, Migrant Health Subcommittee,
New Senate Office Building, Washington, D.C.*

DEAR SENATOR WILLIAMS: AS Wisconsin's State Health Officer and Administrator of the Division of Health, Department of Health and Social Services, I would like to go on record in support of bill S. 2688 relating to the extension of the Migratory Health Act.

The migrant worker is a prototype group which is under-educated with respect to health, insulated by language from the culture which surrounds him, unable to afford major expenses, and kept by his tradition and work from the beneficial habits of hygiene and nutrition. If the health of this group is to be improved during the agricultural and food-processing season in Wisconsin then a continuation of the Migrant Health Act is necessary.

During the past four years migrant grants have enabled local communities to expand health services for the migrants in Wisconsin. Even though these projects are making progress in the health status and personal health practices of the migrant workers and their families, the number they reach is pitifully small.

Reports received from the projects show an increase in the utilization of medical and dental services over the past years. During the 1967 fiscal year 1,909 migrants made 3,403 medical and dental visits to the family health clinics. This represents only 7.7 percent of the migrant population receiving medical and dental services. This means that approximately 93 percent of the migrant population did not or could not obtain the necessary health services needed.

The enclosed report of the utilization of the Wisconsin Migrant Health Services will substantiate the need for an extension of, and an increase in, funds for the Migrant Health Act.

Sincerely,

E. H. JORRIS, M.D.,
State Health Officer.

A BRIEF REPORT OF WISCONSIN'S MIGRANT HEALTH PROGRAM, 1967

There are six areas of concentration of migrants in the State of Wisconsin, covering 30 counties. There were approximately 12,000 migratory workers employed during the seasonal agricultural and food-processing activities in

Wisconsin during 1967. The total estimated migratory population during the peak season was 24,767.

ESTIMATED POPULATION, 1967
[During Agricultural and Food-Processing Season]

	Project areas						Totals
	Beaver Dam	Endeavor	Door	Oconto	Waushara	UMOS ¹	
Counties served.....	3	1	2	3	6	15	30
Estimated population.....	3,650	890	4,113	639	11,998	3,477	24,767

¹ United Migrant Opportunity Services, Inc.

There are five formal Migrant Health Projects in the State of Wisconsin. Three (3) are supported by local, state and federal funds; and two (2) are voluntary programs supported locally.

The three health projects which are assisted by federal funds are those in Endeavor, operated by the Catholic Diocese of Madison; in Beaver Dam, operated by St. Joseph's Hospital; and in Wautoma, operated by the Waushara County Committee for Economic Opportunity. These programs were awarded a total sum of \$60,845 by the Public Health Service for the fiscal year July 1, 1967-June 30, 1968.

The federal funds authorized under the Migrant Health Act were used to continue and expand the medical and dental care programs, nursing services, in-hospital care, sanitation services, and health education for migrant agricultural workers and their families in the project areas.

The migrant allotment by project and compared with past fiscal years is as follows:

Project	1966-67	1967-68	Requested for 1968-69
Beaver Dam.....	\$8,654	\$16,410	\$18,960
Endeavor.....	19,709	23,730	24,058
Wautoma.....	12,705	20,705	30,808
Total.....	41,068	60,845	73,826

The two voluntary health projects are: the Oconto program, operated by voluntary groups from Oconto and Oconto Falls; and the Door County program, operated by voluntary groups and sponsored by the Catholic Apostolate of the Green Bay Diocese. The counties served by UMOS received no formal health services.

The migrant projects in Wisconsin were awarded \$13,200 (which was included in the total \$60,845 grant) for hospitalization. Of this sum, \$9,600 was allocated for in-hospital care and \$3,600 for physician in-hospital services.

Project	In-hospital care	Physician in-hospital care	Total allotment
Beaver Dam.....	\$1,700	\$300	\$2,000
Endeavor.....	3,000	1,400	4,400
Wautoma.....	4,900	1,900	6,800
Total.....	9,600	3,600	13,200

During the fiscal year July 1, 1966-June 30, 1967 the health care services (medical and dental), and for the first time in-patient hospitalization, was made available to 24,767 migrant people.

Of the total migrant population (24,767) only 1,538 received medical services. Approximately six percent received some type of medical services and 23,229 migrants (94% of pop.) did not receive any medical care.

Dental care was given to only 371 migrants, 1.7 percent of the total population. Eighty-four percent (84.0%) of those who received dental care were children

under 19 years of age. Ninety-eight percent (98.0%) of the total migrant population did not receive any dental care.

One-hundred seven (107) migrants were in-hospital patients at a cost of \$22,611.13, and only \$13,200.00 was allocated by the migrant hospital health grant. Even though part of the costs were paid for by County Welfare and Title XIX programs, there was still \$12,150.54 of outstanding hospital bills. The in-hospital portion of the Migrant Health Grants is inadequate as it only pays 58 percent of what balance is remaining after other state and local funds are exhausted.

For a complete picture of the utilization of the health services by the migrants offered by the five health projects, see Attachments #I, #II, and #III.

ATTACHMENT I

NUMBER MIGRANTS VISITING FAMILY HEALTH SERVICE CLINICS, 1967, WISCONSIN

	Number clinic sessions	Number clinic hours	Number clinic visits	Number individuals seen
Health clinics:				
Beaver Dam.....	25	60	667	391
Endeavor.....	40	132	718	413
Door.....	5	15	165	165
Oconto.....	2	5	56	56
Waushara.....	37	84	1,050	508
UMOS ¹	0	0	0	0
Total.....	109	296	2,656	1,533
Dental clinics:				
Beaver Dam.....	35	73	151	71
Endeavor.....	64	402	470	204
Door.....	0	0	0	0
Oconto.....	0	0	0	0
Waushara.....	25	62	126	96
UMOS ¹	0	0	0	0
Total.....	124	537	747	371

¹ United Migrant Opportunity Services, Inc.

ATTACHMENT II

NUMBER AND PERCENT OF MIGRANTS RECEIVING HEALTH SERVICES, WISCONSIN

Project	Number counties served	Estimated population	Number received medical services	Percent of population received medical services	Number ¹ received dental services	Percent of population received dental services
Beaver Dam.....	3	3,650	391	10.1	71	1.9
Endeavor.....	1	890	418	47.0	204	22.9
Door.....	2	4,113	165	4.0	0	0
Oconto.....	3	639	56	8.8	0	0
Waushara.....	6	11,998	508	4.2	96	.8
UMOS.....	15	3,477	0	0	0	0
Total.....	30	24,767	1,538	6.2	371	1.7

¹ 84 percent of those receiving dental care were children ages 2 to 19.

Note.—23,229 migrants did not receive any medical services—94 percent of population; 24,396 migrants did not receive any dental services—98 percent of population.

ATTACHMENT III

UTILIZATION OF IN-HOSPITAL AND PHYSICIAN IN-HOSPITAL CARE, WISCONSIN

Project	Number of patients	Paid in-hospital costs	Outstanding costs	Paid physician in-hospital costs	Outstanding physician in-hospital costs	Total costs
Beaver Dam.....	20	\$3,165.62	\$3,329.05	10	0	\$6,494.67
Endeavor.....	3	783.47	75.00	\$365.00	\$500.00	1,723.47
Wautoma.....	84	5,148.50	8,746.49	293.00	205.00	14,392.99
Total.....	107	9,097.59	12,150.54	658.00	705.00	22,611.13

¹ Beaver Dam, physicians donated their services.

² See the following table:

Wautoma	Number patients	Paid in-hospital costs	Outstanding in-hospital costs	Total costs
Self-pay migrants.....	27	\$2,110.10	\$508.45	\$2,618.55
Insurance.....	3	93.15	367.70	460.85
Migrant clinic.....	11	454.87	250.00	704.87
M. A. Prog. (title XIX).....	25	377.35	4,249.42	4,626.77
County welfare.....	18	2,567.90	3,505.17	6,073.07
Total.....	84	5,603.37	8,880.74	14,484.11

Senator WILLIAMS. Thank you very much, gentlemen.

Mr. GONZALEZ. Thank you.

Subsequent to the conclusion of the hearings, the following letter was received from Dr. Radebaugh:

THE UNIVERSITY OF ROCHESTER
SCHOOL OF MEDICINE AND DENTISTRY
AND STRONG MEMORIAL HOSPITAL,
Rochester, N.Y., January 25, 1968.

SENATE SUBCOMMITTEE ON MIGRATORY LABOR,
New Senate Office Building,
Washington, D.C.

GENTLEMEN: My testimony to the Senate Subcommittee on Migratory Labor on December 7, 1967 has aroused considerable controversy in Wayne County. The Curtice-Burns Company and the Wayne County physicians are justifiably upset.

In reference to the testimony concerning J. C. Gonzales, this was obtained shortly after forty men had left the Curtice-Burns Company in Bergen, N.Y. in Genesee County. This man, as the others, was upset and presented this check as evidence. Further information from the Curtice-Burns Company indicates that this man may have received another check for the same period. I understand that the Senate Subcommittee on Migratory Labor is in communication with the Curtice-Burns Company to clarify this matter.

In reference to the patient, Mr. John Cowart, who had difficulty in obtaining medical care in Wayne County, there is a need for me to correct some of my statements. Mr. Reginald Carter, who works for Basic Education for Adult Migrants, BEAM, was called to try to help Mr. Cowart obtain medical care. Mr. Carter informed me that he transported Mr. Cowart to three hospital emergency rooms, before he was able to find help. Two of these hospital emergency rooms have no record of seeing Mr. Cowart; the third referred him to the office of Drs. Reed and Davis. Dr. Davis, in Newark, New York, did, according to Mr. Carter, see Mr. Cowart, a fact unknown to me at the time of testimony. On the following day, Dr. Davis called the Veteran's Administration Hospital in Syracuse, New York to arrange for Mr. Cowart's admission.

Mr. Carter has been called upon to transport a number of seasonal workers for medical care; this patient is an example of some of the difficulties. However, it in no way absolves me from trying to obtain *all* of the facts before using material to illustrate a need.

I met with a number of Wayne County physicians and Dr. Davis, and was made aware of other details in relation to Mr. Cowart. I apologized to Dr. Davis for not realizing his interest and efforts on behalf of this patient.

This testimony to the Senate Subcommittee on Migratory Labor was used to illustrate a need for further medical efforts on behalf of the seasonal farm worker. It is not an attempt to reflect upon any one physician or group of physicians; for all of us as a profession, have a responsibility. Whether we are in a medical school setting or a practicing physician who extends major efforts in trying to provide care for the seasonal worker, we need to cooperate in making medical care more accessible to the seasonal worker. To accomplish this end more support is clearly needed to solve the serious problems presented to all responsible for health care.

Sincerely yours,

JOHN RADEBAUGH, M.D.

(Whereupon, at 1:24 p.m., the subcommittee adjourned subject to the call of the Chair.)

